Region 9 AAA	Local Policy #	A-19
Policy Name:	**False Claims Act Policy**	
Original Policy Date:	September 2014	
Revise Date:	August 2016, September 2019	
Review Date:	January 2015, June 2017, January 2019	

Policy:

Under the Deficit Reduction Act of 2005, the Region 9 Area Agency on Aging (AAA) is required to provide employees, providers and volunteers with information regarding federal and state false claims laws, administrative remedies under those laws, whistle-blower protections to employees who report incidents of false claims, and Region 9 AAA's methods for detecting and preventing fraud, waste and abuse in Medicaid programs. The AAA is committed to ensuring Medicaid programs, the participants served and providers of service are protected through the implementation fraud, waste and abuse mitigation activities.

Purpose:

The purpose of this policy is to ensure that employees, providers and volunteers fully understand the requirements of the Deficit Reduction Act of 2005 which contains provisions to combat fraud and abuse in government health care programs.

Procedure:

The policy is intended to cover the following Acts:

Federal False Claims Act (*31 U.S.C. §3729 et seq.)*

The False Claims Act prohibits any person from knowingly presenting or causing to be presented, a false or fraudulent claim to the United States government for payment. The False Claims Act imposes civil liability on any person who:

- Knowingly presents a false or fraudulent claim for payment or approval.
- Knowingly makes or uses a false record or statement to get a false or fraudulent claim paid or approved.
- Conspires with another to get a false or fraudulent claim paid or allowed.
- Knowingly makes or uses a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property.
- Commits other fraudulent acts enumerated in the statute.

Medicaid False Claim Act (*M.C.L. 400.601 et seq.)*

The State of Michigan has a companion law known as the Medicaid False Claims Act. This act imposes prison terms of up to four (4) years and fines up to $50,000 for:

- Knowingly making a false statement or false representation of a material fact in any application for Medicaid benefits or for use in determining rights to a Medicaid benefit;
- Concealing or failing to report an event which would affect the person's right to receive or continue to receive benefits;
- Soliciting, offering or receiving kickbacks or bribes for referrals to another for Medicaid-funded services (fine up to $30,000);
- Entering an agreement with another to defraud Medicaid through a False Claim; or
- Making or presenting to the State of Michigan a False Claim for payment.

Safeguards:

Both the federal and Michigan False Claims Acts provide for criminal penalties and include a whistleblower provision to report misconduct involving false claims. This provision allows any private person with actual knowledge of allegedly false claims to file a lawsuit on behalf of the United States government or State government as the case may be.

The federal or state government has the opportunity to intervene in the lawsuit and assume primary responsibility for prosecuting, dismissing or settling the action. If the government decides to intervene, the private person who initiated the action may be eligible for a portion of the proceeds of the action or settlement of the claim. If the government does not proceed with the action, the private person may continue with the lawsuit or settle the claim and he or she may receive a portion of the proceeds of the action or settlement. The person filing such an action may also receive an amount for reasonable expenses, including reasonable attorney fees and costs incurred in connection with bringing the lawsuit.

Violations of the federal false claims act can result in penalties of not less than $5,500.00 and not more than $11,000.00 per claim, plus three times the amount of damages that the government sustains. The Michigan act makes violation a felony punishable by imprisonment and fines up to $50,000.00.

Whistleblower Protection Laws:

Both the federal and state laws protect individuals who investigate or report possible False Claims Act violations made by their employer against discharge or discrimination in employment because of participation in such investigation. Employees who are discriminated against or are subjected to adverse employment actions based on good faith participation in an investigation may sue in court for damages. Under either the federal or state law, any employer who violates the whistleblower protection law is liable to the employee for (1) reinstatement of the employee's position without loss of seniority, (2) two times the amount of

lost back pay, (3) interest and compensation for any special damages, and such other relief necessary to make the employee whole.

