Minimum Operating Standards For MI Health Link Program and MI Health Link HCBS Waiver

Michigan Department of Community Health

Medical Services Administration

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Definitions

Activities of Daily Living (ADLs): personal care services such as eating, grooming, dressing, bathing, toileting, mobility and transferring.

Instrumental Activities of Daily Living (IADLs): personal laundry, light housekeeping, shopping, meal preparation and cleanup, and medication administration.

Individual Integrated Care and Supports Plan (IICSP): the name of the person-centered plan for the MI Health Link program

Three-Way Contract: The Capitated Financial Alignment Demonstration contract signed by the Centers for Medicare and Medicaid Services (CMS), Michigan Department of Community Health (MDCH), and each Integrated Care Organization.

This document will be updated as needed to reflect any information changes for the MI Health Link program.

As used throughout this document, "ICO" refers to Integrated Care Organizations or the first tier downstream or related entities as per the Three-Way Contract and the contracts between the ICO and the first tier downstream or related entities.

I. Care Coordination

Once finalized, details about care coordination will be included in this document or as an Appendix.

II. Nursing Facility Level of Care Determination

1. ICOs must conduct the Michigan Medicaid Nursing Facility Level of Care Determination (NFLOCD) tool for all MI Health Link enrollees in nursing homes and those who are applying for the MI Health Link HCBS waiver.
2. ICOs must follow Michigan Medicaid NFLOCD policy and other guidance provided by MDCH.
3. ICOs must use the electronic or paper format of the tool and the Freedom of Choice form provided by MDCH until changes are made to the existing NFLOCD system to allow ICOs to use it.
4. ICOs must notify enrollees of the results of the NFLOCD and provide information about appeal rights in the event of negative determinations.
5. For the enrollees in MI Health Link nursing facilities and the MI Health Link HCBS waiver, the ICO must enter certain information from the NFLOCD tool into the NFLOC Determination page that is included in the Community Health Automated Medicaid Processing System (CHAMPS). The ICO must obtain access to CHAMPS and request the role and profile specifically associated with this NFLOC Determination page. The name of the profile is NFLOCD Tech. The following information will need to be added to the NFLOC Determination page based on information included in the completed NFLOCD tool.
    a. Medicaid ID (Member ID), Member Name
    b. ICO Provider ID, ICO Name
    c. NFLOCD Screening Results
        i. Nursing Facility NPI (if applicable)
        ii. Nursing Facility Name
        iii. NFLOCD status (choose the appropriate option from the drop-down menu):
            - Met
            - Not met
        iv. Qualifying Door

- 1 – Activities of Daily Living
- 2- Cognitive Performance
- 3- Physician Involvement
- 4 – Treatments and Conditions
- 5- Skilled Rehabilitation Therapies
- 6- Behavior
- 7- Service Dependency
- 8- Exception Review

v. NFLOCD Start Date
vi. NFLOCD End Date
vii. NFLOCD Completion Date
viii. Appeal Status (as applicable)
ix. Comments
x. NFLOCD Completed By

6. Once all necessary information has been entered on the NFLOC Determination page in CHAMPS, the ICO must submit the record for MDCH review and approval (done electronically by clicking “ok” on the “Add NFLOCD Details” page). The ICO will then need to update the record as needed based on any annual or periodic reassessment, or changes in NFLOCD status or condition. A new record must be created as needed if the individual meets NFLOC through a different door than indicated in the previously entered record. Any time a change is made on the NFLOC Determination page or a new record is added, this change must be electronically submitted to MDCH for approval. This submission to MDCH will happen automatically when “ok” is clicked in the “Add NFLOCD Details,” or “Save” is clicked in the “Manage NFLOCD Details” window.
7. When complete, the NFLOCD tool must be sent to MDCH for review and approval.
    a. For NFLOCDs completed for enrollees in nursing homes, the ICO must send the NFLOCD tool in an encrypted and/or password protected file to MSA-MHL-Enrollment@michigan.gov. The subject line for the email should be Nursing Home NFLOCD.
    b. For NFLOCDs completed for the MI Health Link HCBS waiver, ICOs must send the NFLOCD tool to MDCH electronically via the Waiver Support Application system or via hard copy paper format using U.S. Mail, United Postal Service, FedEx or fax.

III. State Plan Personal Care Services

Personal care services must be provided by the ICO according to procedures and protocol provided by the State. The following process and procedure codes must be followed for billing and submitting encounters for personal care services:

1. Use procedure code T1019 for personal care services, per 15 minute increments.
2. For personal care supplement payment:
    a. The ICO must use the invoice provided by MDCH. The ICO must give this invoice to Adult Foster Care and Homes for the Aged providers for billing purposes. This invoice will be returned to the ICO, and the ICO will pay the personal care supplement to the provider as appropriate. There must an invoice for each enrollee residing in one of these settings.
    b. The ICO will need to track the amount and date paid to the Adult Foster Care home or Home for the Aged for each enrollee.
    c. For personal care supplement payments, the ICO should use procedure code ”T1019” (personal care services, per 15-min increments) with modifier “CG” (policy criteria applied).
    d. The ICO may find Place of Service code “14” (Group Home) applicable in Loop 2300.
    e. The ICO must submit encounters for each enrollee based on the information on the invoice and using the codes provided by MDCH.
3. Encounters will require a diagnosis code as well. For ICD-9, MDCH recommends “V60.89” (Other specified housing or economic circumstances) or “V60.4” (No other household member able to render care). For ICD-10, MDCH recommends “Z74.1” (Need assistance with personal care) or “Z74.2” (No other household member able to render care).
4. Additional information about the personal care benefit was provided to ICOs in draft form. Once this information has been finalized, it will be added to this Minimum Operating Standards document as an appendix.

IV. Level of Care Codes

MDCH has assigned specific level of care codes for the MI Health Link program. These are as follows:

Level of Care Code	Description	Associated Rate Tier
07	General managed care population in the community	Tier 3
03	Individual meets nursing facility level of care, lives in the community, and participates in the MI Health Link HCBS home and community-based services waiver program	Tier 2
05	Resident of any nursing facility or hospital long term care unit (private or county owned) that is not a County Medical Care Facility	Tier 1 (Subtier A)
15	Resident of a County Medical Care Facility	Tier 1 (Subtier B)

V. Critical Incident Reporting

The ICO must report critical incidents to MDCH and other required authorities according to state policies and processes and as approved in the MI Health Link HCBS waiver application.

The types of critical incidents that MDCH requires to be reported for review and follow-up action are:

1. Exploitation - An action by an employee, volunteer, or agent of a provider that involves the misappropriation or misuse of an enrollee's property or funds for the benefit of an individual or individuals other than the enrollee.

2. Illegal activity in the home with potential to cause a serious or major negative event – Any illegal activity in the home that puts the enrollee or the providers coming into the home at risk.

3. Neglect - Acts of commission or omission by an employee, volunteer, or agent of a provider that result from noncompliance with a standard of care or treatment required by law or rules, policies, guidelines, written directives, procedures, or Individual Integrated Care and Supports Plans that cause or contribute to non-serious physical harm or emotional harm,

death, or sexual abuse of, serious physical harm to an enrollee, or the intentional, knowing or reckless acts of omission or deprivation of essential needs (including medication management).

4. Physical abuse - The use of unreasonable force on an enrollee with or without apparent harm. Includes unreasonable confinement (physical or chemical restraints, seclusion, and restrictive interventions).

5. Provider no shows - Instances when a provider is scheduled to be at an enrollee’s home but does not come and back-up service plan is either not put into effect or fails to get an individual to the enrollee’s home in a timely manner. This becomes a critical incident when the enrollee is bed bound or in critical need and is dependent on others.

6. Sexual abuse - (i) Criminal sexual conduct as defined by sections 520b to 520e of 1931 PA 318, MCL 750.520b to MCL 750.520e involving an employee, volunteer, or agent of a provider and an enrollee.

   a. Any sexual contact or sexual penetration involving an employee, volunteer, or agent of a department operated hospital or center, a facility licensed by the department under section 137 of the act or an adult foster care facility and an enrollee.

   b. Any sexual contact or sexual penetration involving an employee, volunteer, or agent of a provider and an enrollee for whom the employee, volunteer, or agent provides direct services.

   "Sexual contact" means the intentional touching of the enrollee's or employee's intimate parts or the touching of the clothing covering the immediate area of the enrollee's or employee's intimate parts, if that intentional touching can reasonably be construed as being for the purpose of sexual arousal or ratification, done for a sexual purpose, or in a sexual manner for any of the following:

   1. Revenge.
   2. To inflict humiliation.
   3. Out of anger.

   "Sexual penetration" means sexual intercourse, cunnilingus, fellatio, anal intercourse, or any other intrusion, however slight, of

any part of a person's body or of any object into the genital or anal openings of another person's body, but emission of semen is not required.

7. Theft - A person intentionally and fraudulently takes personal property of another without permission or consent and with the intent to convert it to the taker's use (including potential sale).

8. Verbal abuse - Intimidation or cruel punishment that causes or is likely to cause mental anguish or emotional harm.

9. Worker consuming drugs or alcohol on the job – Use of any drugs or alcohol that would affect the abilities of the worker to do his or her job.

10. Suspicious or Unexpected Death - That which does not occur as a natural outcome to a chronic condition (e.g., terminal illness) or old age. These incidents are often also reported to law enforcement.

11. Medication errors - Wrong medication, wrong dosage, double dosage, or missed dosage which resulted in death or loss of limb or function or the risk thereof.

The ICO has first line responsibility for identifying, investigating, evaluating and follow-up of critical incidents that occur with enrollees as listed above. The ICO maintains policies and procedures defining appropriate actions to take upon suspicion or determination of abuse, neglect and exploitation. The ICO establishes local reporting procedures, based on MDCH requirements, for all complaints and critical incidents that jeopardize or potentially jeopardize the health and welfare of enrollees conveyed and detected by The ICO, provider agencies, individual workers, independent supports brokers and enrollees and their allies. MDCH reviews and approves these reporting procedures.

Michigan Public Act 519 of 1982 (as amended) and MCL 400.11a(1) mandate that all human service providers and health care professionals make referrals to the Department of Human Services Adult Protective Services (DHS-APS) unit as soon as possible when the professional suspects or believes an adult is being abused, neglected, or exploited. The Vulnerable Adult Abuse Act (P.A. 149 of 1994) creates a criminal charge of adult abuse for vulnerable adults harmed by a caregiver. The ICO also must report suspected financial abuse per the Financial Abuse Act (MCL 750.174a). Policies and procedures that

ICOs develop must include procedures for follow up activities with DHS-APS to determine the result of the reported incident and next steps to be taken if the results are unsatisfactory. All reports of the suspected abuse, neglect or exploitation, as well as the referral to DHS-APS, must be maintained in the enrollee's case record.

The ICO should begin to investigate and evaluate critical incidents with the enrollee within two business days of identification that an incident occurred. Suspicious or unexpected death that is also reported to law enforcement agencies must be reported to MDCH within two business days.

The ICO is responsible for tracking and responding to individual critical incidents using the MI Health Link Critical Incident Reporting system. The ICO is required to report the types of critical incidents and the responses to those incidents for each event within 30 days of the date of incident. Outcomes and resolutions for each incident must be reported within 30 days of the date of the incident if possible. If outcomes or resolutions extend beyond 30 days, ICOs must provide periodic updates in the system until the matter is resolved. The online system allows MDCH to review the reports in real time and ask questions or address concerns with the ICO.

The ICO manages critical incidents at the local level. The ICO is responsible to receive reports of critical incidents and ensure the immediate health and welfare of the enrollee. The ICO must also report to the following entities if the incident was not already reported to these entities:

1. Exploitation - Required to report to DHS-APS, MDCH

2. Neglect - Required to report to DHS-APS, MDCH

3. Verbal abuse - Required to report to DHS-APS, MDCH

4. Physical abuse - Required to report to DHS-APS, MDCH

5. Sexual abuse - Required to report to DHS-APS, MDCH

6. Theft - MDCH

7. Provider no shows, particularly when enrollee is bed bound all day or there is a critical need - MDCH

8. Illegal activity in the home with potential to cause a serious or major negative event - local authorities/police, MDCH

9. Worker consuming drugs/alcohol on the job - MDCH

10. Suspicious or Unexpected Death - Death should be reported to law enforcement if it is a suspicious death possibly linked to abuse or neglect. These types of incidents must also be reported to MDCH within two business days of the ICO receiving the notice.

11. Medication errors - MDCH

The ICO must begin to investigate and evaluate critical incidents with the enrollee within two business days of identification that an incident occurred. The ICO is expected to investigate a critical incident until the enrollee is no longer in danger and until the situation is resolved. This may include a removal of the service provider effective the date of the incident or it may involve securing an alternate guardian for the enrollee, which may take several weeks or months. For this reason, MDCH does not require cases be resolved within a specific timeframe. Cases are only resolved when the enrollee's health and welfare is assured to the extent possible given the enrollee's informed choice for assuming risks. However, MDCH expects to see an attempt at a resolution within 60 days from the date the incident is reported. If the ICO does not appear to be resolving the issue in a timely manner, MDCH will contact the ICO to get additional information and provide assistance in resolving the critical incident when possible.

The ICO is required to maintain written policy and procedures defining appropriate action to take upon suspicion of abuse, neglect or exploitation. This includes identifying and evaluating each incident, initiating prevention strategies and interventions approved by enrollees to reduce or ameliorate further incidents, and follow-up, track, and compile mandatory critical incident reports. The policies and procedures must include procedures for follow-up activities with DHS-APS and law enforcement to determine the result of the reported incident and the next steps to be taken if the results are unsatisfactory. To the extent possible given confidentiality and security concerns covered under Michigan law, the ICO must notify MDCH via the critical incident reporting system whether the incident was reported to DHS-APS or other entities as required by the State.

The enrollee and any chosen family or allies are updated on the investigation as it progresses. The ICO shall communicate with the enrollee and family or allies at a minimum of monthly via telephone, but more often as updates or actions occur with the critical incident. Remediation of a critical incident often includes changing services or providers. Care coordinators use a person-centered planning approach with enrollees when suggesting and selecting various options to ensure the health and welfare of enrollees.

For enrollees who are also receiving supports and services through the PIHP for behavioral health, intellectual/developmental disability, or substance use needs, the ICO is required to obtain critical incident reporting information on a monthly basis for any MI Health Link enrollees for critical incidents reported by the PIHP via the critical incident reporting system that exists between PIHPs and MDCH. The ICO is required to ensure the incidents have been investigated as appropriate. Immediately after being notified that an incident occurred, the PIHP must report to the ICO any of the critical incident types mentioned above that are not already being reported through the PIHP's critical incident reporting system, the Office of Recipient Rights, DHS- APS, or LARA.

MDCH evaluates and trends the incident reports submitted by the ICO. Analysis of the strategies employed by the ICO in an attempt to reduce or ameliorate incidents from reoccurring is conducted to ensure that adequate precautions and preventative measures were taken. Training is provided to the ICO as necessary to educate staff on abuse and to strengthen preventive interventions and strategies. The ICO must complete the critical incident training module(s) provided by MDCH.

In addition to this Minimum Operating Standards document, materials and resources for critical incident reporting may be found at:

Michigan Department of Human Services - Adult Protective Services:
http://www.michigan.gov/dhs/0,4562,7-124-7119-15663--,00.html.

Michigan Department of Licensing and Regulatory Affairs:
http://www.michigan.gov/lara/0,4601,7-154-35299_63294---,00.html.

Michigan Department of Human Services – Bureau of Child and Adult Licensing:

http://www.michigan.gov/dhs/0,4562,7-124-5455_27716_27721-80945--,00.html.

VI. MI Choice/PACE Transitions to MI Health Link

1. If MI Choice or PACE participants express a desire to disenroll from MI Choice or PACE to join MI Health Link, MDCH will coordinate the transfer of individuals from MI Choice/PACE to MI Health Link, but MDCH will evaluate each specific case prior disenrolling the individual from their program.
2. MDCH will review the current plan of service, nursing facility level of care determination, and other assessment documentation to determine if the individual's needs may be met in MI Health Link without the individual losing Medicaid eligibility. Additionally, residential and non-residential settings will be evaluated by MDCH to ensure immediate compliance with the HCBS Final Rule.
3. If, after the case evaluation by MDCH, the individual would still like to enroll in MI Health Link and qualifies for the MI Health Link HCBS waiver, MDCH will enroll the individual in the waiver with his or her chosen ICO. MDCH will communicate the waiver enrollment to the ICO, and the ICO will provide the necessary services according to the individual's MI Choice/PACE records and MDCH's recommendations until a new Level II assessment is due (one year after the start date on the MI Choice/PACE assessment) or the individual has a significant change in condition. The ICO is not required to conduct a new Level II assessment and NFLOCD immediately after the individual enrolls in MI Health Link.

VII. Training

The ICO and other providers must complete required training as identified by MDCH. Trainings will be added to the protocol as they are developed.

VIII. Hospice Services

The ICO is not responsible for coverage of hospice services. If an enrollee elects to receive hospice services, the enrollee will be disenrolled from the ICO effective the last day of the same month in which he or she begins hospice services. For example, if the ICO enrollee elects to receive hospice services on March 15, he or she will be disenrolled from MI Health Link effective April 1.

The ICO is responsible for non-hospice related care until the individual disenrolls from the ICO. In the MI Health Link regions after disenrollment from the ICO, the individual's options for Medicaid services will be fee-for-service. Medicare will cover the hospice services as well as any other non-hospice related services traditionally covered by Medicare. Individuals will not be eligible for the MI Health Link program as long as they continue to receive hospice care.

IX. Supplemental Services

These services are available to individuals who do not meet nursing facility level of care or are not enrolled in the MI Health Link HCBS waiver.