Detection of Potential Fraud or Abuse:

The Region 9 AAA combats Medicaid fraud, waste and abuse by investigating complaints, raising awareness of anti-fraud initiatives, and assuring compliance with state and federal laws. Quality measures are also used to detect and prevent potential fraud, waste or abuse that includes the following:

- Proactive review of claims and other types of data
- Recommending and implementing claims processing safeguards
- Conducting education on fraud and abuse prevention, recognition and reporting at the time of hire and at minimum once per each fiscal year with all applicable AAA employees.
- Ensuring that all contracted agencies conduct training related to fraud, waste and abuse, including the False Claims Acts, at the time of hire and at minimum once per each fiscal year with all employees.
- Mandatory reporting of fraud or abuse by employees and contractors

Types Of Fraud Prosecuted Under The FCA and MFCA:

The AAA, as well as its contracted providers, are required to ensure that they remain up to date with any and all changes to types of fraud prosecuted under the FCA and MFCA. The following is a list, including but not limited to, the types of fraud prosecuted under FCA and MFCA.

- Billing for goods or services that were not delivered or rendered
- Submitting false service records or samples in order to show better-than-actual performance
- Performing inappropriate or unnecessary medical procedures
- Providing inappropriate or unnecessary medical equipment
- Billing in order to increase revenue instead of billing to reflect actual work performed
- Up-coding, or inflating bills by using diagnosis billing codes that suggest a more expensive illness or treatment
- Double billing, or charging more than once for the same service or goods
- Prescribing a medicine or recommending a type of treatment regimen in order to earn kickbacks from hospital, labs or pharmaceutical companies
- Billing for unlicensed or unapproved drugs
- Forging physician signatures when such signatures are required for reimbursement from Medicare or Medicaid
- Billing for work or tests that were not performed
- Phantom employees and doctored time slips: charging for employees that were not actually on the job, or billing for made-up hours in order to maximize reimbursements

- A grant recipient charging grantor for costs not related to the program
- Making or inducing another to make false statements or using false records to obtain or continue Medicaid eligibility.

Notice/Information:

The Region 9 AAA prohibits the actions listed above, and any other action (or in action) that results in fraud, waste, or abuse of public resources, and shall provide all employees, contractors and agents with a copy of this policy to inform them about the about federal and state false claim laws. This policy shall be included in the Region 9 AAA's Programmatic Policies and referred to in vendor Contract Standards as well as distributed to all contractors and agents as required by the Deficit Reduction Act of 2005.

The following websites outline the provisions of the Acts:

Federal False Claims Act : http://www.justice.gov/civil/docs_forms/C-FRAUDS_FCA_Primer.pdf

Michigan's The Whistleblowers' Protection Act:
http://www.legislature.mi.gov/(S(sd0gkwnskdhodsf00xmjpb55))/mileg.aspx?page=GetObject&objectname=mcl-Act-469-of-1980

Michigan's The Medicaid False Claim Act:
http://legislature.mi.gov/doc.aspx?mcl-act-72-of-1977

Response/Reporting:

To the extent that Region 9 AAA becomes aware or suspects fraud or abuse, it is obligated to respond in accordance with Federal and State regulations.

To report Medicaid Fraud:
http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-220188--,00.html

Enforcement:

All management level personnel are responsible for enforcing this policy. All **employees, vendors and volunteers** will be given a copy of this policy and required to sign an attestation of compliance. The Region 9 AAA reserves the right to modify or amend this policy at any time as it may deem necessary.

False Claims Act Policy Attestation:

I attest that I have read and understand the False Claims Act Policy and hereby agree to abide by the contents of said policy. I understand that as a contracted provider of services reimbursed by Medicaid, that my provider agency is required to report any identified or suspected fraud, waste and abuse immediately to NEMCSA – Region 9 AAA and to the Office of Inspector General (OIG) for investigation and subsequent action as deemed appropriate by the OIG. I agree to ensure that all employees of my agency will receive training related to fraud, waste and abuse, including the False Claims Acts, at the time of hire and at minimum once per each fiscal year. As a provider of services reimbursed by Medicaid, I will ensure that my provider agency verifies the eligibility of employees in the System for Award Management (SAM), Michigan Department of Licensing and Regulatory Affairs (LARA) and/or the OIG Exclusions Database at the time of hire and at minimum once per each fiscal year.

_____

Provider Representative Signature

_____

Provider Representative Name (Printed)

_____

Provider Agency Name

Date: _____

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

MINIMUM OPERATING STANDARDS

FOR MI CHOICE SERVICES

Home and Community Based Services Waiver
For the Elderly and Younger Adults with Disabilities

October 1, 2020

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MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Minimum Operating Standards for MI Choice Waiver Program Services

I. GENERAL OPERATING STANDARDS FOR WAIVER AGENCIES AND CONTRACTED DIRECT SERVICE PROVIDERS

Administering agencies of the MI Choice Waiver program and direct service providers must comply with all general program requirements established by the Michigan Department of Health and Human Services (MDHHS).

Required Program Components

A. **Contractual Agreement**

MI Choice waiver agencies may only administer the MI Choice waiver program through a formal contractual agreement between the waiver agency and MDHHS. Service providers may only deliver MI Choice waiver services through a formal subcontract agreement between the waiver agency and the service provider agency. In-network providers must have a formal contract with the waiver agency. Out-of-network providers must have an agreement with the waiver agency to provide the necessary services. Each subcontract must contain all applicable contract components required by MDHHS.

B. **Compliance with Service Definitions**

State and Federal funds awarded by MDHHS may only pay for those services that MDHHS has included and defined in the Centers for Medicare and Medicaid Services (CMS) approved waiver application, and for which MDHHS has defined minimum standards. Each waiver agency and direct service provider must adhere to the definition and minimum standards to be eligible to receive reimbursement of allowable expenses.

C. **Person-Centered Planning Process**

Waiver agencies and direct service providers must utilize a person-centered planning process and knowledge of person-centered planning must be evident throughout the delivery of services. This includes assessing the needs and desires of participants, developing service/support plans, and continuously updating and revising those plans, as the participant's needs and preferences change. Waiver agencies and direct service providers must implement person-centered planning in accordance with the MDHHS Person-Centered Planning Guideline.

D. **Contributions**

1. Neither the waiver agency nor any service provider under contract with the waiver agency may require monetary donations from participants of the MI Choice waiver program as a condition of participation in the MI Choice waiver.

2. The waiver agency and each direct service provider must accept MI Choice payments for services as payment in full for such services. Consistent with the Code of Federal Regulations, Chapter 42, Section 438.60 (42 CFR §438.60) service providers must not seek nor receive payment other than payment from the waiver agency for services covered under the contract between MDHHS and the waiver agency, except when these payments are specifically required to be made by the State in Title XIX of the Social Security Act, in 42 CFR

chapter IV, or when MDHHS makes direct payments to service providers for graduate medical education costs approved under the Medicaid State Plan.

3. No paid or volunteer staff person of a direct service provider may solicit contributions from program participants, offer for sale any type of merchandise or service, or seek to encourage the acceptance of any particular belief or philosophy by any program participant.

E. Confidentiality

Each waiver agency and direct service provider must have procedures to protect the confidentiality of information about participants or persons seeking services collected in the conduct of its responsibilities. The procedures must ensure that no information about a participant or person seeking services, or obtained from a participant or person seeking services by a service provider, is disclosed in a form that identifies the person without the informed consent of that person or of his or her legal representative. However, disclosure may be allowed by court order, or for program monitoring by authorized federal, state, or local agencies (which are also bound to protect the confidentiality of the client information) so long as access is in conformity with the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act of 1996. Waiver agencies and direct service providers must maintain all client information in controlled access files. This requirement applies to all protected information whether written, electronic, or oral.

F. Insurance Coverage

1. Each waiver agency and direct service provider must have sufficient insurance to indemnify loss of federal, state, and local resources, due to casualty or fraud. Insurance coverage sufficient to reimburse MDHHS or the waiver agency for the fair market value of the asset at the time of loss must cover all buildings, equipment, supplies, and other property purchased in whole or in part with funds awarded by MDHHS. The following insurances are required for each waiver agency or direct service provider:

    a. Worker's compensation
    b. Unemployment
    c. Property and theft coverage
    d. Fidelity bonding (for persons handling cash)
    e. No-fault vehicle insurance (for agency owned vehicles)
    f. General liability and hazard insurance (including facilities coverage)

2. MDHHS recommends the following insurances for additional agency protection:

    a. Insurance to protect the waiver agency or direct service provider from claims against waiver agency or direct service provider drivers and/or passengers
    b. Professional liability (both individual and corporate)
    c. Umbrella liability
    d. Errors and Omission Insurance for Board members and officers
    e. Special multi-peril
    f. Reinsurance/Stop-loss insurance

G. **Volunteers**

Each waiver agency or direct service provider utilizing volunteers must have a written procedure governing the recruiting, training, and supervising of volunteers. Volunteers must receive a written position description, orientation, training, and a yearly performance evaluation, if appropriate.