Adaptive Medical Equipment and Supplies	
Description	Devices, controls, or appliances specified in the Individual Integrated Care and Supports Plan (IICSP) that enable enrollees to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment and medical supplies not available under the Medicaid state plan and Medicare that are necessary to address enrollee functional limitations. All items shall meet applicable standards of manufacture, design, and installation. This will also cover the costs of maintenance and upkeep of equipment. The coverage includes training the enrollee or caregivers in the operation and/or maintenance of the equipment or the use of a supply when initially purchased.
HCPCS Codes	Please see the list indicated below.
Units	Per item, unless otherwise specified.
Service Delivery Options	☑ Traditional ☐ Self-Determination

Minimum Standards for Service Delivery

1. It must be documented on the Individual Integrated Care and Supports Plan (IICSP) or Care Bridge record that the item is the most cost-effective alternative to meeting the enrollee's needs.
2. Items must meet applicable standards of manufacture, design, and installation.
3. There must be documentation on the IICSP or Care Bridge record that the best value in warranty coverage was obtained at the time of purchase.
4. Items must be of direct medical or remedial benefit to the enrollee, and this benefit must be documented in the enrollee's record.
5. Liquid nutritional supplement orders must be renewed every six months by a physician, physician's assistant, or nurse practitioner (in accordance with scope of practice).
6. Each direct service provider must enroll in Medicare and/or Medicaid as a Durable Medical Equipment provider, pharmacy, etc., as appropriate. This must be verified at the beginning of service delivery and annually thereafter.
7. The ICO may obtain some items directly from a retail store that offers the item to the general public (i.e. Wal-Mart, K-mart, Meijer, Costco, etc.). When utilizing retail stores, the ICO must assure the item purchased meets the service standards. The ICO may choose to open a business account with a retail store for such purchases. The ICO must maintain the original receipts and maintain accurate systems of accounting to verify the specific enrollee who received the purchased item.
8. Where feasible, the ICO and/or direct service provider shall seek confirmation of the need for the item from the enrollee's physician.
9. The ICO shall not authorize payment for herbal remedies, nutraceuticals, and/or other over-the-counter medications for uses not authorized by the FDA.
10. Some examples (not an exhaustive list) of these items would be shower chairs/benches, lift chairs, raised toilet seats, reachers, jar openers, transfer seats, bath lifts/room lifts, swivel discs, bath aids such as long handle scrubbers, telephone aids, automated telephones or watches that assist with medication reminders, button hooks or zipper pulls, modified eating utensils, modified oral hygiene aids, modified grooming tools, heating pads, sharps containers, exercise items and other therapy items, voice output blood pressure monitor, nutritional supplements such as Ensure, specialized turner or pointer, mouth stick for TDD, foot massaging unit, talking timepiece, adaptive eating or drinking device, book holder, medical alert bracelet, adapted mirror, weighted blanket, and back knobber.

11. The following HCPCS codes are approved for use under the Adaptive Medical Equipment and Supplies service:

    a. **A4931**, Oral Thermometer, Reusable, any type, each
    b. **A4932**, Rectal Thermometer, Reusable, any type, each
    c. **A9300**, Exercise Equipment
    d. **B4100**, Food thickener, administered orally, per ounce
    e. **B4150/BO**, Enteral Formulae; Category 1; Semi-synthetic Intact Protein/Protein isolates, administered thru an enteral feeding tube, 100 calories=1unit
        i. The ICO must use the BO modifier to indicate oral administration. The state plan covers formulae for tube feeding.
        ii. This product may be in any form, liquid, solid, powder, bar, etc.
        iii. For cans of nutritional supplement, one can equals one unit.
        iv. For bars of nutritional supplement, one bar equals one unit.
    f. **E0160**, Sitz type bath or equipment, portable, used with or without commode
    g. **E0161**, Sitz type bath or equipment, portable, used with or without commode, with faucet attachment
    h. **E0210**, Electric heat pad, standard
    i. **E0215**, Electric heat pad, moist
    j. **E0241**, Bathtub wall rail, each
    k. **E0242**, Bathtub rail, floor base
    l. **E0243**, Toilet rail, each
    m. **E0244**, Raised toilet seat
    n. **E0245**, Tub stool or bench
    o. **E0315**, Bed accessory; board, table, or support device, any type
    p. **E0627**, Seat lift mechanism incorporated into a combination lift chair mechanism
    q. **E0628**, Separate seat lift mechanism for use with patient owned furniture, electric
    r. **E0629**, Separate seat lift mechanism for use with patient owned furniture, non-electric
    s. **E0745** Neuromuscular stimulator, electronic shock unit
    t. **E1300** Whirlpool, portable (over the tub type)
    u. **E1310** Whirlpool, non-portable (built-in type)
    v. **E1639**, Scale, each
    w. **S5162**, Emergency response system; purchase only
    x. **S5199**, Personal care item, NOS, each
        i. Use this code for items that the enrollee uses to perform activities of daily living (ADLs) or instrumental activities of daily living (IADLs), or that assist the enrollee in the performance of ADLs or IADLs.

   ii. This category shall exclude items such as shampoo, soap, toothpaste, toothbrushes, dent-tips, shaving cream, and razors.
   iii. The ICO must include a description of this item in the appropriate loop for approval of a claim.
   iv. Standardized remarks are available.

y. **T1999**, Misc. Therapeutic items & supplies, retail purchases, NOC, identify product in “remarks”
   i. Items in this category have a therapeutic use for the enrollee.
   ii. The ICO must include a description of this item in the appropriate loop for approval of a claim.
   iii. Standardized remarks are available.
   iv. Does not include items specified under the Assistive Technology service

z. **T2028**, Specialized supply, NOS, waiver
   i. Items in this category include specialized supplies that the Medicaid state plan does not cover.
   ii. This may include items that do not meet the “medically necessary” standard for state plan coverage, or quantities above state plan coverage.
   iii. The ICO must include a description of this item in the appropriate loop for approval of a claim.
   iv. Standardized remarks are available.

aa. **T2029**, Specialized medical equipment, NOS, waiver
   i. Items in this category include specialized equipment that the Medicaid state plan does not cover, or does not cover for adults.
   ii. This may include items that do not meet the “medically necessary” standard for state plan coverage.
   iii. The ICO must include a description of this item in the appropriate loop for approval of a claim.
   iv. Standardized remarks are available.

Community Transition Services	
Description	This service includes non-reoccurring expenses for enrollees transitioning from a nursing facility to another residence where the enrollee is responsible for his or her own living arrangement.
HCPCS Codes	**T1028** Assessment of home, physical and family environment, to determine suitability to meet enrollee's medical needs **T2038** Community Transition, waiver; per service
Units	T1028, per encounter T2038, per service
Service Delivery Options	☑ Traditional ☐ Self-Determination

Minimum Standards for Service Delivery

1. Allowable transition costs include the following:
   i. Housing or security deposits; A one-time expense to secure housing or obtain a lease.
   ii. Utility hook-ups and deposits: A one-time expense to initiate and secure utilities (television and internet are excluded).
   iii. Furniture, appliances, and moving expenses: One-time expenses necessary to occupy and safely reside in a community residence (diversion or recreational devices are excluded).
   iv. Cleaning: A one-time cleaning expense to assure a clean environment, including pest eradication, allergen control, and over-all cleaning.
   v. Coordination and support services: To facilitate transitioning of enrollee to a community setting.
   vi. Other services deemed necessary and documented within the enrollee's plan of service to accomplish the transition into a community setting. Excludes ongoing monthly rental or mortgage expense, regular utility charges, or items that are intended for purely diversional or recreational purposes.
2. The timeframes associated with this service may be extended in unique circumstances that require additional support and coordination efforts.

3. The ICO may obtain some items directly from a retail store that offers the item to the general public (i.e. Wal-Mart, K-mart, Meijer, Costco, etc.). When utilizing retail stores, the ICO must assure the item purchased meets the service standards. The ICO may choose to open a business account with a retail store for such purchases. The ICO must maintain the original receipts and maintain accurate systems of accounting to verify the specific enrollee who received the purchased item.
4. Person-centered planning must be used throughout the entire community transition process.
5. Providers may bill for assessments of potential residential settings using HCPCS code T1028. The ICO may use this code more than once per transition, **but the federal government limits use to one unit per day.** This service includes supports and coordination provided by a knowledgeable health professional (i.e. physical therapist or occupational therapist) during the assessment of the potential residential setting. HCPCS code T1028 is a per encounter code. This health professional cannot be a paid staff member of the ICO. When ICO staff provides the assessment of the home, this is considered a regular care coordination function.
6. When an ICO authorizes more than one potential home assessment for an enrollee per transition, the units shall equal no more than one per day, regardless of the number of assessments completed. The cost shall equal the total cost of all assessments.
7. The ICO shall report all other transition services using HCPCS code T2038 with the appropriate standard remark for each transition service. A listing of standard remarks is provided at the end of this document. When a transitioning enrollee requires a transition service that does not have an appropriate standard remark, the ICO shall contact MDCH for assistance. The ICO shall s report encounters under HCPCS code T2038 that are provided after the first date of waiver enrollment using the date of service delivery as the billed date of service.
8. When an ICO anticipates that a nursing facility resident receiving CTS will require MI Health Link HCBS waiver services in the community, the ICO shall make necessary arrangements and apply for waiver enrollment for that person. CMS requires the ICO to authorize all CTS to persons expected to enroll in the waiver upon transition. Therefore, an ICO or entity under contract with an ICO shall perform all transition activity for a nursing facility resident expected to enroll in the waiver upon transition.
9. Using a person-centered planning process, the ICO must develop a transition plan that includes all enrollee goals, and is based on individual needs. This transition plan becomes part of

the enrollee's case record maintained by the ICO and must minimally include the following elements:

a. Nursing facility resident name.
b. Nursing facility resident identifying information including Social Security Number and Medicaid ID number.
c. Name and address of nursing facility in which the resident resides.
d. Date of initial contact.
e. Estimated date of transition to the community and the waiver.
f. Needed or anticipated Community Transition Services.
g. Enrollee goals and expected outcomes of community transition.
h. Dated signature of enrollee or legal representative.
i. Dated signature of care coordinator assisting with the development of the plan.

10. For persons expected to enroll in the MI Health Link HCBS waiver, when a transitioning enrollee requires a home modification (ramp, widened doorways, etc.) before the transition can take place, the ICO shall authorize only those modifications immediately necessary for community transition as CTS. The ICO shall authorize all other needed modifications as Environmental Modifications services or Chore services through the waiver, as appropriate.
11. The ICO shall begin CTS no more than six months before the expected discharge from the nursing facility.

Personal Emergency Response System (PERS)	
Description	This electronic device enables enrollees to secure help in an emergency. The enrollee may also wear a portable "help" button to allow for mobility. The system is connected to the enrollee's phone and programmed to signal a response center once a "help" button is activated.
HCPCS Codes	**S5160**, Emergency response system; installation and testing **S5161**, Emergency response system; service fee, per month (excludes installation and testing)
Units	S5160, per installation S5161, per month
Service Delivery Options	☑ Traditional ☐ Self-Determination

Minimum Standards for Service Delivery

1. The Federal Communication Commission must approve the equipment used for the response system. The equipment must meet UL® safety standards 1637 specifications for Home Health Signaling Equipment.
2. The provider may offer this service for cellular or mobile phones and devices. The device must meet industry standards. The enrollee must reside in an area where the cellular or mobile coverage is reliable. When the enrollee uses the device to signal and otherwise communicate with the PERS provider, the technology for the response system must meet all other service standards.
3. The provider must assure at least monthly testing of each PERS unit to assure continued functioning.
4. PERS does not cover monthly telephone charges associated with phone service.
5. PERS is limited to persons who either live alone or who are left alone for significant periods of time on a routine basis and who could not summon help in an emergency without this device. The ICO may authorize PERS units for persons who do not live alone if both the waiver enrollee and the person with whom they reside would require extensive routine supervision

without a PERS unit in the home. An example of this is two individuals who live together and both are physically and/or cognitively unable to assist the other individual in the event of an emergency.

6. The provider must staff the response center with trained personnel 24 hours per day, 365 days per year. The response center will provide accommodations for persons with limited English proficiency.
7. The response center must maintain the monitoring capacity to respond to all incoming emergency signals.
8. The response center must have the ability to accept multiple signals simultaneously. The response center must not disconnect calls for a return call or put in a first call, first serve basis.
9. The provider will furnish each responder with written instructions and provide training, as appropriate.

Respite (provided at the enrollee's home or in the home of another person)	
Description	Respite care services are provided on a short-term, intermittent basis to relieve the enrollee's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care.
HCPCS Codes	**S5150**, Unskilled respite care, not hospice, per 15 minutes **S5151**, Unskilled respite care, not hospice, per diem
Units	S5150 = 15 minutes S5151 = per diem
Service Delivery Options	☑ Traditional ☐ Self-Determination

Minimum Standards for Traditional Service Delivery

1. Enrollees choosing the traditional method of service delivery **may not** choose to have respite furnished in the home of another.

2. The ICO must establish and follow written eligibility criteria for in-home respite that include, at a minimum:
   a. Enrollees must require continual supervision to live in their own homes or the home of a primary caregiver, or require a substitute caregiver while their primary caregiver needs relief or is otherwise unavailable.
   b. Enrollees have difficulty performing or are unable to perform ADLs without assistance.
3. Respite services include:
   a. Attendant care (enrollee is not bed-bound) such as companionship, supervision, and/or assistance with toileting, eating, and ambulation.
   b. Basic care (enrollee may or may not be bed-bound) such as assistance with ADLs, a routine exercise regimen, and self-medication.
4. The direct service provider must obtain a copy of appropriate portions of the assessment conducted by the ICO before initiating service. The assessment information must include a recommendation made by the assessing individual describing the respite support services the enrollee needs. Each ICO or direct service provider shall ensure the skills and training of the respite provider assigned are appropriate for the condition and needs of the enrollee.
5. With the assistance of the enrollee and/or enrollee's caregiver, the ICO or direct service provider shall determine an emergency notification plan for each enrollee, pursuant to each visit for emergencies and provider no-shows or late arrivals.
6. Each direct service provider shall establish written procedures that govern the medication assistance given by staff to enrollees. These procedures shall be reviewed by a consulting pharmacist, physician, or registered nurse and shall include, at a minimum:
   a. The provider staff authorized to assist enrollees with taking their own prescription or over-the-counter medications and the conditions under which such assistance may take place. This must include a review of the type of medication the enrollee takes and its impact upon the enrollee.
   b. Verification of prescription medications and their dosages. The enrollee shall maintain all medications in their original, labeled containers.
   c. Instructions for entering medication information in enrollee files.
   d. A clear statement of the enrollee's and his or her family's responsibility regarding medications taken by the enrollee and the provision for informing the enrollee and the enrollee's family of the provider's procedures and responsibilities regarding assisted self-administration of

medications.

7. Each direct service provider shall employ a professionally qualified supervisor that is available to staff during their shift while providing respite care.
8. Members of an enrollee's family who are not the enrollee's regular caregiver may provide respite for the regular caregiver. However, the ICO shall not authorize funds to pay for services furnished to an enrollee by that person's spouse.
9. Family members who provide respite services must meet the same standards as providers who are unrelated to the enrollee.
10. Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work elsewhere full time.
11. Respite is limited to 14 overnight stays per 365 days. The ICO may provide more Respite services as a flexible benefit or on a case by case basis.
12. Respite services cannot be scheduled on a daily basis
13. Respite should be used on an intermittent basis to provide scheduled relief of informal caregivers
14. Members of an enrollee's family who are not the enrollee's regular caregiver may provide respite for the regular caregiver. However, the ICO shall not authorize waiver funds to pay for services furnished to an enrollee by that person's spouse.
15. The costs of room and board are not included.
16. For enrollees receiving respite services through the PIHP, they must first exhaust the respite benefit through the PIHP before using this respite service as an ICO supplemental service.

Respite (provided outside of the home)	
Description	Respite care services are provided on a short-term, intermittent basis to relieve the enrollee's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care. Respite services may be provided in a licensed Adult Foster Care or Home for the Aged facility. Respite may include the cost of room and board if the service is provided in a licensed Adult Foster Care home or licensed Home for the Aged.
HCPCS Codes	**H0045**, Respite services not in the home, per diem
Units	H0045 = per day
Service Delivery Options	☑ Traditional ☐ Self-Determination

Minimum Standards for Traditional Service Delivery

1. Each out of home respite service provider must be a licensed group home as defined in MCL 400.701ff, which includes adult foster care homes and homes for the aged.
2. Each ICO must establish and follow written eligibility criteria for out-of-home respite that include, at a minimum:

    a. Enrollees must require continual supervision to live in their own homes or the home of a primary caregiver, or require a substitute caregiver while their primary caregiver needs relief or is otherwise unavailable.
    b. Enrollees have difficulty performing or are unable to perform activities of daily living without assistance.
3. Respite services include:
    a. Attendant care (enrollee is not bed-bound) such as

companionship, supervision and/or assistance with toileting, eating, and ambulation.

b. Basic care (enrollee may or may not be bed-bound) such as assistance with ADLs, a routine exercise regimen, and self-medication.

4. The direct service provider must obtain a copy of the assessment conducted by the ICO before initiating service. The assessment information must include a recommendation made by the assessing individual describing the respite care support services the enrollee needs.
5. With the assistance of the enrollee and/or enrollee's caregiver, the ICO and/or direct service provider shall determine an emergency notification and contingency plan for each enrollee for emergencies.
6. Each direct service provider shall establish written procedures to govern assistance given by staff to enrollees who need help with medications. These procedures shall be reviewed by a consulting pharmacist, physician, or registered nurse and shall include, at a minimum:
   a. The provider staff authorized to assist enrollees in taking either prescription or over- the-counter medications and under what conditions such assistance may take place. This must include a review of the type of medication the enrollee takes and its impact upon the enrollee.
   b. Verification of prescription medications and their dosages. The enrollee shall maintain all medications in their original, labeled containers.
   c. Instructions for entering medication information in enrollee files.
   d. A clear statement of the enrollee's and his or her family's responsibility regarding medications taken by the enrollee while at the facility and the provision for informing the enrollee and his or her family of the program's procedures and responsibilities regarding assisted self-administration of medications.
7. Each direct service provider shall employ a professionally qualified program director that directly supervises program staff.
8. Respite is limited to 14 overnight stays per 365 days. The ICO may provide more Respite services as a flexible benefit.
9. MDCH does not intend Respite services to be furnished on a continual basis. Respite services should be utilized for the sole purpose of providing temporary, intermittent relief to an unpaid caregiver. When a caregiver is unable to furnish unpaid medically-necessary services on a regular basis, the ICO should work with the enrollee and caregiver to develop a plan of service that includes other waiver services, as appropriate.
10. Respite services cannot be continually scheduled on a daily basis.

Out of home respite may be scheduled for several days in a row, depending upon the needs of the enrollee and the enrollee's caregivers.

11. For enrollees receiving respite services through the PIHP, they must first exhaust the respite benefit through the PIHP before using this respite service as an ICO supplemental service.

MI Health Link HCBS Waiver

I. Eligibility

The individual must:

- -be enrolled in the MI Health Link program,
- -meet nursing facility level of care as determined by Michigan's Medicaid Nursing Facility Level of Care Determination tool,
- -have a need for one or more of the 15 services listed below.

Individuals must receive at least one waiver service each month to remain on the waiver.

II. Services

The ICO and direct service providers must adhere to the definition and operating standards to be eligible to receive payment of waiver expenses.

Adaptive Medical Equipment and Supplies	
Description	Devices, controls, or appliances specified in the IICSP that enable enrollees to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment and medical supplies not available through the ICO under the Medicaid state plan and Medicare that are necessary to address enrollee functional limitations. All items shall meet applicable standards of manufacture, design, and installation. This will also cover the costs of maintenance and upkeep of equipment. The coverage includes training the enrollee or caregivers in the operation and/or maintenance of the equipment or the use of a supply when initially purchased.
HCPCS Codes	Please see the list indicated below.

Units	Per item, unless otherwise specified.
Service Delivery Options	☑ Traditional ☐ Self-Determination

Minimum Standards for Service Delivery

1. It must be documented on the IICSP or case record that the item is the most cost-effective alternative to meeting the enrollee’s needs.
2. Items must meet applicable standards of manufacture, design, and installation.
3. There must be documentation on the IICSP or case record that the best value in warranty coverage was obtained at the time of purchase.
4. Items must be of direct medical or remedial benefit to the enrollee, and this benefit must be documented in the IICSP.
5. Liquid nutritional supplement orders must be renewed every six months by a physician, physician’s assistant, or nurse practitioner (in accordance with scope of practice).
6. Each direct service provider must enroll in Medicare and/or Medicaid as a Durable Medical Equipment provider, pharmacy, etc., as appropriate. This must be verified at the beginning of service delivery and annually thereafter.
7. The ICO may obtain some items directly from a retail store that offers the item to the general public (i.e. Wal-Mart, K-mart, Meijer, Costco, etc.). When utilizing retail stores, the ICO must assure the item purchased meets the service standards. The ICO may choose to open a business account with a retail store for such purchases. The ICO must maintain the original receipts and maintain accurate systems of accounting to verify the specific enrollee who received the purchased item.
8. Where feasible, the ICO and/or direct service provider shall seek confirmation of the need for the item from the enrollee’s physician.
9. The ICO shall not authorize waiver payment for herbal remedies, nutraceuticals, and/or other over-the-counter medications for uses not authorized by the FDA.
10. Some examples (not an exhaustive list) of covered items would be shower chairs/benches, lift chairs, raised toilet seats, reachers, jar openers, transfer seats, bath lifts/room lifts, swivel discs, bath aids such as long handle scrubbers, telephone aids, automated telephones or watches that assist with medication reminders, button hooks or zipper pulls, modified eating utensils, modified oral hygiene aids, modified grooming tools,

heating pads, sharps containers, exercise items and other therapy items, voice output blood pressure monitor, nutritional supplements such as Ensure, specialized turner or pointer, mouthstick for TDD, foot massaging unit, talking timepiece, adaptive eating or drinking device, book holder, medical alert bracelet, adapted mirror, weighted blanket, and back knobber.

11. The following HCPCS codes are approved for use under the Adaptive Medical Equipment and Supplies service:

    a. **A4931**, Oral Thermometer, Reusable, any type, each
    b. **A4932**, Rectal Thermometer, Reusable, any type, each
    c. **A9300**, Exercise Equipment
    d. **B4100**, Food thickener, administered orally, per ounce
    e. **B4150/BO**, Enteral Formulae; Category 1; Semi-synthetic Intact Protein/Protein isolates, administered thru an enteral feeding tube, 100 calories=1unit
        i. The ICO must use the BO modifier to indicate oral administration. The state plan covers formulae for tube feeding.
        ii. This product may be in any form, liquid, solid, powder, bar, etc.
        iii. For cans of nutritional supplement, one can equals one unit.
        iv. For bars of nutritional supplement, one bar equals one unit.
    f. **E0160**, Sitz type bath or equipment, portable, used with or without commode
    g. **E0161**, Sitz type bath or equipment, portable, used with or without commode, with faucet attachment
    h. **E0210**, Electric heat pad, standard
    i. **E0215**, Electric heat pad, moist
    j. **E0241**, Bathtub wall rail, each
    k. **E0242**, Bathtub rail, floor base
    l. **E0243**, Toilet rail, each
    m. **E0244**, Raised toilet seat
    n. **E0245**, Tub stool or bench
    o. **E0315**, Bed accessory; board, table, or support device, any type
    p. **E0627**, Seat lift mechanism incorporated into a combination lift chair mechanism
    q. **E0628**, Separate seat lift mechanism for use with patient owned furniture, electric
    r. **E0629**, Separate seat lift mechanism for use with patient owned furniture, non-electric
    s. **E0745** Neuromuscular stimulator, electronic shock unit
    t. **E1300** Whirlpool, portable (overtub type)
    u. **E1310** Whirlpool, non-portable (built-in type)

v. **E1639**, Scale, each
w. **S5162**, Emergency response system; purchase only
x. **S5199**, Personal care item, NOS, each
    i. Use this code for items that the enrollee uses to perform ADLs or IADLs, or that assist the enrollee in the performance of ADLs or IADLs.
    ii. This category shall exclude items such as shampoo, soap, toothpaste, toothbrushes, dent-tips, shaving cream, and razors.
    iii. The ICO must include a description of this item in the appropriate loop for approval of a claim.
    iv. Standardized remarks are available.
y. **T1999**, Misc. Therapeutic items & supplies, retail purchases, NOC, identify product in “remarks”
    i. Items in this category have a therapeutic use for the enrollee.
    ii. The ICO must include a description of this item in the appropriate loop for approval of a claim.
    iii. Standardized remarks are available.
    iv. Does not include items specified under the Assistive Technology service.
z. **T2028**, Specialized supply, NOS, waiver
    i. Items in this category include specialized supplies that the Medicaid state plan does not cover.
    ii. This may include items that do not meet the “medically necessary” standard for state plan coverage, or quantities above state plan coverage.
    iii. The ICO must include a description of this item in the appropriate loop for approval of a claim.
    iv. Standardized remarks are available.
aa. **T2029**, Specialized medical equipment, NOS, waiver
    i. Items in this category include specialized equipment that the Medicaid state plan does not cover, or does not cover for adults.
    ii. This may include items that do not meet the “medically necessary” standard for state plan coverage.
    iii. The ICO must include a description of this item in the appropriate loop for approval of a claim.
    iv. Standardized remarks are available.

Adult Day Program	
Description	Adult Day Program services are furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, or as specified in the IICSP, in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the enrollee. Meals provided as part of these services shall not constitute a “full nutritional regimen,” i.e., three meals per day. Physical, occupational and speech therapies may be furnished as component parts of this service. Transportation between the enrollee’s residence and the Adult Day Program center is provided when it is a standard component of the service. Not all Adult Day Program centers offer transportation to and from their location. Adult Day Program centers that do offer transportation may only offer it in a specified area. When the Adult Day Program Center offers transportation, it is a component part of the Adult Day Program service. If the center does not offer transportation, then the ICO will pay for the transportation to and from the Adult Day Program center separately.
HCPCS Codes	S5100, Day care services, adult, per 15 minutes S5101, Day care services, adult, per half day S5102, Day care services, adult, per diem
Units	S5100 = 15 minutes S5101 = half day, as defined by ICO and provider S5102 = per diem
Service Delivery Options	☑ Traditional ☐ Self-Determination

Minimum Standards for Service Delivery

1. Enrollees cannot receive personal care services or Expanded Community Living Supports during the time spent at the Adult Day Program facility. Payment for Adult Day Program includes all services provided while at the facility. Personal care services and Expanded Community Living Supports may be used in conjunction with Adult Day Program services, but cannot be provided at the exact same time unless the specific component of the service includes laundry, housecleaning, etc., that does not require the enrollee to be present.
2. Adult Day Program should only be authorized if the enrollee meets at least one of the following criteria:
   a. Requires regular supervision to live in his or her own home or the home of a relative
   b. If he or she has a caregiver, the enrollee must require a substitute caregiver while his or her regular caregiver is unavailable
   c. Has difficulty or is unable to perform ADLs without assistance
   d. Capable of leaving his or her residence with assistance to receive services
   e. In need of intervention in the form of enrichment and opportunities for social activities to prevent and/or postpone deterioration that may lead to institutionalization

   A referral from an ICO for a waiver enrollee shall replace any screening or assessment activities performed for other Adult Day Program enrollees at the setting. The direct adult day program service provider shall accept copies of the ICO's assessments and Individual Integrated Care and Supports Plan (IICSP) to eliminate duplicate assessment and service planning activities.
3. Each program shall provide directly, or arrange for the provision of the following services.
   a. Transportation
   b. Personal Care
   c. Nutrition: one hot meal per eight-hour day which provides one-third of the recommended daily allowances and follows the meal pattern specified in the home delivered meals service standard. Enrollees in attendance from eight to fourteen hours per day shall receive an additional meal to meet a combined two-thirds of the recommended daily allowances. Modified diet menus should be provided where feasible and appropriate. Such modifications shall take into consideration enrollee choice, health, religious and ethnic diet preferences
   d. Recreation: consisting of planned activities suited to the needs of the enrollee and designed to encourage

physical exercise, to maintain or restore abilities and skill, to prevent deterioration, and to stimulate social interaction

If the program arranges for provision of any service at a place other than program operated facilities, a written agreement specifying supervision requirements and responsibilities shall be in place. For MI Health Link HCBS enrollees, the ICO shall provide care coordination.

4. Each program shall maintain comprehensive and complete files that include, at a minimum:
    a. Details of the enrollee's referral to the adult day program.
    b. Intake records.
    c. Assessment of individual need or copy of assessment (and reassessments from referring program.
    d. IICSP and any other service plan developed by the program site.
    e. Listing of enrollee contacts and attendance.
    f. Progress notes in response to observations (at least monthly).
    g. Notation of all medications taken on premises, including:
        i. the medication;
        ii. the dosage;
        iii. the date and time of administration;
        iv. the initials of the staff person assisting with administration; and
        v. comments
    h. Notation of basic and optional services provided to the enrollee.
    i. Notation of any and all release of information about the enrollee.
    j. Signed release of information form.

    Each program shall keep all enrollee files confidential in controlled access files. Each program shall use a standard release of information form that is time limited and specific as to the released information.
5. Each provider shall employ a full-time program director with a minimum of a bachelor's degree in a health or human services field or be a qualified health professional. The provider shall continually provide support staff at a ratio of no less than one staff person for every ten participants. The provider may only provide health support services under the supervision of a registered nurse. If the program acquires either required or optional services from other individuals or organizations, the provider shall maintain a written agreement that clearly specifies the terms of the arrangement between the provider and other individual or organization.
6. Each program shall establish written procedures (reviewed and approved by a consulting Pharmacist, Physician, or Registered Nurse) that govern the assistance given by staff to enrollees

taking their own medications while participating in the program. The policies and procedures must minimally address:

a. Written consent from the enrollee or enrollee's representative, to assist in taking medications.
b. Verification of the enrollee's medication regiment, including the prescriptions and dosages.
c. The training and authority of staff to assist enrollees with taking their own prescribed or non-prescription medications and under what conditions such assistance may take place.
d. Procedures for medication set up.
e. Secure storage of medications belonging to and brought in by enrollees. Medications must be returned to the enrollee.
f. Instructions for entering medication information in enrollee files, including times and frequency of assistance.

7. Program staff shall have basic first-aid training and any other training as required by MDCH and the ICO.
8. If the provider operates its own vehicles for transporting enrollees to and from the program site, the provider shall meet the following transportation minimum standards:

   a. The Secretary of State shall appropriately license all drivers and vehicles and all vehicles shall be appropriately insured.
   b. All paid drivers shall be physically capable and willing to assist persons requiring help to get in and out of vehicles. The provider shall make such assistance available unless expressly prohibited by either a labor contract or an insurance policy.
   c. All paid drivers shall be trained to cope with medical emergencies unless expressly prohibited by a labor contract.
   d. Each program shall operate in compliance with P.A. 1 of 1985 regarding seat belt usage.
9. Each adult day program center shall have the following furnishings:

   a. At least one straight back or sturdy folding chair for each enrollee and staff person.
   b. Lounge chairs and/or day beds as needed for naps and rest periods.
   c. Storage space for enrollees' personal belongings.
   d. Tables for both ambulatory and non-ambulatory enrollees.
   e. A telephone accessible to all enrollees.
   f. Special equipment as needed to assist persons with disabilities.

   The provider shall maintain all equipment and furnishings used during program activities or by program enrollees in safe and functional condition.
10. Each provider shall post procedures to follow in emergencies (fire, severe weather, etc.) in each room of the program site. Providers

shall conduct practice drills of emergency procedures once every six months. The program shall maintain a record of all practice drills.

11. Each adult day program center shall document that it is in compliance with:
    a. Barrier-free design specification of Michigan and local building codes.
    b. Fire safety standards.
    c. Applicable Michigan and local public health codes.
12. HCPCS codes S5101 and S5102 are limited to one unit per day.
13. Adult Day Program settings must be compliant with the HCBS Final Rule.

Assistive Technology	
Description	This includes technology items used to increase, maintain, or improve an enrollee's functioning and promote independence. The service may include assisting the enrollee in the selection, design, purchase, lease, acquisition, application, or use of the technology item. This service also includes vehicle modifications to the vehicle that is the enrollee's primary method of transportation. This service includes repairs and maintenance of assistive technology devices. Vehicle modifications must be of direct medical or remedial benefit to the enrollee and specified under the IICSP.
HCPCS Codes	**T1999,** Misc. Therapeutic items & supplies, retail purchase, any type. Some specific items are: - 0204, Adaptive or specialized communication device - 0206, Assistive dialing device - 0208, Adaptive door opener - 0209, Specialized alarm or intercom - 0218, Other adaptive or assistive device **T2039**, Vehicle Modifications, waiver, per service **V5268**, Assistive listening device, telephone amplifier, any type **V5269**, Assistive listening device, alerting, any type **V5270**, Assistive listening device, television amplifier, any type Other assistive technology devices not included under Adaptive Medical Equipment and Supplies
Units	Per item unless otherwise specified
Service Delivery Options	☑ Traditional ☐ Self-Determination

Minimum Standards for Service Delivery

1. Some examples include, but are not limited to, van lifts, hand controls, computerized voice system, communication boards, voice activated door locks, power door mechanisms, adaptive or specialized communication devices, assistive dialing device, adaptive door opener, specialized alarm or intercom.
2. Items like cell phones, internet service, full-home wiring systems would be excluded from this benefit.
3. This does not include paying for or leasing vehicles, vehicle insurance and vehicle repairs.
4. It must be documented in the IICSP that the item is the most cost-effective alternative to meeting the enrollee's needs.
5. Items must meet applicable standards of manufacture, design, and installation.
6. There must be documentation that the best value in warranty coverage was obtained at the time of purchase.
7. Items must be of direct medical or physical benefit to the enrollee.
8. $15,000 maximum for van lifts, including tie downs, for the duration of the 5-year waiver period.
9. $5000 yearly (waiver year) maximum for all other assistive technology devices.
10. Modifications will only be made to vehicles with proper insurance coverage, with the exception of new vehicles coming directly from an automotive factory to the entity performing the modification.
11. Each direct service provider must enroll in Medicare and Medicaid as a DMEPOS provider, pharmacy, etc., as appropriate. Verification of provider qualifications must be conducted prior to service delivery and annually thereafter.
12. The ICO may obtain some items directly from a retail store that offers the item to the general public (i.e. Wal-Mart, K-mart, Meijer, Costco, etc.). When utilizing retail stores, the ICO must assure the item purchased meets the service standards. The ICO may choose to open a business account with a retail store for such purchases. The ICO must maintain the original receipts and maintain accurate systems of accounting to verify the specific enrollee who received the purchased item.
13. Other contracted or subcontracted providers must have written policies and procedures compatible with requirements as specified in the contract between MDCH and the ICO and/or the three-way contract. Contracted/subcontracted providers must have any appropriate state

licensure or certification required to complete or provide the service or item. Verification of provider qualifications must be conducted prior to service delivery and annually thereafter.

14. Where feasible, the ICO and/or direct service provider shall seek confirmation of the need for the item from the enrollee's physician.

Chore Services	
Description	Services needed to maintain the home in a clean, sanitary, and safe environment to provide safe access inside the home and yard maintenance and snow plowing to provide access to and egress outside of the home. This service includes tasks such as heavy household chores (washing floors, windows, and walls), tacking loose rugs and tiles, moving heavy items of furniture, mowing, raking, and cleaning hazardous debris such as fallen branches and trees. May include materials and disposable supplies used to complete chore tasks. Chore services are allowed only in cases when neither the enrollee nor anyone else in the household is capable of performing or financially paying for them, and where no other relative, caregiver, landlord, community or volunteer agency, or third party payer is capable of, or responsible for, their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.
HCPCS Codes	**S5120**, Chore Services, per 15 minutes **S5121**, Chore Services, per diem
Units	S5120 = 15 minutes S5121 = Per diem
Service Delivery Options	☑ Traditional ☑ Self-Determination

Minimum Standards for Traditional Service Delivery

1. Waiver funds used to pay for chore services may include materials and disposable supplies used to complete the chore tasks. The ICO may also use waiver funds to purchase or rent the equipment or tools used to perform chore tasks for waiver enrollees.
2. Each ICO must develop working relationships with the Home Repair and Weatherization service providers, as available, in their program area to ensure effective coordination of efforts.
3. Pest control suppliers must be properly licensed.
4. Providers must be able to communicate effectively both orally and in writing. Verification of provider qualifications must be conducted prior to service delivery and annually thereafter.

Minimum Standards for Self-Determined Service Delivery

1. Providers must have previous relevant experience and/or training for the tasks specified and authorized in the IICSP.
2. The ICO must deem the chosen provider capable of performing the required tasks.