H. **Staffing**

Each waiver agency or direct service provider must employ competent personnel who have the necessary skills to provide quality supports and services to participants at levels sufficient to provide services pursuant to the contractual agreement. Each waiver agency or direct service provider must demonstrate an organizational structure including established lines of authority. Each direct service provider must identify a contact person with whom the waiver agency can discuss work orders and service delivery schedules or problems.

I. **Staff Identification**

Every waiver agency or direct service provider staff person, paid or volunteer, who enters a participant's home, must display proper identification. Proper identification may consist of either an agency picture card or a Michigan driver's license and some other form of agency identification.

J. **Orientation and Training Participation**

New waiver agency or direct service provider staff must receive an orientation training that includes, at a minimum:

1. Introduction to the MI Choice waiver;
2. The waiver agency's grievance and appeal process;
3. Maintenance of records and files (as appropriate);
4. Emergency procedures
5. Assessment and observation skills; and
6. Ethics, specifically;
    a. Acceptable work ethics
    b. Honoring the MI Choice participant's dignity
    c. Respect of the MI Choice participant and their property
    d. Prevention of theft of the MI Choice participant's belongings

Employers must maintain records detailing dates of training and topics covered in employee personnel files.

Waiver agencies and/or direct service providers must ensure that each employee has the support and training needed to competently and confidently deliver services to participants prior to working with each participant. Waiver agency or direct service provider staff must participate in relevant in-service training as appropriate and feasible. Some MI Choice services have specific requirements for in-service training. When applicable, the service standard stipulates the required in-service training topics.

K. **Civil Rights Compliance**

Each waiver agency or direct service provider must not discriminate against any employee or applicant for employment, or against any MI Choice applicant or participant, pursuant to the Federal Civil Rights Act of 1964, the Elliot-Larsen Civil Rights Act (P.A. 453 of 1976), and Section 504 of the Federal Rehabilitation Acts of 1973. Each waiver agency or direct service provider must complete an appropriate Federal Department of Health and Human Services form assuring compliance with the Civil Rights Act of 1964. Each waiver agency or direct service provider must clearly post signs at agency offices and public locations where services are provided in English and other languages as appropriate, indicating non-discrimination in hiring, employment practices, and provision of services.

L. **Nondiscrimination (Section 1557 of the Patient Protection and Affordable Care Act)**

Section 1557 of the Patient Protection and Affordable Care Act (ACA) applies to the MI Choice program and provides that, except as provided in Title I of the ACA, an individual shall not, on the grounds prohibited under Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, or Section 504 of the Rehabilitation Act of 1973, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under Title I of the ACA. This part applies to health programs or activities administered by recipients of Federal financial assistance from the Department, Title I entities that administer health programs or activities, and Department-administered health programs or activities.

M. **Equal Employment**

Each waiver agency and direct service provider must comply with equal employment opportunity principles in keeping with Executive Order 1979-4 and Civil Rights Compliance in state and federal contracts.

N. **Standard Precautions**

Each waiver agency and direct service provider must evaluate the occupational exposure of employees to blood or other potentially infectious materials that may result from the employee's performance of duties. Each waiver agency and direct service provider must establish appropriate standard precautions based upon the potential exposure to blood or infectious materials. Each waiver agency and direct service provider with employees who may experience occupational exposure must also develop an exposure control plan that complies with the Federal regulations implementing the Occupational Safety and Health Act.

O. **Drug Free Workplace**

MDHHS prohibits the unlawful manufacture, distribution, dispensing, possession, or use of controlled substances in all waiver agency and direct service provider workplaces. Each waiver

agency and direct service provider must operate in compliance with the Drug-Free Workplace Act of 1988.

P. **Americans with Disabilities Act**

Each program must operate in compliance with the Americans with Disabilities Act (PL 101-336).

Q. **Record Retention**

Each waiver agency and direct service provider must keep all records related to or generated from the provision of services to waiver participants for not less than ten years.