Community Transition Services	
Description	This service includes non-reoccurring expenses for enrollees transitioning from a nursing facility to another residence where the enrollee is responsible for his or her own living arrangement.
HCPCS Codes	**T1023** Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter **T1028** Assessment of home, physical and family environment, to determine suitability to meet enrollee's medical needs **T2038** Community Transition, waiver; per service
Units	T1023 and T1028, per encounter T2038, per service
Service Delivery Options	☑ Traditional ☐ Self-Determination

Minimum Standards for Service Delivery

1. Allowable transition costs include the following:
    a. Housing or security deposits; A one-time expense to secure housing or obtain a lease.
    b. Utility hook-ups and deposits: A one-time expense to initiate and secure utilities (television and internet are excluded).
    c. Furniture, appliances, and moving expenses: One-time expenses necessary to occupy and safely reside in a community residence (diversion or recreational devices are excluded).
    d. Cleaning: A one-time cleaning expense to assure a clean environment, including pest eradication, allergen control, and over-all cleaning.
    e. Coordination and support services: To facilitate transitioning of enrollee to a community setting.
    f. Other: Services deemed necessary and documented within the enrollee's plan of service to accomplish the transition into a community setting. Costs for Community Transition Services are billable upon enrollment into the MI Health Link HCBS waiver.
2. Excludes ongoing monthly rental or mortgage expense, regular utility charges, or items that are intended for purely diversional or recreational purposes.
3. The timeframes associated with this service may be extended in unique circumstances that require additional support and coordination efforts.
4. The ICO may obtain some items directly from a retail store that offers the item to the general public (i.e. Wal-Mart, K-mart, Meijer, Costco, etc.). When utilizing retail stores, the ICO must assure the item purchased meets the service standards. The ICO may choose to open a business account with a retail store for such purchases. The ICO must maintain the original receipts and maintain accurate systems of accounting to verify the specific enrollee who received the purchased item.
5. Person-centered planning must be use throughout the entire community transition process
6. The ICO shall bill assessments of potential residential settings using HCPCS code T1028. The ICO may use this code more than once per transition, but the federal government limits use to one unit per day. The cost of this service includes supports and coordination provided by a knowledgeable health professional (i.e. physical therapist or occupational therapist) during the assessment of the potential residential setting.

HCPCS code T1028 is a per encounter code. This health professional cannot be a paid staff member of the ICO. When ICO staff provides the assessment of the home, this is considered a regular care coordination function.

7. When an ICO authorizes more than one potential home assessment for an enrollee per transition, the units shall equal no more than one per day, regardless of the number of assessments completed. The cost shall equal the total cost of all assessments.
8. The ICO shall bill all other transition services using HCPCS code T2038 with the appropriate standard remark for each transition service. A listing of standard remarks is provided at the end of this document. When a transitioning enrollee requires a transition service that does not have an appropriate standard remark, the ICO shall contact MDCH for assistance. The ICO shall bill services or report encounters under HCPCS code T2038 that are provided after the first date of waiver enrollment using the date of service delivery as the billed date of service.
9. When an ICO anticipates that a nursing facility resident receiving CTS will require MI Health Link HCBS waiver services in the community, the ICO shall make necessary arrangements and apply for waiver enrollment. CMS requires the ICO to authorize all CTS to persons expected to enroll in the waiver upon transition. Therefore, an ICO or entity under contract with an ICO shall perform all transition activity for a nursing facility resident expected to enroll in the waiver upon transition.
10. Using a person-centered planning process, the ICO must develop a transition plan that includes all projected transition costs, enrollee goals, and is based on individual needs. This transition plan becomes part of the enrollee's Care Bridge Record maintained by the ICO and must minimally include the following elements:

    a. Nursing facility resident name.
    b. Nursing facility resident identifying information including Social Security Number and Medicaid ID number.
    c. Name and address of nursing facility in which the resident resides.
    d. Date of initial contact.
    e. Estimated date of transition to the community and the waiver.
    f. Needed or anticipated Community Transition Services.
    g. Enrollee goals and expected outcomes of community transition.
    h. Dated signature of enrollee or legal representative.
    i. Dated signature of care coordinator assisting with the development of the plan.
11. For persons expected to enroll in the MI Health Link HCBS waiver, when a transitioning enrollee requires a home modification (ramp,

widened doorways, etc.) before the transition can take place, the ICO shall authorize only those modifications immediately necessary for community transition as CTS. The ICO shall authorize all other needed modifications as Environmental Modifications services or Chore services through the waiver, as appropriate.

12. Within 15 days of the date of transition to the community, the ICO should identify and include in the transition plan all CTS items required to complete the transition. Items identified after this date will need to be discussed with MDCH and justified as a transition expense.

Environmental Modifications	
Description	Physical adaptations to the home, required by the enrollee's IICSP, that are necessary to ensure the health and welfare of the enrollee or that enable the enrollee to function with greater independence in the home. Such adaptations include the installation of ramps and grab bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the enrollee.
HCPCS Codes	**S5165**, Home modifications, per service
Units	One modification or adaptation
Service Delivery Options	☑ Traditional ☑ Self-Determination

Minimum Standards for Service Delivery

1. Such adaptations include the installation of ramps and grab bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the enrollee. Complex kitchen and bathroom modifications may be competed if medically necessary for the enrollee. Environmental modifications are those which are installed in the residence versus

enhanced equipment or assistive technology which are portable from residence to residence.

2. The modification/adaptation must be the most cost-effective and reasonable alternative.
3. This service shall not be used for upgrades to the home or for additions to homes (adding square footage, etc.). Modifications/adaptations shall only be used to modify existing spaces or structures.
4. The modification/adaptation must be for a primary residence, but may include additional residences subject to prior authorization by the ICO. Examples of additional residences might be a family member's cottage or the enrollee's second home or cottage so the individual can go there and be with family.
5. The ICO may use MI Health Link funds for labor costs and to purchase materials used to complete the modification to prevent or remedy a safety hazard. The direct service provider shall provide the equipment or tools needed to perform the tasks unless another source can provide the equipment or tools at a lower cost or free of charge and the provider agrees to use those tools.
6. This service does not include modifications to rental properties if the rental agreement states that it is the responsibility of the landlord to provide such modifications.
7. Prior to the start of the modification of a rental property or unit, the landlord must approve the modification plan. A written agreement between the landlord, the enrollee, and the ICO must specify that the ICO and enrollee are not responsible for any costs to restore the property to the original condition.
8. Modifications must comply with local building codes.
9. Repairs, modifications, or adaptations shall not be performed on a condemned structure.
10. As applicable, the ICO should explore and utilize other funding sources prior to using MI Health Link funds for the modifications.
11. Excluded are those adaptations or improvements to the home that:
    a. Are of general utility;
    b. Are considered to be standard housing obligations of the enrollee or homeowner; and
    c. Are not of direct medical or remedial benefit to the enrollee. For example, kitchen modifications must be required for the enrollee to prepare his or her own meals.

    Examples of exclusions include, but are not limited to, carpeting, roof repair, sidewalks, driveways, heating, central air conditioning (unless it is

the most cost effective and reasonable alternative), garages, raised garage doors, storage and organizers, hot tubs, whirlpool tubs, swimming pools, landscaping and general home repairs.

12. Environmental adaptations shall exclude costs for improvements exclusively required to meet local building codes and not directly related to an enrollee's medical or physical condition.
13. The infrastructure of the home involved in the funded adaptations (e.g., electrical system, plumbing, well or septic, foundation, heating and cooling, smoke detector systems, or roof) must be in compliance with any applicable local codes.
14. Environmental adaptations required to support proper functioning of medical equipment, such as electrical upgrades, are limited to the requirements for safe operation of the specified equipment and are not intended to correct existing code violations in an enrollee's home.
15. The existing structure must have the capability to accept and support the proposed changes.
16. The ICO shall not cover general construction costs in a new home or additions to a home purchased after the enrollee is enrolled in the waiver. If an enrollee or the enrollee's family purchases or builds a home while receiving waiver services, it is the enrollee's or family's responsibility to assure the home will meet basic needs, such as having a ground floor bath or bedroom if the enrollee has mobility limitations. However, MI Health Link funds may be authorized to assist with the adaptations noted above (e.g. ramps, grab bars, widening doorways, bathroom modifications, etc.) for a home recently purchased. If modifications are needed to a home under construction that require special adaptation to the plan (e.g. roll-in shower), the ICO may fund the difference between the standard fixture and the modification required to accommodate the enrollee's need.
17. A ramp or lift will be covered for only one exterior door or other entrance.
18. Contracted providers such as licensed building contractors, must have appropriate certification or licensure under Michigan regulations and law such as MCL 339.601(1), MCL 339.601.2401, or MCL 339.601.2403(3). Verification of certification, licensure, or other provider qualifications must be done prior to execution of the contract related to the modification project to be done.

Expanded Community Living Supports	
Description	To receive Expanded Community Living Supports (ECLS), enrollees MUST have a need for prompting, cueing, observing, guiding, teaching, and/or reminding to independently complete activities of daily living (ADLs) such as eating, bathing, dressing, toileting, other personal hygiene, etc. **ECLS does not include hands on assistance for ADLs** unless something happens to occur incidental to this service. Enrollees may also receive hands-on assistance for instrumental activities of daily living (IADLs) such as laundry, meal preparation, transportation, help with finances, help with medication, shopping, attending medical appointments, and other household tasks, as needed. ECLS also includes prompting, cueing, guiding, teaching, observing, reminding, and/or other support for the enrollee to complete the IADLs independently if he or she chooses. ECLS includes social/community participation, relationship maintenance, and attendance at medical appointments.
HCPCS Codes	**H2015**, Comprehensive community support services, per 15 minutes **H2016**, Comprehensive community support services, per diem
Units	H2015 = 15 minutes H2016 = Per diem
Service Delivery Options	☑ Traditional ☑ Self-Determination

Minimum Standards for Traditional Service Delivery:

1. Expanded Community Living Supports (ECLS) include:

    a. Assisting, reminding, cueing, observing, guiding and/or training in the following activities:

    i. Meal preparation
    ii. Laundry
    iii. Routine, seasonal, and heavy household care and

maintenance

iv. Activities of daily living such as bathing, eating, dressing, and personal hygiene
v. Shopping for food and other necessities of daily living

b. Assistance, support, and/or guidance with such activities as:
   i. Money management
   ii. Non-medical care (not requiring nursing or physician intervention)
   iii. Social participation, relationship maintenance, and building community connections to reduce personal isolation
   iv. Transportation (excluding to and from medical appointments) from the enrollee's residence to community activities, among community activities, and from the community activities back to the enrollee's residence
   v. Participation in regular community activities incidental to meeting the individual's community living preferences
   vi. Attendance at medical appointments
   vii. Acquiring or procuring goods and services necessary for home and community living
c. Reminding, cueing, observing, and/or monitoring of medication administration
d. Staff assistance with preserving the health and safety of the enrollee in order that he/she may reside and be supported in the most integrated independent community setting.
e. Training or assistance on activities that promote community participation, such as using public transportation, using libraries, or volunteer work.
f. Dementia support, including but not limited to redirection, reminding, modeling, socialization activities, and activities that assist the enrollee as identified in the enrollee's IICSP.
g. Observing and reporting to the care coordinator any changes in the enrollee's condition and the home environment.

2. Individual providers who are chosen by the enrollee must meet the following provider qualifications (qualifications must be verified prior to initial service delivery and annually thereafter):
   a. Providers must be at least 18 years of age, have ability to communicate effectively both orally and in writing and follow instructions, be trained in first aid and cardiopulmonary resuscitation, be able to prevent transmission of communicable disease and be in good standing with the law as validated by a criminal history review. If providing transportation related to this

service, the provider must possess a valid Michigan driver's license.

b. Individuals providing ECLS must have previous relevant experience or training and skills in housekeeping, household management, good health practices, observation, reporting, recording information, and reporting and identifying abuse and neglect. The individual(s) must also be trained in the enrollee's IICSP. Additionally, skills, knowledge, and experience with food preparation, safe food handling procedures are highly desirable.
c. Previous relevant experience and training to meet MDCH operating standards. Refer to the ICO contract for more details.
d. Must be deemed capable of performing the required tasks by ICO.

3. Home Care agency providers must meet the following provider qualifications (qualifications must be verified prior to initial service delivery and annually thereafter):
    a. Providers must be at least 18 years of age, have the ability to communicate effectively both orally and in writing and follow instructions, be trained in first aid, be trained in universal precautions and blood-born pathogens, and be in good standing with the law as validated by a criminal history review.
    b. A registered nurse licensed to practice nursing in the State shall furnish supervision of ECLS providers. At the State's discretion, other qualified individuals may supervise ECLS providers. The direct care worker's supervisor shall be available to the worker at all times the worker is furnishing ECLS services.
    c. The ICO and/or provider agency must train each worker to properly perform each task required for each enrollee the worker serves before delivering the service to that enrollee. The supervisor must assure that each worker can competently and confidently perform every task assigned for each enrollee served. MDCH strongly recommends each worker delivering ECLS services complete a certified nursing assistance training course.
    d. ECLS providers may prompt, cue, or supervise the enrollee to perform higher-level, non-invasive tasks such as maintenance of catheters and feeding tubes, minor dressing changes, and wound care if the direct care worker has been individually trained and supervised by an RN for each enrollee who requires such care. The supervising RN must assure each workers confidence and competence in the performance of each task required.

e. Individuals providing ECLS services must have previous relevant experience or training and skills in housekeeping, household management, good health practices, observation, reporting, and recording information. Additionally, skills, knowledge, and/or experience with food preparation, safe food handling procedures, and reporting and identifying abuse and neglect are highly desirable.

4. When the ECLS services provided to the enrollee include transportation, the following standards apply:
   a. The ICO may not use MI Health Link funds to purchase or lease vehicles for providing transportation services to waiver enrollees.
   b. The Secretary of State must appropriately license all drivers and register all vehicles used for transportation supported all or in part by MI Health Link funds. The provider must cover all vehicles used with liability insurance.
   c. All paid drivers for transportation providers supported entirely or in part by MI Health Link funds shall be physically capable and willing to assist persons requiring help to and from and to get in and out of vehicles. The provider shall offer such assistance unless expressly prohibited by either a labor contract or insurance policy.
   d. The provider shall train all paid drivers for transportation programs supported entirely or in part by MI Health Link funds to cope with medical emergencies, unless expressly prohibited by a labor contract or insurance policy.
   e. Each provider shall operate in compliance with P.A. 1 of 1985 regarding seat belt usage.
5. Each direct service provider who chooses to allow staff to assist enrollees with self-medication shall establish written procedures that govern the assistance given by staff. These procedures shall be reviewed by a consulting pharmacist, physician, or RN and shall include, at a minimum:
   a. The provider staff authorized to assist enrollees with taking their own prescription or over-the-counter medications and under what conditions such assistance may take place. This must include a review of the type of medication the enrollee takes and its impact upon the enrollee.
   b. Verification of prescription medications and their dosages. The enrollee shall maintain all medications in their original, labeled containers.
   c. Instructions for entering medication information in enrollee files.
   d. A clear statement of the enrollee's and his/her family's responsibility regarding medications taken by the enrollee

and the provision for informing the enrollee and his/her family of the provider's procedures and responsibilities regarding assisted self-administration of medications.

6. ECLS providers may only administer medications in compliance with Michigan Administrative Rule 330.7158:
   a. A provider shall only administer medication at the order of a physician and in compliance with the provisions of section 719 of the act, if applicable.
   b. A provider shall assure that medication use conforms to federal standards and the standards of the medical community.
   c. A provider shall not use medication as punishment, for the convenience of the staff, or as a substitute for other appropriate treatment.
   d. A provider shall review the administration of a psychotropic medication periodically as set forth in the enrollee's IICSP and based upon the enrollee's clinical status.
   e. If an enrollee cannot administer his or her own medication, a provider shall ensure that medication is administered by or under the supervision of personnel who are qualified and trained.
   f. A provider shall record the administration of all medication in the enrollee's record. The ICO may do this electronically or via paper format, but the records must be readily available if requested by MDCH.
   g. A provider shall ensure that medication errors and adverse drug reactions are immediately and properly reported to a physician and recorded in the enrollee's record.
7. ECLS cannot be provided in circumstances where they would be a duplication of services available through MI Health Link. The distinction must be apparent by unique hours and units in the approved IICSP.
8. ECLS does not include the cost associated with room and board.
9. ECLS may be furnished outside the enrollee's home.
10. The enrollee oversees and supervises individual providers on an on-going basis when participating in arrangements that support self-determination. This may also include transportation to allow people to get out into the community when it is incidental to the IICSP.
11. When transportation incidental to the provision of ECLS is included, the ICO shall not also authorize transportation as a separate waiver service for the enrollee.
12. ECLS services cannot be provided in circumstances where they would be a duplication of services available under the state plan or elsewhere.
13. ECLS excludes nursing and skilled therapy services.
14. Members of an enrollee's family may provide ECLS to the enrollee.

However, the ICO shall not directly authorize funds to pay for services furnished to an enrollee by that person's spouse or legal guardian or other financially responsible person. Family members who provide this service must meet the same standards as providers who are unrelated to the enrollee. Roommates or other individuals who live with the enrollee may provide ECLS services, but payment for services must be pro-rated by one-half if the service will also benefit the person performing the service (i.e. meal preparation, laundry, housecleaning, etc.). Paid ECLS services are **only** for the benefit of the enrollee receiving the services.

15. In shared living arrangements where there is more than one person in the home receiving the service by the same caregiver, payment for services must be based on a pro-rated percentage/fraction relative to the care each person receives. When services can be clearly documented separately from other individuals in the home, payment need not be pro-rated.Providers must be trained to perform each required task prior to service delivery. The supervisor must assure the provider can competently and confidently perform each assigned task.
16. ECLS may be provided in addition to Medicaid State Plan Personal Care Services if the enrollee requires hands-on assistance with some ADLs and/or IADLS, as covered under the State Plan service, but requires prompting, cueing, guiding, teaching, observing, reminding, or other support (not hands-on) to complete other ADLs or IADLs independently, but to ensure safety, health, and welfare of the enrollee.
17. Some activities under ECLS may also fall under activities in other waiver services. If other waiver services are used for these activities, this must be clearly identified in the IICSP and other documentation and billed under the appropriate procedure codes to avoid duplication of services.
18. With the assistance of the enrollee and/or enrollee's caregiver, the ICO or direct service provider shall determine an emergency notification plan for each enrollee, pursuant to each visit for emergencies and provider no-shows or late arrivals.