R. **Compliance with Home and Community Based Services Settings Requirements**

Each waiver agency and direct service provider must comply with the Federal Home and Community Based Services Settings Requirements as specified in 42 CFR 441.301(c)(4) as well as in the Home and Community-Based Services Chapter in the Michigan Medicaid Provider Manual. Direct service providers with subcontracts secured prior to September 30, 2015 will have until March 17, 2019 to become fully compliant with this regulation, unless they are included in the heightened scrutiny process. All direct service providers added to the waiver agency's provider network after September 30, 2015 must be compliant with this ruling before the direct service provider may furnish services to a waiver participant.

MDHHS will use the following process to ensure compliance to this requirement:

1) Each waiver agency will assess all applicable providers using the survey found in Attachment J of this contract. The results of the surveys will be submitted electronically to MDHHS for a determination of compliance to the requirements.
2) MDHHS will notify both the provider and the MI Choice waiver agency regarding the provider's compliance based upon the completed survey tool that was submitted to MDHHS.
3) For providers who are non-compliant, the provider will have one to two weeks to correct all issues that cause the non-compliance.
4) Once the issues are corrected, the provider will notify the waiver agency and schedule another on-site survey.
5) The waiver agency will have one to two weeks to complete another on-site survey and submit the survey to MDHHS for review.
6) If a provider does not contact the waiver agency within one to two weeks, the waiver agency will contact the provider to determine progress on the corrective action and schedule another on-site visit accordingly.
7) If the provider has not satisfactorily resolved the compliance issues, the waiver agency will suspend the provider from receiving new MI Choice participants until such time as the provider comes into compliance.
8) Some providers may require Heightened Scrutiny to determine compliance. These providers will follow the Heightened Scrutiny Process defined by MDHHS to assure compliance and to continue participation with the MI Choice program.

9) Regardless of the original notification date, all providers in all MI Choice provider networks will be compliant with the ruling no later than March 17, 2019, or the date approved in the State Transition Plan, whichever is sooner.
10) Waiver agencies will start transition plans with individuals served by non-compliant providers as of October 1, 2018. This planning will be person-centered and will focus on meeting the wishes of each participant regarding their preference of a qualified provider and enrollment in the MI Choice program.
11) By March 17, 2019, no MI Choice participants will be served by non-compliant providers, and all non-compliant providers will be removed from the MI Choice provider network.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Minimum Operating Standards for MI Choice Waiver Program Services

II. GENERAL OPERATING STANDARDS FOR MI CHOICE WAIVER PROVIDERS

In addition to the general operating standards for MI Choice waiver agencies and their contracted direct service providers, the following general standards apply to all entities providing either home-based or community-based MI Choice waiver services, as applicable, unless otherwise specified.

A. Home-Based Service Providers

MI Choice waiver home-based services include community living supports, respite services provided in the home, chore services, personal emergency response systems, private duty nursing/respiratory care, nursing services, counseling, home delivered meals, training services, and community health workers.

1. Charging for MI Choice Services

   Waiver agencies and direct service providers must not charge participants a fee to receive MI Choice waiver services.

2. Participant Assessments

   Each waiver agency must complete the state-approved assessment instrument for each participant according to established standards before initiating service. Direct providers of home-based services must avoid duplicating assessments of individual participants to the maximum extent possible. Home-based service providers must accept assessments conducted by waiver agencies and initiate home-based services without having to conduct a separate assessment unless there is a legitimate reason to conduct the separate assessment. Waiver agencies must make every attempt to supply direct providers of home-based services with enough information about each participant served by that organization to provide needed services properly.

3. Service Need Level

   Waiver agencies must classify each MI Choice participant into a service need level based upon the participant's immediacy of need for the provision of services and the availability of informal supports. Waiver agencies must establish and utilize written procedures consistent with the service need levels specified below to assure each participant's needs are met in the event of an emergency. Waiver agencies must make direct service providers aware of the service need levels and the classification of each participant served by that provider so that the service provider can target services to the highest priority participants in emergencies.

   a. Immediacy of need for the provision of services
      1. Immediate – the participant cannot be left alone
      2. Urgent – the participant can be left alone for a short time (less than 12 hours)
      3. Routine – the participant can be left alone for a day or two

   b. Availability of Informal Supports
      A. No informal supports are available for the participant
      B. Informal supports are available for the participant

C. The participant resides in a supervised residential setting

c. Grid of Service Need Levels

Immediacy	Informal Supports	Service Need Level	Service Need Level Description
Immediate	None	1A	This means you cannot be left alone. If your services are not delivered as planned, your backup plan needs to start immediately.
Immediate	Available	1B	This means you cannot be left alone. If your services are not delivered as planned, your family or friends need to be contacted immediately.
Immediate	SRS	1C	This means you cannot be left alone. Staff at your place of residence must be available to you as planned or follow established emergency procedures.
Urgent	None	2A	This means you can be left alone for a short time. If your services are not delivered as planned, your backup plan needs to start within 12 hours.
Urgent	Available	2B	This means you can be left alone for a short time. If your services are not delivered as planned, your family or friends need to be contacted within 12 hours.
Urgent	SRS	2C	This means you can be left alone for a short time. Staff at your place of residence must check on you periodically each day. Follow established emergency procedures if no staff is present in the home.
Routine	None	3A	This means you can be left alone for a day or two. If your services are not delivered as planned, your backup plan needs to start within a couple of days.
Routine	Available	3B	This means you can be left alone for a day or two. If your services are not delivered as planned, your family or friends need to be contacted within a couple of days.
Routine	SRS	N/A	There is not a 3C service need level because participants in supervised residential settings typically require 24-hour supervision and cannot be left alone for long periods.

4. Person-Centered Service Plans

Using a person-centered planning process, each waiver agency must establish a written person-centered service plan (PCSP) for each participant based upon the assessment of needs, goals, and preferences. The waiver agency and participant must develop the PCSP

before providing services. The participant must approve of all services in the PCSP. The waiver agency must document participant approval on the PCSP.

The PCSP must contain at a minimum:

a. The individual chose the setting in which he or she resides
b. The services and supports that are important to the individual to meet the needs identified during the individual's assessment
c. The individual's strengths and preferences
d. The clinical and support needs identified by a functional assessment
e. The amount of service authorized
f. The frequency and duration of each service, and the individual's preference for receiving those services and supports
g. The type of provider to furnish each service
h. Participant focused goals and outcomes
i. For participants receiving home delivered meals, notations regarding the number of meals served per day, the days of service, and special diet orders or requests
j. Risk factors and measures identified to mitigate them
k. Individuals responsible for monitoring the plan
l. The informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation

5. Supervision of Direct-Care Workers

Home-based service providers must always have a supervisor available to direct care workers while the worker is furnishing services to MI Choice participants. The provider may offer supervisor availability by telephone. Home-based service providers must conduct in-home supervision of their staff at least twice each fiscal year. A qualified professional must conduct the supervisory visit.

6. Participant Records

Each direct provider of home-based services must maintain comprehensive and complete participant records that contain, at a minimum:

a. Details of the request to provide services.
b. A copy of the waiver agency's evaluation of the participant's need (this may be appropriate portions of the MI Choice assessment or reassessment).
c. Service authorizations or work orders.
d. Providers with multiple sources of funding must specifically identify waiver participants; records must contain a listing of all dates of service for each participant and the number of units provided during each visit.
e. Notes in response to participant, family, and agency contacts (not required for home delivered meal programs).
f. A record of release of any personal information about the participant and a copy of a signed release of information form.

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

7. Notifying Participant of Rights

Each waiver agency or direct provider of home-based services must notify each participant, in writing, at the initiation of service of his or her right to comment about service provision or appeal the denial, reduction, suspension, or termination of services. Such notice must also advise the participant that they may file complaints of discrimination with the respective waiver agency, the Department of Health and Human Services Office of Civil Rights, or the Michigan Department of Civil Rights. The MI Choice Participant Handbook meets this requirement.

8. In-Service Training

Staff of waiver agencies and direct providers of home-based services must receive in-service training at least twice each fiscal year. Waiver agencies and providers must design the training so that it increases staff knowledge and understanding of the program and its participants and improves staff skills at tasks performed in the provision of service. Waiver agencies and direct providers of home-based services must maintain comprehensive records identifying dates of training and topics covered in an agency training log or in each employee's personnel file. The employer must develop an individualized in-service training plan for each employee when performance evaluations indicate a need.