Additional Standards for Enrollees Who Reside in Licensed Settings

1. ECLS provided in a licensed setting includes only those supports and services that are in addition to, and shall not replace, usual and customary care furnished to residents in the licensed setting.
2. Documentation in the enrollee's record must clearly identify the enrollee's need for additional supports and services not covered by licensure.
3. The IICSP must clearly identify the portion of the enrollee's supports and services covered by ECLS.

Minimum Standards for Self-Determined Service Delivery

1. When authorizing ECLS for enrollees choosing the self-

determination option, The ICO must comply with service definitions described in the Minimum Standards for Traditional Service Delivery specified above.

2. Each chosen provider furnishing transportation as a component of this service must have a valid Michigan driver's license.
3. Providers must meet the same qualifications as those under the traditional service delivery model.
4. When the ECLS services provided to the enrollee include tasks specified in 1.a.iv, 1.b.ii, 1.c, 1.d, 1.e, 1.f, or 1.g above under Minimum Standards for Traditional Service Delivery, the individual furnishing ECLS must also be trained in cardiopulmonary resuscitation. This training may be waived when the provider is furnishing services to an enrollee who has a "Do Not Resuscitate" order.

Fiscal Intermediary	
Description	Fiscal Intermediary (FI) services assist the enrollee, or a representative identified in the enrollee's IICSP to live independently in the community while controlling his/her individual budget and choosing the staff to work with him/her. The FI helps the enrollee to manage and distribute funds contained in the individual budget. The enrollee uses funds to purchase home and community based services authorized in the IICSP.
HCPCS Codes	**T2025**, Waiver Services, not otherwise specified.
Units	As specified in the contract between the Fiscal Intermediary and the ICO, usually a monthly or bi-weekly fee.
Service Delivery Options	☐ Traditional ☑ Self-Determination

<u>**Minimum Standards for Self-Determined Service Delivery**</u>

1. Fiscal Intermediary services are available only to enrollees participating in arrangements that support self-determination. Additionally, Fiscal

Intermediary services may not be provided by the enrollee's family, guardian, or providers of other services for the same enrollee.

2. FI services include, but are not limited to, the facilitation of the employment of service workers by the enrollee, including federal, state, and local tax withholding/payments, unemployment compensation fees, wage settlements; fiscal accounting; tracking and monitoring enrollee-directed budget expenditures and identify potential over and under expenditures; assuring compliance with documentation requirements related to management of public funds. The FI helps the enrollee manage and distribute funds contained in the individual budget. The FI also assists with training the enrollee and providers, as necessary, in tasks related to the duties of the FI including, but not limited to, billing processes and documentation requirements.
3. Each FI must be bonded and insured. The insured amount must exceed the total budgetary amount the FI is responsible for administering.
4. Each FI must demonstrate the ability to manage budgets and perform all functions of the FI including all activities related to employment taxation, worker's compensation, and state, local, and federal regulations.
5. Each FI must demonstrate competence in managing budgets and performing other functions and responsibilities of a fiscal intermediary.
6. Each FI will provide four basic areas of performance:
    a. Function as the employer agency for enrollees directly employing workers to assure compliance with payroll tax and insurance requirements;
    b. Ensure compliance with requirements related to management of public funds, the direct employment of workers by enrollees, and contracting for other authorized supports and services;
    c. Facilitate successful implementation of the self-determination arrangements by monitoring the use of the budget and providing monthly budget status reports to each enrollee and ICO; and
    d. Offer supportive services to enable enrollees to self-determine and direct the supports and services they need.
7. The ICO and fiscal intermediary must abide by the Self-Determination Implementation Technical Advisory and any other requirements set forth by MDCH.

Home Delivered Meals	
Description	The provision of one to two nutritionally sound meals per day to enrollees who are unable to care for their nutritional needs. This service must include and prioritize healthy meal choices that meet any established criteria under state or federal law. Meal options must meet enrollee preferences in relation to specific food items, portion size, dietary needs, and cultural and/or religious preferences. Each provider shall document meals served.
HCPCS Codes	**S5170**, Home delivered meals, including preparation, per meal.
Units	One delivered meal
Service Delivery Options	☑ Traditional ☐ Self-Determination

Minimum Standards for Service Delivery

1. Each ICO must have written eligibility criteria for persons receiving home delivered meals through the waiver which include, at a minimum:
    a. The enrollee must be unable to obtain food or prepare complete meals.
    b. The enrollee does not have an adult living at the same residence or in the vicinity that is able and willing to prepare all meals.
    c. The enrollee does not have a paid caregiver that is able and willing to prepare meals for the enrollee.
    d. The provider can appropriately meet the enrollee's special dietary needs and the meals available would not jeopardize the health of the individual.
    e. The enrollee must be able to feed himself/herself.
    f. The enrollee must agree to be home when meals are delivered, or contact the program when absence is unavoidable.
2. Each home delivered meals provider shall have the capacity to

provide three meals per day, which together meet the Dietary Reference Intakes (DRI) and recommended dietary allowances (RDA) as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences. Each provider must have meals available at least five days per week. Enrollees may select to have **up to two meals per day**, which means they could receive breakfast and lunch, lunch and dinner, or breakfast and dinner.

3. Federal regulations prohibit from providing three meals per day to enrollees. Meal service should be offered in relation to variable availability of allies or formal caregivers and changes in the enrollee's condition. When the ICO provides home delivered meals less than seven days per week, the ICO shall identify and/or document in the Care Bridge Record or IICSP, the alternative source of all meals that are not provided by the ICO.
4. The program may offer liquid meals to enrollees when ordered by a physician. The regional dietitian must approve all liquid meal products used by the provider. The provider or care coordinator must provide instruction to the enrollee and/or the enrollee's caregiver and family in the proper care and handling of liquid meals. The ICO and provider must meet the following requirements when liquid meals are the sole source of nutrition:
    a. Diet orders shall include enrollee weight and specify the required nutritional content of the liquid meals.
    b. The care coordinator must ensure the enrollee's physician renews the diet orders every three months, and
    c. The ICO and enrollee must develop the plan of care for the enrollee receiving liquid meals in consultation with the enrollee's physician. This plan must be included in the enrollee's IICSP.
5. The provider may furnish frozen meals when feasible and appropriate. When furnishing frozen meals, the following standards must be met:
    a. The care coordinator must verify and maintain records (Care Bridge Record or IICSP) that indicate each enrollee receiving frozen meals has and maintains the ability to store and handle frozen meals properly.
    b. The provider may only provide frozen meals in situations where it is not logistically feasible to provide the enrollee with a hot meal, with the exception of holidays, weekends, or emergencies.

c. Providers shall not furnish more than a two-week supply of frozen meals to an enrollee during one home delivery visit.

6. Each provider shall develop and have available written plans for continuing services in emergency situations such as short term natural disasters (e.g., snow and/or ice storms), loss of power, physical plant malfunctions, etc. The provider shall train staff and volunteers on procedures to follow in the event of severe weather or natural disasters and the county emergency plan.
7. The meals authorized under this service shall not constitute a full nutritional regimen.
8. Providers shall not solicit donations from waiver enrollees.
9. Dietary supplements are not covered under this service.

General Requirements

1. Providers may present hot, cold, frozen or shelf-stable meals according to the following meal pattern, but also **may be customized based on the enrollee's preferences**:

Meal Requirement	Servings per meal	Notations
Bread or Bread Alternate	2 servings of bread, rice, pasta, or cereal. A starchy vegetable may replace one bread	Encourage whole grains.
Vegetable	2 servings: 1 serving = ½ cup or equivalent measure	Fresh, frozen, or canned and prepared without added sodium. Focus on deep colored and dark green leafy vegetables. Cooked dried beans or peas are a good fiber source.
Fruit	1 serving: ½ cup or equivalent measure (may serve an additional fruit instead of a vegetable)	Fresh, frozen, canned, or dried. Deep colored fruits and good sources of Vitamin C are encouraged daily.
Milk or Milk Alternate	1 serving: 1 cup or equivalent measure	Encourage low-fat or skim milk, buttermilk, yogurt or cottage cheese.
Meat or Meat Alternate	1 serving: 2-3 oz. or equivalent measure	Encourage lean and low-fat meats and cheeses. Dried beans and peas are a good choice. Peanut butter, cottage cheese, tofu, and eggs also qualify.
Fats	1 serving: 1 teaspoon or equivalent measure	Select choices that are good sources of mono-and poly-unsaturated fats. Limit total fat to no more than 30% of total daily calories. Each week's meals shall contain no more than 25 grams average total fat.
Dessert	Optional	Choose nutrient dense desserts such as fruits, whole grain quick breads, puddings with limited fats and sugars. Limit high calorie desserts such as pies, cakes, cookies etc.
Sodium	No more than 1200 mg per meal average weekly total.	Select and prepare foods with less salt or sodium and use salt-free seasonings.
Fiber	3 choices out of a 5 day week high fiber	Choose whole grains, fruits and vegetables

2. In addition to the meal pattern above, servings may include the following, but **also may be customized based on the enrollee's preferences**:

Bread or Bread Alternate

- 1 small 2 ounce muffin
- 2" cube cornbread
- 1 biscuit, 2.5" diameter
- 1 waffle, 7" diameter
- 1 slice French toast
- ½ English muffin
- 1 tortilla, 6" diameter
- 2 pancakes, 4" diameter
- ½ bagel
- 1 small sandwich bun
- ½ cup cooked cereal, grits, barley, bulgur or masa
- 4-6 crackers
- ½ large sandwich bun
- ¾ cup ready to eat cereal
- ¼ cup granola
- 2 graham cracker squares
- ½ cup bread dressing or stuffing
- ½ cup pasta, noodles, rice

A variety of enriched and/or whole grain bread products, particularly those high in fiber, are recommended.

Vegetables

- A serving of vegetable (including dried beans, peas, and lentils) is generally ½ cup cooked or raw vegetable; ¾ cup 100% vegetable juice; or, 1 cup raw leafy vegetable. For pre-packed 100% vegetable juices, a ½ cup juice pack may be counted as a serving if a ¾ cup pre-packed serving is not available.
- Fresh or frozen vegetables are preferred. Canned vegetables are acceptable but may be high in sodium.
- Vegetables as a primary ingredient in soups, stews, casseroles or other combination dishes should total ½ cup per serving.
- Starchy vegetables, such as potatoes, sweet potatoes, corn, yams, or plantains, may replace one of the two bread servings.

Fruits

- A serving of fruit is generally a medium apple, banana, orange, or pear; ½ cup chopped, cooked, or canned fruit; or ¾ cup 100% fruit juice. For pre-packed 100% fruit juices, a ½ cup juice pack may be counted as a serving if a ¾ cup pre-

packed serving is not available.

- Fresh, frozen, or canned fruit should be preferably packed in juice, light syrup or without sugar.

Milk or Milk Alternates

- One cup low-fat, skim, whole, buttermilk, low-fat chocolate, or lactose-free milk fortified with Vitamins A and D should be used. Low fat or skim milk is recommended for the general population. Powdered dry milk (1/3 cup) or evaporated milk (1/2 cup) may be served as part of a home delivered meal.
- Milk alternates for the equivalent of one cup of milk include:
    - 1 cup yogurt
    - 1 ½ cups cottage cheese
    - 8 ounces tofu (processed with calcium salt)
    - 8 ounces calcium fortified soy milk
    - 1+½ ounces natural or 2 ounces processed cheese

Meat or Meat Alternates

- Two to three ounces of cooked meat or meat alternate should generally be provided for the lunch or supper meal. Meat serving weight is the edible portion, not including skin, bone, or coating.
- The following are equivalent to 1 ounce of meat:
    - 1 large egg
    - 1 ounce cheese (nutritionally equivalent measure of pasteurized process cheese, cheese food, cheese spread, or other cheese product). It is best to choose low-fat cheese such as mozzarella, feta, ricotta, etc.
    - ½ cup cooked dried beans, peas or lentils (separate from vegetable serving)
    - 2 tablespoons peanut butter or 1/3 cup nuts
    - ¼ cup cottage cheese
    - ½ cup or 4 ounces tofu
    - ¼ cup tempeh
- A one ounce serving or equivalent portion of meat, poultry, or fish may be served in combination with other high protein foods.
- Except to meet cultural and/or religious preferences and for emergency meals, avoid serving dried beans, peas, lentils, peanut butter or peanuts, and tofu for consecutive meals or on consecutive days.
- Imitation cheese (which the Food and Drug Administration defines as one not meeting nutritional equivalency requirements for the natural, non-imitation product) cannot be

served as meat alternates.

- To limit the sodium content of the meals, serve cured and processed meats (e.g., ham, smoked or Polish sausage, corned beef, wieners, luncheon meats, dried beef) no more than once a week.

Accompaniments
Include traditional meal accompaniments as appropriate, e.g., condiments, spreads, and garnishes. Examples include: ketchup, mustard and/or mayonnaise with a meat sandwich; tartar sauce with fish; salad dressing with tossed salad; margarine with bread or rolls. Whenever feasible, provide reduced fat alternatives. Minimize use of fat in food preparation. Fats should be primarily from vegetable sources and in a liquid or soft (spreadable) form that are lower in hydrogenated fat, saturated fat, and cholesterol.

Desserts
Serving a dessert is optional. Healthier desserts generally include fruit, low-fat puddings, whole grains, low-fat products, and limited sugar items such as quick breads (banana or pumpkin bread). Fresh, frozen, or canned fruits packed in their own juice are encouraged as a dessert item in addition to the serving of fruit provided as part of the meal.

Beverages
Fluid intake should be encouraged, as dehydration is a common problem in older adults. It is a good practice to have drinking water available.

Vegetarian Meals
Vegetarian meals can be served and should follow the principle of complementary proteins, where proteins from plant sources (legumes such as cooked dried beans and peas) are combined with grains (rice, breads, pasta) at the same meal. Vegetarian meals are a good opportunity to provide variety to menus and highlight the many ethnic food traditions found in Michigan.

Breakfast Meals
A breakfast meal may contain three fruit servings and no vegetable as an option to the required meal plan.

3. Each provider shall utilize a menu development process that prioritizes healthy choices and creativity and minimally includes:

a. Use of written, standardized recipes.
b. Consultation with the regional dietitian during the menu development process and use of cycle menus for cost containment and/or convenience are encouraged, but not required.
c. Provision for review and approval of all menus by the regional dietitian who must be a registered dietitian, or an individual who is dietitian-registration eligible.
d. The provision of information on the nutrition content of menus upon request.
e. The provision, where feasible and appropriate, of modified diet menus that considers enrollee choice, health, religious and ethnic diet preferences.
f. A record of the menu actually served each day. The provider shall maintain this record for each fiscal year's operation.
g. Written procedures for revising menus after approval.

4. The provider must operate according to current provisions of the Michigan Food Code. Local Health Departments establish minimum food safety standards. Each provider must keep copy of the Michigan Food Code available for reference. MDCH encourages providers to monitor food safety alerts.
5. Each provider that operates a kitchen for food production, shall have at least one key staff person (manager, cook or lead food handler) complete a Food Service Manager Certification Training Program approved by the Michigan Department of Agriculture. MDCH prefers, but does not require a trained and certified staff member at satellite serving and packing sites.
6. The provider shall feasibly minimize the time between the end of preparation of food and home delivery to the enrollee. The provider shall prepare, hold, and serve food at safe temperatures. The provider shall develop in conjunction with the respective local Health Department acceptable documentation requirements for food safety procedures.
7. The enrollee is responsible for the safety of food after it has been served or when it has been removed from the meal site.
8. The provider must use food from commercial sources that comply with the Michigan Food Code. Unacceptable items include: home canned or preserved foods; foods cooked or prepared in an individual's home kitchen; meat from any animal not killed by a licensed facility; any wild game taken by hunters; fresh or frozen fish donated by sport fishers; raw seafood or eggs; and, any un-pasteurized products (i.e., dairy, juices and honey).
9. The provider may use contributed food only when they meet the same standards of quality, sanitation, and safety as apply to

food purchased from commercial sources. Acceptable contributed food include fresh fruits and vegetables, and wild game from a licensed farm processed within two hours of killing by a licensed processor.

10. Each provider shall use standardized portion control procedures to ensure that each meal served is uniform and satisfies meal pattern requirements. The provider may alter standard portions at the request of an enrollee for less than the standard serving of an item or if an enrollee refuses an item. The provider shall not serve less than standard portions to "stretch" available food to serve additional persons.
11. Each provider shall implement procedures designed to minimize waste of food (leftovers/uneaten meals).
12. Each provider shall use an adequate food cost and inventory system at each food preparation facility. The provider shall base the inventory control on the first-in/first-out (FIFO) method and conform to generally-accepted accounting principles. The system shall have the ability to provide daily food costs, inventory control records, and monthly compilation of daily food costs. Each provider have the ability to calculate the component costs of each meal provided according to the following categories:

Raw Food	All costs of acquiring food to be used in the program.
Labor	Food Service Operations: all expenditures for salaries and wages, including valuation of volunteer hours, for personnel involved in food preparation, cooking, delivery, serving, and cleaning of meal sites, equipment and kitchens; Project Manager: all expenses for salary wages for persons involved in project management.
Equipment	All expenditures for purchase and maintenance of items with a useful life of more than one year and an acquisition cost of greater than $5,000.
Supplies	All expenditures for items with a useful life of less than one year and an acquisition cost of less than $5,000.
Utilities	All expenditures for gas, electricity, water, sewer, waste disposal, etc.
Other	Expenditures for all other items that do not belong in any of the above categories (e.g., rent, insurance, fuel, etc.) to be

	identified and itemized.

If a provider operates more than one meal/feeding program, the provider shall accurately distribute costs among the respective meal programs. The provider shall only charge costs directly related to a specific program.

13. Each provider shall provide or arrange for monthly nutrition education appropriate to enrollees receiving home delivered meals. Topics shall include, but are not limited to, food, nutrition, wellness issues, consumerism, and health. The regional dietitian must approve all nutrition education materials and presenters.
14. MDCH encourages each meal provider to use volunteers, as feasible, in program operations.
15. Each provider shall develop and utilize a system for documenting meals served. Obtaining daily signatures of enrollees receiving meals is the most acceptable method of documenting meals. Other acceptable methods may include maintaining a daily or weekly route sheet signed by the driver which identifies the enrollee's name, address, and number of meals served to him or her each day.
16. Each provider shall carry product liability insurance sufficient to cover its operation.
17. The ICO shall take steps to inform enrollees about local, State, and Federal food assistance programs and assist enrollees to obtain such benefits.

Non-Medical Transportation	
Description	Service offered to enable enrollees to gain access to waiver and other community services, activities, and resources, specified by the Individual Integrated Care and Supports Plan (IICSP).
HCPCS Codes	**A0130**, Non-Emergency Transportation; Wheelchair van; per trip **S0209**, Wheelchair van, mileage, per mile **S0215**, Non-Emergency Transportation, mileage, per mile **T2003**, Non-Emergency Transportation; encounter/trip **T2004**, Non-Emergency Transportation; commercial carrier, multi-pass
Units	A0130 = per mile S0209 = per mile S0215 = per mile T2003 = per encounter or trip T2004 = per pass
Service Delivery Options	☑ Traditional ☑ Self-Determination

Minimum Standards of Service Delivery

1. Whenever possible, the ICO shall utilize family, neighbors, friends, or community agencies that can provide this service free of charge.
2. Direct service providers shall be a centrally organized transportation company or agency. The provider may provide transportation utilizing any of the following methods:
    a. Demand/Response: Characterized by scheduling of small vehicles to provide door-to-door or curb-to-curb service on demand. The provider may include a passenger assistance component and either or both of the following variations:
        i. Route Deviation Variation: A normally fixed-route vehicle leaves the scheduled route upon request to pick up the enrollee.
        ii. Flexible Routing Variation: Providers constantly modify routes to accommodate service requests.

b. Public Transit: Characterized by partial or full payment of the cost for an enrollee to use an available public transit system. (This can be either a fixed route or demand/response). The provider may include a passenger assistance component.
c. Volunteer: Characterized by reimbursement of out-of-pocket expenses for individuals who transport enrollees in their private vehicles. The provider may include a passenger assistance component.
d. Ambu-cab: Characterized by a wheelchair-equipped van to provide door-to-door service on demand. The provider shall include a passenger assistance component.

3. Transportation vehicles must be properly licensed and registered by the State and must be covered with liability insurance.
4. MI Health Link funds may not be used to purchase or lease vehicles for providing transportation services to waiver enrollees.
5. MI Health Link funds shall not be used to reimburse caregivers (paid or informal) to run errands for enrollees when the enrollee does not accompany the driver of the vehicle.
6. All paid drivers for transportation providers supported entirely or in part by MI Health Link funds shall be physically capable and willing to assist persons requiring help to and from and to get in and out of vehicles. The provider shall offer such assistance unless expressly prohibited by either a labor contract or insurance policy.
7. The provider shall train all paid drivers for transportation programs supported entirely or in part by waiver funds to cope with medical emergencies, unless expressly prohibited by a labor contract or insurance policy.
8. Each provider shall operate in compliance with P.A. 1 of 1985 regarding seat belt usage.

Personal Emergency Response System (PERS)	
Description	This electronic device enables enrollees to secure help in an emergency. The enrollee may also wear a portable “help” button to allow for mobility. The system is connected to the enrollee’s phone and programmed to signal a response center once a “help” button is activated.
HCPCS Codes	**S5160**, Emergency response system; installation and testing **S5161**, Emergency response system; service fee, per month (excludes installation and testing)
Units	S5160, per installation S5161, per month
Service Delivery Options	☑ Traditional ☐ Self-Determination

Minimum Standards for Service Delivery

1. The Federal Communication Commission must approve the equipment used for the response system. The equipment must meet UL® safety standards 1637 specifications for Home Health Signaling Equipment.
2. The provider may offer this service for cellular or mobile phones and devices. The device must meet industry standards. The enrollee must reside in an area where the cellular or mobile coverage is reliable. When the enrollee uses the device to signal and otherwise communicate with the PERS provider, the technology for the response system must meet all other service standards.
3. The provider must assure at least monthly testing of each PERS unit to assure continued functioning.
4. PERS does not cover monthly telephone charges associated with phone service.
5. PERS is limited to persons who either live alone or who are left alone for significant periods of time on a routine basis and who could not summon help in an emergency without this device. The ICO may authorize PERS units for persons who do not live alone if both the waiver enrollee and the person with whom they reside would require extensive routine supervision without a PERS unit in the home. An example of this is two individuals

who live together and both are physically and/or cognitively unable to assist the other individual in the event of an emergency.

6. The provider must staff the response center with trained personnel 24 hours per day, 365 days per year. The response center will provide accommodations for persons with limited English proficiency.
7. The response center must maintain the monitoring capacity to respond to all incoming emergency signals.
8. The response center must have the ability to accept multiple signals simultaneously. The response center must not disconnect calls for a return call or put in a first call, first serve basis.
9. The provider will furnish each responder with written instructions and provide training, as appropriate.

Preventive Nursing Services	
Description	Preventive Nursing Services are covered on a part-time, intermittent (separated intervals of time) basis for an enrollee who generally requires nursing services for the management of a chronic illness or physical disorder in the enrollee's home and are provided by a registered nurse (RN) or a licensed practical nurse (LPN) under the supervision of a RN. Nursing services are for enrollees who require more periodic or intermittent nursing than otherwise available for the purpose of preventive interventions to reduce the occurrence of adverse outcomes for the enrollee such as hospitalizations and nursing facility admissions. An enrollee using this service must demonstrate a need for observation and evaluation.
HCPCS Codes	**T1002**, RN Services, up to 15 minutes **T1003**, LPN/LVN services, up to 15 minutes
Units	15 minutes
Service Delivery Options	☑ Traditional ☑ Self-Determination

Minimum Standards for Traditional Service Delivery

1. When the enrollee's condition is unstable, could easily deteriorate, or when significant changes occur, the ICO covers nurse visits for observation and evaluation. The purpose of the observation and evaluation is to monitor the enrollee's condition and report findings to the enrollee's physician or other appropriate health care professional to prevent additional decline, illness, or injury to the enrollee.
2. The care coordinator shall communicate with both the nurse providing this service and the enrollee's health care professional to assure the nursing needs of the enrollee are being addressed.
3. Enrollees must meet at least one of the following criteria to qualify for this service:
    a. Be at high risk of developing skin ulcers, or have a history of resolved skin ulcers that could easily redevelop.
    b. Require professional monitoring of vital signs when changes may indicate the need for modifications to the medication regimen.
    c. Require professional monitoring or oversight of blood sugar levels, including enrollee-recorded blood sugar levels, to assist with effective pre-diabetes or diabetes management.
    d. Require professional assessment of the enrollee's cognitive status or alertness and orientation to encourage optimal cognitive status and mental function or identify the need for modifications to the medication regimen.
    e. Require professional evaluation of the enrollee's success with a prescribed exercise routine to assure its effectiveness and identify the need for additional instruction or modifications when necessary.
    f. Require professional evaluation of the enrollee's physical status to encourage optimal functioning and discourage adverse outcomes.
    g. Have a condition that is unstable, could easily deteriorate, or experience significant changes AND a lack of competent informal supports able to readily report life- threatening changes to the enrollee's physician or other health care professional.
4. In addition to the observation and evaluation, a nursing visit may also include, but is not limited to, one or more of the following nursing services:
    a. Administering prescribed medications that cannot be self-administered (as defined under Michigan Complied Law (MCL) 333.7103(1)).
    b. Setting up medications according to physician orders.
    c. Monitoring enrollee adherence to his or her medication regimen.
    d. Applying dressings that require prescribed medications and aseptic

techniques.

e. Providing refresher training to the enrollee or informal caregivers to assure the use of proper techniques for health-related tasks such as diet, exercise regimens, body positioning, taking medications according to physician's orders, proper use of medical equipment, performing activities of daily living, or safe ambulation within the home.

5. This service is limited to **no more than two hours per visit**
6. Enrollees receiving Private Duty Nursing services are not eligible to receive Preventive Nursing Services
7. All providers must be licensed in the State of Michigan as a Registered Nurse or Licensed Practical Nurse
8. This service must not duplicate Home Health Services

Minimum Standards for Self-Determined Service Delivery

When authorizing Preventive Nursing Services for enrollees choosing the self-determination option, the ICO must comply with rules described above in the service definition and Minimum Standards for Traditional Service Delivery.

Private Duty Nursing	
Description	Private Duty Nursing (PDN) services are skilled nursing interventions provided to an enrollee age 21 or older on an individual and continuous basis, up to a maximum of 16 hours per day, to meet the enrollee's health needs directly related to the enrollee's physical disability.
HCPCS Codes	**T1000**, Private duty/independent nursing service(s); Licensed, up to 15 minutes.* *Use TD modifier to indicate an RN, and TE modifier to indicate an LPN
Units	Up to 15 minutes
Service Delivery Options	☑ Traditional ☑ Self-Determination

Medical Criteria

1. To be eligible for PDN services, the ICO must find the enrollee meets either Medical Criteria I or Medical Criteria II, and Medical Criteria III (see criteria below). Regardless of whether the enrollee meets Medical Criteria I or II, the enrollee must also meet Medical Criteria III.
    a. Medical Criteria I – The enrollee is dependent daily on technology-based medical equipment to sustain life. "Dependent daily on technology-based medical equipment" means:
        i. Mechanical rate-dependent ventilation (four or more hours per day), or assisted rate dependent respiration (e.g., some models of Bi-PAP); or
        ii. Deep oral (past the tonsils) or tracheostomy suctioning eight or more times in a 24-hour period; or
        iii. Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility; or
        iv. Total parenteral nutrition delivered via a central line, associated with complex medical problems or medical fragility; or
        v. Continuous oxygen administration (eight or more hours per day), in combination with a pulse oximeter and a documented need for skilled nursing assessment, judgment, and intervention in the rate of oxygen administration. This would not be met if oxygen adjustment is done only according to a written protocol with no skilled assessment, judgment or intervention required. Continuous use of oxygen therapy is a covered Medicaid benefit for enrollees age 21 or older when tested at rest while breathing room air and the oxygen saturation rate is 88 percent or below, or the PO2 level is 55 mm HG or below.

    b. Medical Criteria II – Frequent episodes of medical instability within the past three to six months, requiring skilled nursing assessments, judgments, or interventions (as described in III below) as a result of a substantiated medical condition directly related to the physical disorder. Definitions:
        i. "Frequent" means at least 12 episodes of medical instability related to the progressively debilitating

physical disorder within the past six months, or at least six episodes of medical instability related to the progressively debilitating physical disorder within the past three months.

ii. "Medical instability" means emergency medical treatment in a hospital emergency room or inpatient hospitalization related to the underlying progressively debilitating physical disorder.

iii. "Emergency medical treatment" means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services and are needed to evaluate or stabilize an emergency medical condition.

iv. "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention would result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

v. "Directly related to the physical disorder" means an illness, diagnosis, physical impairment, or syndrome that is likely to continue indefinitely, and results in significant functional limitations in 3 or more activities of daily living.

vi. "Substantiated" means documented in the clinical or medical record, including the nursing notes.

c. Medical Criteria III – The enrollee requires continuous skilled nursing care on a daily basis during the time when a licensed nurse is paid to provide services. Definitions:

i. "Continuous" means at least once every 3 hours throughout a 24-hour period, and when delayed interventions may result in further deterioration of health status, in loss of function or death, in acceleration of the chronic condition, or in a

preventable acute episode. Equipment needs alone do not create the need for skilled nursing services.

ii. "Skilled nursing" means assessments, judgments, interventions, and evaluations of interventions requiring the education, training, and experience of a licensed nurse. Skilled nursing care includes, but is not limited to:

1. Performing assessments to determine the basis for acting or a need for action, and documentation to support the frequency and scope of those decisions or actions;
2. Managing mechanical rate-dependent ventilation or assisted rate-dependent respiration (e.g., some models of Bi-PAP) that is required by the enrollee four or more hours per day;
3. Deep oral (past the tonsils) or tracheostomy suctioning;
4. Injections when there is a regular or predicted schedule, or injections that are required as the situation demands (prn), but at least once per month (insulin administration is not considered a skilled nursing intervention);
5. Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility;
6. Total parenteral nutrition delivered via a central line and care of the central line;
7. Continuous oxygen administration (eight or more hours per day), in combination with a pulse oximeter, and a documented need for adjustments in the rate of oxygen administration requiring skilled nursing assessments, judgments and interventions. This would not be met if oxygen adjustment is done only according to a written protocol with no skilled assessment, judgment or intervention required. Continuous use of oxygen therapy is a covered Medicaid benefit for beneficiaries age 21 or older when

tested at rest while breathing room air and the oxygen saturation rate is 88 percent or below, or the PO2 level is 55 mm HG or below;

8. Monitoring fluid and electrolyte balances where imbalances may occur rapidly due to complex medical problems or medical fragility. Monitoring by a skilled nurse would include maintaining strict intake and output, monitoring skin for edema or dehydration, and watching for cardiac and respiratory signs and symptoms. Taking routine blood pressure and pulse once per shift that does not require any skilled assessment, judgment or intervention at least once every three hours during a 24-hour period, as documented in the nursing notes, would not be considered skilled nursing.

Minimum Standards for Traditional Service Delivery

1. All nurses providing Private Duty Nursing (PDN) to waiver enrollees must maintain a current State of Michigan nursing license, and meet licensure requirements and standards according to Michigan laws found under MCL 333.17201-17242.
2. PDN may include medication administration according to MCL 333.7103(1).
3. This service must be ordered by a physician, physician's assistant, or nurse practitioner.
4. Through a person-centered planning process, the ICO shall determine the amount, scope and duration of services provided.
5. The direct service provider shall maintain close contact with the authorizing ICO to promptly report changes in each enrollee's condition and/or treatment needs upon observation of such changes.
6. The direct service provider shall send case notes to the care coordinator on a regular basis, preferably monthly, but no less than quarterly, to update the care coordinator on the condition of the enrollee.
7. This service may include medication administration as defined under MCL 333.7103(1).
8. The ICO is responsible for assuring there is a physician order for the private duty nursing services authorized. The physician may issue this order directly to the provider furnishing PDN services. However, the ICO is responsible for assuring the PDN provider has a copy of these orders and delivers PDN services according to the orders.
9. The ICO shall maintain a copy of the physician orders in the Care Bridge Record.

10. **PDN is limited to 16 hours per day.**
11. Enrollees receiving Preventive Nursing Services are not eligible to receive Private Duty Nursing Services.
12. All PDN services authorized must be medically necessary as indicated through the assessment and meet the medical criteria described above.
13. The enrollee's physician, physician's assistant, or nurse practitioner must order PDN services and work in conjunction with the ICO and provider agency to assure services are delivered according to that order.
14. Services covered under the waiver shall not replace services that could be provided by the ICO in accordance with the Medicaid State Plan.

Minimum Standards for Self-Determined Service Delivery

When authorizing Private Duty Nursing for enrollees choosing the self-determination option, the ICO must comply with rules described in the Minimum Standards for Traditional Service Delivery in addition to the rest of the service definition as specified above.

Respite (provided at the enrollee's home or in the home of another person)	
Description	Respite care services are provided on a short-term, intermittent basis to relieve the enrollee's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care.
HCPCS Codes	**S5150**, Unskilled respite care, not hospice, per 15 minutes **S5151**, Unskilled respite care, not hospice, per diem
Units	S5150 = 15 minutes S5151 = per diem
Service Delivery Options	☑ Traditional ☑ Self-Determination

Minimum Standards for Traditional Service Delivery

1. Enrollees choosing the traditional method of service delivery **may not** choose to have respite furnished in the home of another.
2. The ICO must establish and follow written eligibility criteria for in-home respite that include, at a minimum:
   a. Enrollees must require continual supervision to live in their own homes or the home of a primary caregiver, or require a substitute caregiver while their primary caregiver needs relief or is otherwise unavailable.
   b. Enrollees have difficulty performing or are unable to perform activities of daily living without assistance.
3. Respite services include:
   a. Attendant care (enrollee is not bed-bound) such as companionship, supervision, and/or assistance with toileting, eating, and ambulation.
   b. Basic care (enrollee may or may not be bed-bound) such as assistance with ADLs, a routine exercise regimen, and self-medication.

   The direct service provider must obtain a copy of appropriate portions of the assessment conducted by the ICO before initiating service. The assessment information must include a recommendation made by the assessing RN describing the respite support services the enrollee needs. Each ICO or direct service provider shall ensure the skills and training of the respite provider assigned are appropriate for the condition and needs of the enrollee.
4. With the assistance of the enrollee and/or enrollee's caregiver, the ICO or direct service provider shall determine an emergency notification plan for each enrollee, pursuant to each visit for emergencies and provider no-shows or late arrivals.
5. Each direct service provider shall establish written procedures that govern the medication assistance given by staff to enrollees. These procedures shall be reviewed by a consulting pharmacist, physician, or registered nurse and shall include, at a minimum:
   a. The provider staff authorized to assist enrollees with taking their own prescription or over-the-counter medications and under what conditions such assistance may take place. This must include a review of the type of medication the enrollee takes and its impact upon the enrollee.
   b. Verification of prescription medications and their dosages. The enrollee shall maintain all medications in their original, labeled containers.
   c. Instructions for entering medication information in enrollee files.
   d. A clear statement of the enrollee's and his or her family's

responsibility regarding medications taken by the enrollee and the provision for informing the enrollee and the enrollee's family of the provider's procedures and responsibilities regarding assisted self-administration of medications.

6. Each direct service provider shall employ a professionally qualified supervisor that is available to staff during their shift while providing respite care.
7. Members of an enrollee's family who are not the enrollee's regular caregiver may provide respite for the regular caregiver. However, the ICO shall not authorize MI Health Link funds to pay for services furnished to an enrollee by that person's spouse, guardian or other legally or financially responsible individual.
8. Family members who provide respite services must meet the same standards as providers who are unrelated to the individual.
9. The ICO shall not authorize respite services to relieve a caregiver that receives MI Health Link funds to provide another service to the waiver enrollee. For example, if the ICO has authorized a daughter to provide 20 hours per week of expanded community living supports to the enrollee and pays for this service with MI Health Link funds, the ICO shall not also authorize additional hours of respite to relieve the daughter of her caregiver duties. Rather, the ICO should decrease the daughter's paid hours and authorize another caregiver to provide the needed services and support to the enrollee. This requirement may be waived if:
    a. The case record demonstrates the enrollee has a medical need for supports and services in excess of the authorized amount of waiver services (i.e. in the example above the enrollee has a medical need for 50 hours per week of services); **and**
    b. The case record demonstrates the paid caregiver furnishes unpaid supports and services to the enrollee (i.e. the daughter is paid for 20 hours per week, but actually delivers 50 hours per week of services); **and**
    c. The paid caregiver is requesting respite for the supports and services not usually authorized through the waiver (i.e. for all or part of the 20 hours of medically necessary, but unpaid services the daughter regularly furnishes).
10. Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work elsewhere full time.
11. Respite services cannot be scheduled on a daily basis

12. Respite should be used on an intermittent basis to provide scheduled relief of informal caregivers
13. Respite services shall not be provided by the enrollee's usual caregiver who provides other waiver services to the enrollee
14. When a caregiver is unable to furnish unpaid medically-necessary services on a regular basis, the ICO should work with the enrollee and caregiver to develop an Individual Integrated Care and Supports Plan (IICSP) that includes other waiver services, as appropriate.
15. **The costs of room and board are not included.**

Minimum Standards for Self-Determined Service Delivery

1. Enrollee's choosing this method of service delivery **may** choose to have respite services delivered in the home of another.
2. When authorizing Respite services for enrollees choosing the self-determination option, the ICO must comply with the rules described in the service definition and Minimum Standards for Traditional Service Delivery specified above.

Respite (provided outside of the home)	
Description	Respite care services are provided on a short-term, intermittent basis to relieve the enrollee's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care.
HCPCS Codes	**H0045**, Respite services not in the home, per diem
Units	H0045 = per day
Service Delivery Options	☑ Traditional ☐ Self-Determination

Minimum Standards for Traditional Service Delivery

1. Each out-of-home respite service provider must be a licensed setting as defined in MCL 400.701ff, which includes adult foster care homes and homes for the aged.
2. Respite may include the cost of room and board if the service is provided in a licensed Adult Foster Care home or licensed Home for the Aged.
3. Each ICO must establish and follow written eligibility criteria for out-of-home respite that include, at a minimum:
   a. Enrollees must require continual supervision to live in their own homes or the home of a primary caregiver, or require a substitute caregiver while their primary caregiver needs relief or is otherwise unavailable.
   b. Enrollees have difficulty performing or are unable to perform activities of daily living without assistance.
4. Respite services include:
   a. Attendant care (enrollee is not bed-bound) such as companionship, supervision and/or assistance with toileting, eating, and ambulation.
   b. Basic care (enrollee may or may not be bed-bound) such as assistance with ADLs, a routine exercise regimen, and self-medication.
5. The direct service provider must obtain a copy of the assessment conducted by the ICO before initiating service. The assessment information must include a recommendation made by the assessing RN describing the respite care support services the enrollee needs.
6. With the assistance of the enrollee and/or enrollee's caregiver, the ICO and/or direct service provider shall determine an emergency notification and contingency plan for each enrollee for emergencies.
7. Each direct service provider shall establish written procedures to govern assistance given by staff to enrollees who need help with medications. These procedures shall be reviewed by a consulting pharmacist, physician, or registered nurse and shall include, at a minimum:
   a. The provider staff authorized to assist enrollees in taking either prescription or over-the-counter medications and under what conditions such assistance may take place. This must include a review of the type of medication the enrollee takes and its impact upon the enrollee.
   b. Verification of prescription medications and their dosages. The enrollee shall maintain all medications in their original, labeled containers.
   c. Instructions for entering medication information in enrollee files.
   d. A clear statement of the enrollee's and his or her family's

responsibility regarding medications taken by the enrollee while at the facility and the provision for informing the enrollee and his or her family of the program's procedures and responsibilities regarding assisted self-administration of medications.

8. Each direct service provider shall employ a professionally qualified program director that directly supervises program staff.
9. MDCH does not intend Respite services to be furnished on a continual basis. Respite services should be utilized for the sole purpose of providing temporary, intermittent relief to an unpaid caregiver. When a caregiver is unable to furnish unpaid medically-necessary services on a regular basis, the ICO should work with the enrollee and caregiver to develop a plan of service that includes other waiver services, as appropriate.
10. For each enrollee, the ICO shall not authorize MI Health Link payment for more than 30 days of out-of-home respite service per calendar year.
11. Respite services cannot be continually scheduled on a daily basis. Out of home respite may be scheduled for several days in a row, depending upon the needs of the enrollee and the enrollee's caregivers.
12. The ICO shall not authorize MI Health Link funds to pay for respite services provided by the enrollee's usual caregiver.

III. Application Process

When a MI Health Link enrollee is interested in participating in the MI Health Link HCBS waiver, the ICO must submit an application packet to MDCH for review and approval prior to an enrollee participating in the waiver. The following materials must be included in the application packet:

- Completed Nursing Facility Level of Care Determination tool
- Freedom of Choice form
- Completed MI Health Link HCBS Waiver Application and Consent Form
    - Enrollee must sign this form stating he or she is consenting to participate in the waiver and has been given information about various services and available providers
- Level I and Level II Assessment information
- Individual Integrated Care and Supports Plan (IICSP)
- Completed Provider Survey Tool for HCBS Residential and Non-Residential Settings (this may be submitted to MDCH earlier than the other application materials

Applications may be submitted to MDCH electronically via the Waiver Support Application system or via hard copy paper format using U.S. Mail, United Postal Service, FedEx, or fax.

The ICO will be notified by MDCH of the outcome of the application review, approval, or rejection via telephone, email, U.S. Mail, or the electronic Waiver Support Application system.

IV. Annual Redetermination of Waiver Eligibility

The ICO will be required to submit to MDCH evidence of continued determination of waiver eligibility for each waiver enrollee every twelve months. The submitted evidence of continued waiver eligibility must include updates of the following materials:

- Completed MI Health Link HCBS Waiver Application and Consent Form
  - Enrollee must sign this form stating he or she is consenting to participate in the waiver and has been given information about various services and available providers
- Level I and Level II Assessment information
- Individual Integrated Care and Supports Plan (IICSP)
- Completed Nursing Facility Level of Care Determination tool

V. HCBS Final Rule Requirements for Residential and Non-Residential Settings

The HCBS Final Rule applies to 1915c waiver programs. The ICO has been provided with the HCBS Final Rule Federal Register, CMS webinars, and other information regarding the rule. The ICO must be familiar with all aspects of the HCBS Final Rule as it applies to the MI Health Link HCBS waiver. All residential settings in which MI Health Link HCBS waiver enrollees live must comply with the requirements of the HCBS Final Rule. Similarly, non-residential settings, such as Adult Day Program settings, must comply with the HCBS Final Rule. This compliance will be assessed prior to the individual's enrollment in the waiver. The ICO must utilize the standard statewide Provider Survey tool produced by MDCH. Licensed settings used for the Respite service do not need to be assessed unless the individual stays in the setting for more than 30 days.

VI. Person-Centered Planning

The ICO must develop the Individual Integrated Care and Supports Plan (IICSP) before providing services. The enrollee must approve of all services in the service plan. The ICO must document enrollee approval and participation on the service plan.

1. Enrollee's preferences for care, services, supports, residential settings, and non-residential settings
   - i. Must include supports and services options that were discussed with the enrollee, and his or her (or legal representative's) choice of those services and providers
   - ii. When the enrollee selects controlled residential settings such as licensed Adult Foster Care or Homes for the Aged, or others, the following must be included in the IICSP
     - The chosen setting
     - The individual's resources
     - Whether or not the individual chooses to have a roommate as well as any specific preferences for roommates, bathroom schedules, etc.
     - Preference for engaging in community activities outside the home, and whether or not the individual needs assistance with arranging transportation, finding work, or otherwise getting involved in the community outside the home and how to make that happen
     - Personal safety risks, and any interventions, that may affect the individual's ability to engage in community activities outside the home without supervision
     - Any modifications to existing policy and procedure and home and community-based setting requirements (including HCBS Final Rule) at the home to accommodate an enrollee's assessed needs; indicate established timeframes for periodic review of these modifications
2. Enrollee's health and safety risks
3. Enrollee's prioritized list of concerns, goals and objectives, strengths
4. Summary of the enrollee's health status
5. The plan for addressing concerns or goals, actions for achieving the goals, and specific providers, supports and services including amount, scope and duration

   i. Must include the enrollee's (or legal representative's) rights and choices of specific providers (and alternative providers, if necessary)
   ii. Must include a contingency (backup) plan for providers in the event of unscheduled absence of a caregiver, severe weather, or other emergencies
6. Person(s) responsible for specific monitoring, reassessment, and evaluation of health and well-being outcomes
7. Enrollee's informed consent
8. Due date for interventions and reassessment

The IICSP clearly identifies the types of services needed from both paid and non-paid providers of supports and services. The amount (units), frequency, and duration of each waiver service to be provided are included in the IICSP. The enrollee chooses the supports and services that best meet his or her needs and whether to use the option to self-direct applicable services or rely on a Care Coordinator and/or LTSS Supports Coordinator to ensure the services are implemented and provided according to the IICSP. When an enrollee chooses to participate in arrangements that support self-determination, information, support and training are provided by the ICO Care Coordinator and/or LTSS Supports Coordinator and others identified in the IICSP and according to the Self-Determination Implementation Technical Advisory. When an enrollee chooses not to participate in self-determination, the Care Coordinator or LTSS Supports Coordinator ensures that supports and services are implemented as planned. The Care Coordinator and/or LTSS Supports Coordinators, as applicable, oversee the coordination of State Plan and waiver services included in the IICSP. This oversight ensures that waiver services in the IICSP are not duplicative of similar State Plan services available to or received by the enrollee.

VII. Participation in Arrangements that Support Self-Determination

Individuals enrolled in the HCBS waiver have the opportunity to participate in arrangements that support self-determination for certain services as indicated in the service tables above. The ICO and subcontracted entities must follow the guidance set forth in the MI Health Link Self-Determination Implementation Technical Advisory document.

VIII. Quality Improvement Strategy

The ICO must comply with the performance monitoring requirements set forth in the MI Health Link HCBS waiver application. MDCH will provide additional guidance about these requirements.

IX. Waiver Support Application System

The ICO must utilize the waiver management database in the Waiver Support Application system for anything related to MI Health Link HCBS c-waiver enrollments, application submission, slot management, and disenrollments. Training on this database will be provided by MDCH and Optum. The ICO is required to submit a list of users for this system, and the ICO must keep the list updated on a regular basis as staff come onboard or leave. **When approved users leave the organization, the organization must notify Heather Hill at MDCH within 2 business days** via email at hillh3@michigan.gov, or phone 517-241-9960, so Heather can remove the individual from the system.

X. Waiver Slot Allocation

1. Because MI Health Link is being phased in during the first year of operation, the first year of the program has a different total number of waiver slots than subsequent years. r Additional slots are available in the subsequent years of MI Health Link operation in the event all slots are used in the first year. Waiver years are based on waiver approval by CMS. The waiver was approved effective January 1, 2015, so this is the beginning of the waiver year 1 which runs through December 31, 2015. Each subsequent year will be based on the calendar year beginning January 1st and going through December 31st.
2. A small number of waiver slots is reserved for individuals who are at imminent risk of nursing home placement or want to transition from a nursing home to a community setting and the ICO has no vacant slots.
3. Waiver slots are allocated per region and divided among ICOs. The total number per region is proportionate to the number of potential MI Health Link enrollees per region as indicated in the data MDCH provided to ICOs and PIHPs which is saved in the ICO/PIHP SharePoint site. The number of slots per region is divided equally among ICOs for initial implementation purposes. MDCH reserves the right to adjust the number of slots based on regional and ICO-specific HCBS waiver utilization.

4. The number of enrollees served is determined in two ways: there is an unduplicated count and an any point in time count. The unduplicated number of enrollees is the total number of individuals that can be served over the course of the year. This includes the number of individuals who have been enrolled in the waiver and then were disenrolled from the waiver. If an individual comes on and off the waiver more than once during the year and keeps the same Medicaid ID, this person will only account for one slot towards the unduplicated count. The any point in time count is the number of enrollees that may be served at any given time during the waiver year.
5. The Waiver Support Application system will be used to monitor and manage utilization of waiver slots. MDCH will be closely monitoring the number of waiver slots used and adjustments may be made as necessary.
6. MDCH reserves the right to move an enrollee's waiver slot with him or her to another ICO if he or she changes ICOs and the new ICO has no slots available. For example, if an individual is enrolled in the waiver with ICO 1 and decides to move to ICO 2, and ICO 2 has no vacant waiver slots, the waiver slot occupied at ICO 1 will be moved by MDCH to ICO 2.

XI. Provider No Shows and Gaps in Services

The ICO must have requirements in place for a contingency plan in the event of provider no-shows or unexpected gaps in service. Providers may be allowed to refuse to go to a house that is perceived to be structurally unsafe (e.g., imminent risk of the roof falling in, unsafe entrance/exit). The ICO and/or providers must have rules and protocol (e.g., notifying appropriate authorities like Adult Protective Services, or other state or local services) for certain situations that may cause the caregiver to refuse to enter the home.

XII. Additional Provider Requirements

1. The ICO must complete the state-approved assessment instrument for each enrollee according to established standards prior to beginning home-based supports and services. Direct providers of home-based supports and services must avoid duplicating assessments of individual enrollees to the maximum extent possible. Providers of home-based supports and services must accept assessments conducted by the ICO and begin supports and services without having to conduct a separate assessment. The ICO must make every attempt to supply the providers of home-based

services with enough information about each enrollee served by that organization to properly provide needed services.

2. Home-based service providers include those for Expanded Community Living Supports, Chore Services, Respite provided in the home, Personal Emergency Response System, Private Duty Nursing, Preventive Nursing Services, Home Delivered Meals, and Community Transition Services. Other community-based service providers are those for Adult Day Program, Environmental Modifications, Respite services provided outside the home, Adaptive Medical Equipment and Supplies, and Non-Medical Transportation.
3. Home-based service provider requirements:
    i. Home-based providers must have a supervisor available to direct care workers at all times while the worker is furnishing services to enrollees. The provider may offer supervisor availability by telephone. Home-based service providers must conduct in-home supervision of their staff at least twice per year. A qualified professional must conduct the supervisory visit.
    ii. The ICO and direct provider agencies of home-based services must require and thoroughly check references of paid staff that will enter homes of enrollees. Reference checks must be conducted prior to beginning services.
    iii. The ICO and/or providers of home-based services must conduct a criminal history screening through the Michigan State Police via ICHAT or some other method, and in accordance with Michigan Medicaid policy, for each paid or unpaid **direct access staff or other provider** who will be entering homes of enrollees. Criminal history screenings must be completed prior to beginning service delivery. ICOs must follow additional Medicaid policy once MDCH systems are ready.
    iv. ICO staff and direct providers of home-based services must receive in-service training as often as needed to ensure person-centered practices. The ICO and providers must design the training so that it increases staff knowledge and understanding of the program and its enrollees and improves staff skills at tasks performed in the provision of service. Training sessions and materials developed and offered by MDCH must be utilized before training developed by the ICO or its providers. The ICOs and direct providers of home-based services

must maintain comprehensive records identifying dates of training and topics covered in an agency training log, and/or in each employee's personnel file. The employer shall develop an individualized in-service training plan for each employee when performance evaluations indicate a need.

v. Each ICO and direct provider of home-based services will assure MDCH that employees or volunteers who enter and work within enrollee homes abide by the following additional conditions and qualifications:

- Service providers must have procedures in place for obtaining enrollee signatures on the time sheets (or similar document) of direct care workers to verify the direct service worker provided the work ordered by the ICO.
- Direct service workers are prohibited from smoking in enrollee's homes.
- Direct service workers must be able to adequately and appropriately communicate, both orally and in writing, with their employers and the enrollees they serve. This includes the ability to properly follow product instructions in carrying out direct service responsibilities (i.e. read grocery lists, identify items on grocery lists, and properly use cleaning and cooking products.)
- Direct service workers must not threaten or coerce enrollees in any way. Failure to meet this standard is grounds for immediate termination.
- Service contractors and direct service workers will be promptly informed of new service standards or any changes to current services standards.

4. Other Community-Based Service providers:

i. <u>Enrollee Records</u>

Each direct provider of community-based services must maintain enrollee records that contain, at a minimum:

ii. A copy of the request for services.

iii. Pertinent medical, social, and/or functional enrollee information as necessary to the proper delivery of the requested service.

iv. A description of the provided service, including the number of units and cost per unit, as applicable.
v. The date(s) of service provision.
vi. The total cost of each service provided.

Direct providers of community-based services must keep all enrollee records (written, electronic, or other) confidential in controlled access files for ten years.

5. Notifying Enrollee of Rights

Each ICO or direct provider of home-based services must notify each enrollee, in writing, at the time service is initiated of his or her right to comment about service delivery or appeal the denial, reduction, suspension, or termination of services. Such notice must also advise the enrollee that they may file complaints of discrimination with the respective ICO, the U.S. Department of Health and Human Services Office of Civil Rights, or the Michigan Department of Civil Rights.

Appendix 1

Billing and Encounter Procedure Codes

I. Nursing Facilities

Information for provider billing and ICO encounter submission related to nursing facilities may be found at: http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-151018--,00.html. Click on the "**Revenue Code Table**" link.

II. State Plan Personal Care Services

- Use procedure code T1019 for personal care services, per 15 minute increments.
- For personal care supplement payment:
  - The ICO must use the invoice provided by MDCH. The ICO must give this invoice to Adult Foster Care and Homes for the Aged providers for billing purposes. This invoice will be returned to the ICO, and the ICO will pay the personal care supplement to the provider as appropriate. There must an invoice for each enrollee residing in one of these settings.
  - The ICO will need to track the amount and date paid to the Adult Foster Care home or Home for the Aged for each enrollee.
  - For personal care supplement payments, the ICO should use procedure code "T1019" (personal care services, per 15-min increments) with modifier "CG" (policy criteria applied).
  - The ICO may find Place of Service code "14" (Group Home) applicable in Loop 2300.
- The ICO must submit encounters for each enrollee based on the information on the invoice and using the codes provided by MDCH.
- Encounters will require a diagnosis code as well. For ICD-9, MDCH recommends "V60.89" (Other specified housing or economic circumstances) or "V60.4" (No other household member able to render care). For ICD-10, MDCH recommends "Z74.1" (Need assistance with personal care) or "Z74.2" (No other household member able to render care).

III. MI Health Link HCBS Waiver and Supplemental Services

HCPCS/ CPT Code	HCPCS/ CPT Modifier	HCPCS/ CPT Code Description	Standardized Remark	Comment
A0130		Non-emergency transportation; wheel chair van; per trip	7001 Public Transportation	
A0130		Non-emergency transportation; wheel chair van; per trip	7002 Private Transportation	
A0130		Non-emergency transportation; wheel chair van; per trip	7003 Volunteer Transportation	
A4931		Oral Thermometer, Reusable, any type, each		
A4932		Rectal Thermometer, Reusable, any type, each		
A9300		Exercise Equipment		
B4100		Food thickener, administered orally, per ounce		
B4150	BO	Enteral Formulae; Category 1; Semi-synthetic Intact Protein/Protein isolates, administered thru an enteral feeding tube, 100 calories=1unit	8003 Liquid	1 can = 1 unit
B4150	BO	Enteral Formulae; Category 1; Semi-synthetic Intact Protein/Protein isolates, administered thru an enteral feeding tube, 100 calories=1unit	8004 Solid	100 calories = 1 unit
B4150	BO	Enteral Formulae; Category 1; Semi-synthetic Intact Protein/Protein isolates, administered thru an enteral feeding tube, 100 calories=1unit	8005 Bar	1 bar = 1 unit
E0160		Sitz type bath or equipment, portable, used with or without commode		
E0161		Sitz type bath or equipment, portable, used with or without commode, with faucet attachment		
E0210		Electric heat pad, standard		
E0215		Electric heat pad, moist		
E0241		Bathtub wall rail, each		

E0242		Bathtub rail, floor base		
E0243		Toilet rail, each		
E0244		Raised toilet seat		
E0245		Tub stool or bench		
E0315		Bed accessory; board, table, or support device, any type		
E0627		Seat lift mechanism incorporated into a combination lift chair mechanism		
E0628		Separate seat lift mechanism for use with patient owned furniture - electric		
E0629		Separate seat lift mechanism for use with patient owned furniture - nonelectric		
E0745		Neuromuscular stimulator, electronic shock unit		per unit
E1300		Whirlpool, portable (overtub type)		per unit
E1310		Whirlpool, non-portable (built-in type)		per unit - installation charges may fall under another waiver code.
E1639		Scale, each		
H0045		Respite services not in the home, per diem	7500 Adult Foster Care	
H0045		Respite services not in the home, per diem	7501 Hospital	
H2015		Comprehensive community support services, per 15 minutes	5501 Includes transportation	
H2015		Comprehensive community support services, per 15 minutes	5502 Does not include transportation	
H2016		Comprehensive community support services, per diem	5501 Includes transportation	
H2016		Comprehensive community support services, per diem	5502 Does not include transportation	
S0209		Wheelchair van, mileage, per mile	7001 Public Transportation	
S0209		Wheelchair van, mileage, per mile	7002 Private Transportation	
S0209		Wheelchair van, mileage, per mile	7003 Volunteer Transportation	

S0215		Non-emergency transportation, mileage, per mile	7001 Public Transportation	
S0215		Non-emergency transportation, mileage, per mile	7002 Private Transportation	
S0215		Non-emergency transportation, mileage, per mile	7003 Volunteer Transportation	
S5100		Day care services, adult, per 15 minutes	5501 Includes transportation	
S5100		Day care services, adult, per 15 minutes	5502 Does not include transportation	
S5101		Day care services; adult; per half day	5501 Includes transportation	
S5101		Day care services; adult; per half day	5502 Does not include transportation	
S5102		Day care services, adult, per diem	5501 Includes transportation	
S5102		Day care services, adult, per diem	5502 Does not include transportation	
S5120		Chore Services; per 15 minutes	6001 Duct Cleaning	
S5120		Chore Services; per 15 minutes	6002 Install Safety Equipment	
S5120		Chore Services; per 15 minutes	6003 Install Smoke Alarm	
S5120		Chore Services; per 15 minutes	6004 Window Installation	
S5120		Chore Services; per 15 minutes	6005 Window Repair	
S5120		Chore Services; per 15 minutes	6006 Replace/Repair Door Lock	
S5120		Chore Services; per 15 minutes	6007 Replace/Repair Window Catch	
S5120		Chore Services; per 15 minutes	6008 Replace/Repair Electrical	
S5120		Chore Services; per 15 minutes	6009 Replace/Repair Plumbing	
S5120		Chore Services; per 15 minutes	6010 Install	

			Screens or Storm Windows	
S5120		Chore Services; per 15 minutes	6011 Install Storm Door	
S5120		Chore Services; per 15 minutes	6012 Pest Control	
S5120		Chore Services; per 15 minutes	6013 Snow or Ice Removal	
S5120		Chore Services; per 15 minutes	6014 Lawn Mowing or Raking	
S5120		Chore Services; per 15 minutes	6015 Heavy-Duty Household Chores	
S5120		Chore Services; per 15 minutes	6016 Install weather stripping	
S5120		Chore Services; per 15 minutes	6017 Caulk windows	
S5120		Chore Services; per 15 minutes	6018 Remove exterior safety hazard	
S5121		Chore Services; per diem	6001 Duct Cleaning	
S5121		Chore Services; per diem	6002 Install Safety Equipment	
S5121		Chore Services; per diem	6003 Install Smoke Alarm	
S5121		Chore Services; per diem	6004 Window Installation	
S5121		Chore Services; per diem	6005 Window Repair	
S5121		Chore Services; per diem	6006 Replace/Repair Door Lock	
S5121		Chore Services; per diem	6007 Replace/Repair Window Catch	
S5121		Chore Services; per diem	6008 Replace/Repair Electrical	
S5121		Chore Services; per diem	6009 Replace/Repair Plumbing	
S5121		Chore Services; per diem	6010 Install	

			Screens or Storm Windows	
S5121		Chore Services; per diem	6011 Install Storm Door	
S5121		Chore Services; per diem	6012 Pest Control	
S5121		Chore Services; per diem	6013 Snow or Ice Removal	
S5121		Chore Services; per diem	6014 Lawn Mowing or Raking	
S5121		Chore Services; per diem	6015 Heavy-Duty Household Chores	
S5121		Chore Services; per diem	6016 Install weather stripping	
S5121		Chore Services; per diem	6017 Caulk windows	
S5121		Chore Services; per diem	6018 Remove exterior safety hazard	
S5150		Unskilled Respite Care, not Hospice, per 15 minutes	7502 Home of another	
S5150		Unskilled Respite Care, not Hospice, per 15 minutes	7503 Enrollee's home	
S5151		Unskilled Respite Care, not Hospice, per diem	7502 Home of another	
S5151		Unskilled Respite Care, not Hospice, per diem	7503 Enrollee's home	
S5160		Emergency response system; installation and testing		
S5161		Emergency response system; service fee, per month (excludes installation and testing)		
S5162		Emergency response system; purchase only		
S5165		Home modifications, per service	5001 Bathroom Modification	
S5165		Home modifications, per service	5002 Kitchen Modification	
S5165		Home modifications, per service	5003 Specialized Door Locks	
S5165		Home modifications, per service	5004 Doorway Modification	

S5165		Home modifications, per service	5005 Equipment Installation Charge	
S5165		Home modifications, per service	5008 Outside Railings	
S5165		Home modifications, per service	5009 Telephone Conversion for PERS Unit	
S5165		Home modifications, per service	5010 Stair Lift	
S5165		Home modifications, per service	5011 Ramp Installation	
S5165		Home modifications, per service	5012 Ramp Repair	
S5165		Home modifications, per service	5013 Portable Ramp	
S5165		Home modifications, per service	5014 Safety Railings	
S5165		Home modifications, per service	5015 Wireless Door Alarm	
S5165		Home modifications, per service	5016 Specialized Electrical System Installation	
S5165		Home modifications, per service	5017 Specialized Plumbing System Installation	
S5165		Home modifications, per service	5018 Other Repair	
S5165		Home modifications, per service	5019 Weatherization	
S5165		Home modifications, per service	5020 Injury Prevention	
S5170		Home delivered meals, including preparation, per meal	8001 Hot/Frozen	
S5170		Home delivered meals, including preparation, per meal	8002 Cold	
S5170		Home delivered meals, including preparation, per meal	8003 Liquid	
S5170		Home delivered meals, including preparation, per meal	8008 Emergency	
S5170		Home delivered meals, including preparation, per meal	8009 Breakfast	
S5199		Personal care item, NOS, each	0100 Reacher	
S5199		Personal care item, NOS, each	0101 Shower Attachment	

S5199		Personal care item, NOS, each	0102 Back scrubber	
S5199		Personal care item, NOS, each	0103 Beverage Bud	
S5199		Personal care item, NOS, each	0104 Adaptive Clothing	
S5199		Personal care item, NOS, each	0105 Assistive dressing device	
S5199		Personal care item, NOS, each	0106 Specialized bedding	
S5199		Personal care item, NOS, each	0107 Hospital gown	
S5199		Personal care item, NOS, each	0108 Key holder	
S5199		Personal care item, NOS, each	0109 Nail clippers	
S5199		Personal care item, NOS, each	0110 Specialized Shampoo tray	
S5199		Personal care item, NOS, each	0111 Specialized basin	
S5199		Personal care item, NOS, each	0112 Specialized bib unit	
S5199		Personal care item, NOS, each	0113 Assistive device for performing personal care	
S5199		Personal care item, NOS, each	0114 In-bed Vacuumed Bath Unit	
T1000	TD	Private duty/independent nursing service(s); Licensed, up to 15 minutes		TD indicates RN
T1000	TE	Private duty/independent nursing service(s); Licensed, up to 15 minutes		TE indicates LPN
T1002		RN Services, up to 15 minutes		
T1003		LPN/LVN services, up to 15 minutes		
T1028		Assessment of home, physical and family environment, to determine suitability to meet patient's medical needs		Use for assessment of possible domiciles for NF transition
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0200 Specialized turner or pointer, adaptive	

			equipment	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0201 Mouthstick for TDD	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0202 Foot massaging unit	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0203 Talking timepiece	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0204 Adaptive or specialized communication device, retail purchase	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0205 Adaptive eating or drinking devices	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0206 Assistive dialing device	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0207 Book holder	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0208 Adaptive door opener	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0209 Specialized alarm or intercom	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0210 Medical alert bracelet	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0211 Adapted mirror	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0212 Automatic light	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0213 Smokeless ashtray	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0214 No slip stabilizing device	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0215 Assistive writing device	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0216 Weighted blanket	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0217 Back knobber	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0218 Other adaptive or assistive devices	
T2003		Non-Emergency Transportation;	7001 Public	

		per encounter/trip	Transportation	
T2003		Non-Emergency Transportation; per encounter/trip	7002 Private Transportation	
T2003		Non-Emergency Transportation; per encounter/trip	7003 Volunteer Transportation	
T2004		Non-emergency Transportation, commercial carrier, multi-pass	7001 Public Transportation	
T2004		Non-emergency Transportation, commercial carrier, multi-pass	7002 Private Transportation	
T2004		Non-emergency Transportation, commercial carrier, multi-pass	7003 Volunteer Transportation	
T2025		Waiver Services, NOS	8500 Fiscal Intermediary Services, per month	
T2025		Waiver Services, NOS	8501 Self-determination workman's compensation insurance fee	For use only with SD enrollment for WCI fees.
T2028		Specialized supply, NOS, waiver	0301 Specialized Cabinet	
T2028		Specialized supply, NOS, waiver	0302 Non-Orthotic Elbow pad	
T2028		Specialized supply, NOS, waiver	0303 Non-Orthotic Knee pad	
T2028		Specialized supply, NOS, waiver	0304 Lap Tray not for wheelchair	
T2028		Specialized supply, NOS, waiver	0305 Tennis balls for use with walkers	
T2028		Specialized supply, NOS, waiver	0306 Water shield for cast	
T2028		Specialized supply, NOS, waiver	0307 Battery charger for specialized equipment	
T2028		Specialized supply, NOS, waiver	0308 Disinfectant	
T2028		Specialized supply, NOS, waiver	0309 Non-medical air filtering facial	

			mask	
T2028		Specialized supply, NOS, waiver	0310 GT Feeding Plugs, not part of feeding system	
T2028		Specialized supply, NOS, waiver	0311 Specialized holders or cuffs for limbs	
T2028		Specialized supply, NOS, waiver	0312 Medication planner	
T2028		Specialized supply, NOS, waiver	0313 Pill crusher	
T2028		Specialized supply, NOS, waiver	0314 Non-slip mat or strip for bathtub	
T2028		Specialized supply, NOS, waiver	0315 Sharps container	
T2028		Specialized supply, NOS, waiver	0316 Electrostatic Air Filter	
T2028		Specialized supply, NOS, waiver	0317 Quantity above SP PA denial on file	
T2028		Specialized supply, NOS, waiver	0318 Stethoscope	
T2028		Specialized supply, NOS, waiver	0319 Non-Orthotic back support	
T2028		Specialized supply, NOS, waiver	0320 Electrodes for neuromuscular stimulator	To be used in conjunction with E0745
T2029		Specialized medical equipment, NOS, waiver	0400 Bumper pad	
T2029		Specialized medical equipment, NOS, waiver	0401 Air cushion ring	
T2029		Specialized medical equipment, NOS, waiver	0402 Electric cart	
T2029		Specialized medical equipment, NOS, waiver	0403 Geri Chair	
T2029		Specialized medical equipment, NOS, waiver	0404 Shower Stool with Back	
T2029		Specialized medical equipment, NOS, waiver	0405 Portable easy up	
T2029		Specialized medical equipment, NOS, waiver	0406 Safety frame for toilet	

T2029		Specialized medical equipment, NOS, waiver	0407 Walker Accessories; tray, basket, apron	
T2029		Specialized medical equipment, NOS, waiver	0408 Air Filtering Machine	
T2029		Specialized medical equipment, NOS, waiver	0409 Pressure relieving boot for decubitus care	
T2029		Specialized medical equipment, NOS, waiver	0410 Electronic Pill Dispenser	
T2029		Specialized medical equipment, NOS, waiver	0411 Humidifier not used with oxygen equipment	
T2029		Specialized medical equipment, NOS, waiver	0412 Dehumidifier not used with oxygen equipment	
T2029		Specialized medical equipment, NOS, waiver	0413 Specialized holder for insulin syringes	
T2029		Specialized medical equipment, NOS, waiver	0414 Palm cone	
T2029		Specialized medical equipment, NOS, waiver	0415 Air Conditioner	
T2029		Specialized medical equipment, NOS, waiver	0416 Air Purifier	
T2029		Specialized medical equipment, NOS, waiver	0417 Lift Chair Repair	
T2029		Specialized medical equipment, NOS, waiver	0418 Wheelchair stabilizer in vehicle	
T2029		Specialized medical equipment, NOS, waiver	0419 Installation of Elec Pill Dispenser	
T2029		Specialized medical equipment, NOS, waiver	0420 SP PA denied copy of denial on file	
T2029		Specialized medical equipment, NOS, waiver	0421 Specialized patient lift	
T2029		Specialized medical equipment, NOS, waiver	0422 Pivot Disk	
T2029		Specialized medical equipment,	0423 Over-tub	

		NOS, waiver	sliding bath system	
T2029		Specialized medical equipment, NOS, waiver	0424 Bath system accessory	
T2029		Specialized medical equipment, NOS, waiver	0425 Incentive Spirometer	
T2029		Specialized medical equipment, NOS, waiver	0426 Personal locator unit	
T2038		Community Transition, waiver; per service	9006 Appliance	
T2038		Community Transition, waiver; per service	9009 Household Supplies	
T2038		Community Transition, waiver; per service	9010 Moving Expenses	
T2038		Community Transition, waiver; per service	9014 Furniture	
T2038		Community Transition, waiver; per service	9015 Groceries	
T2038		Community Transition, waiver; per service	9016 Roof Repair	
T2038		Community Transition, waiver; per service	9018 Smoke Alarm	
T2038		Community Transition, waiver; per service	9021 Clothing	
T2038		Community Transition, waiver; per service	9022 Interpreter	
T2038		Community Transition, waiver; per service	9026 Fire Extinguisher	
T2038		Community Transition, waiver; per service	9029 Court Fees for Conservator/Guardian	
T2038		Community Transition, waiver; per service	9030 Carbon monoxide detector	
T2038		Community Transition, waiver; per service	9500 Coordination and support, per month	
T2038		Community Transition, waiver; per service	9501 Utility installation fee	
T2038		Community Transition, waiver; per service	9502 Utility deposit	
T2038		Community Transition, waiver; per	9503 Linens	

		service		
T2038		Community Transition, waiver; per service	9504 Pest eradication service	
T2038		Community Transition, waiver; per service	9505 Allergen control service	
T2038		Community Transition, waiver; per service	9506 Residential cleaning service	
T2038		Community Transition, waiver; per service	9507 Individualized training for provision of care in home, per 15 minutes.	
T2038		Community Transition, waiver; per service	9508 Ramp, including installation	
T2038		Community Transition, waiver; per service	9509 Home Modification	
T2038		Community Transition, waiver; per service	9510 NFT Prescriptions, short term only	
T2038		Community Transition, waiver; per service	9512 NFT Credit Check	
T2038		Community Transition, waiver; per service	9513 NFT Application Processing Fee	
T2038		Community Transition, waiver; per service	9514 NFT Transportation	
T2038		Community Transition, waiver; per service	9516 NFT PCA for NF therapeutic leave days, per 15 min	
T2038		Community Transition, waiver; per service	9518 Community Placement Coordination	
T2038		Community Transition, waiver; per service	9909 NFTI Security Deposit	
T2038		Community Transition, waiver; per service	9910 NFTI Section 8 Voucher	
T2039		Vehicle Modifications, waiver, per service		
V5268		Assistive listening device, telephone amplifier, any type		

V5269		Assistive listening device, alerting, any type		
V5270		Assistive listening device, television amplifier, any type		