9. Reference and Criminal History Screening Checks

Each waiver agency and direct provider of home-based services must require and thoroughly check references of paid staff that will enter participant homes. In addition, each waiver agency and direct provider of home-based services must conduct a criminal history screening through the Michigan State Police for each paid and volunteer staff person who will be entering participant homes. The waiver agency and direct provider must conduct the reference and criminal history screening checks before authorizing the employee to furnish services in a participant's home.

10. Additional Conditions and Qualifications

Each waiver agency and direct provider of home-based services will assure MDHHS that employees or volunteers who enter and work within participant homes abide by the following additional conditions and qualifications:

a. Service providers must have procedures in place for obtaining participant signatures on the time sheets (or similar document) of direct care workers to verify the direct service worker provided the work ordered by the waiver agency. Electronic Visit Verification systems may take the place of this requirement as long as the verification is available to the waiver agency. If providers are utilizing electronic visit verification systems, paper time sheets are not needed.
b. Direct service workers are prohibited from smoking in participant's homes.
c. Direct service workers must demonstrate the ability to communicate adequately and appropriately, both orally and in writing, with their employers and the MI Choice

participants they serve. This includes the ability to follow product instructions properly in carrying out direct service responsibilities (i.e. read grocery lists, identify items on grocery lists, and safely use cleaning and cooking products.)

d. Direct service workers must not use their cell phones for personal use while in a participant's home. Exceptions may be made in cases of emergency. The Direct service workers should engage with the participants while furnishing the services specified on the person-centered service plan.
e. Direct service workers must not threaten or coerce participants in any way. Failure to meet this standard is grounds for immediate discharge.
f. Waiver agencies will inform service contractors and direct service workers promptly of new service standards or any changes to current services standards.

B. Community-Based Service Providers

MI Choice waiver community-based services include; environmental accessibility adaptations, respite services provided outside of the home, specialized medical equipment and supplies, transportation, and adult day health.

1. Adherence to Standards

   Direct providers of community-based services must adhere to standards 1-4 of the home-based service provider standards.

2. Participant Records

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

   a. A copy of the request for services.
   b. Pertinent and necessary medical, social, and functional participant information to assure the proper delivery of the requested service.
   c. A description of the provided service, including the number of units and cost per unit, as applicable.
   d. The date(s) of service provision.
   e. The total cost of each service provided.

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

3. Notifying Participant of Rights

   Each waiver agency or direct provider of community-based services must notify each participant, in writing, at the initiation of service of his or her right to comment about service provision or appeal the denial, reduction, suspension, or termination of services. Such notice must also advise the participant that they may file complaints of discrimination with the respective waiver agency, the Department of Health and Human Services Office of Civil Rights, or the Michigan Department of Civil Rights. The MI Choice Participant Handbook meets this requirement.

4. Reference and Criminal History Checks

   Each waiver agency and direct provider of community-based services must require and thoroughly check references of paid staff that will enter participant homes. In addition, each waiver agency and direct provider of community-based services must conduct a criminal history screening through the Michigan State Police for each paid and volunteer staff person who will be entering participant homes. The waiver agency and direct provider must conduct the reference and criminal history screening checks before authorizing the employee to furnish services in a participant's home. Waiver agencies must also check the Michigan Medicaid sanctioned provider list to determine if the provider is on the list; these providers

must be excluded from providing any MI Choice services until the provider is approved by MDHHS to resume providing Medicaid services.

C. Self-Determined Providers

Participants choosing the self-determination option may directly manage service providers for the following home and community-based MI Choice waiver services; chore, community health worker, community living supports, environmental accessibility adaptations, fiscal intermediary, goods and services, transportation, private duty nursing/respiratory care, respite services provided inside the participant's home, and respite services provided in the home of another.

1. Supervision of Direct-Care Workers

   The MI Choice participant, or designated representative, acts as the employer and provides direct supervision of the chosen workers for self-determined services in the participant's PCSP. The participant, or designated representative, directly recruits, hires, and manages employees.

2. Use of a Fiscal Intermediary

   MI Choice participants choosing the self-determination option must use an approved fiscal intermediary agency. The fiscal intermediary agency will help the individual manage and distribute funds contained in the participant's budget. The participant uses the funds in the budget to purchase waiver goods, supports, and services authorized in the participant's PCSP. Refer to the Fiscal Intermediary service standard for more information about this MI Choice service.

3. Reference and Criminal History Screening Checks

   Each MI Choice participant, or fiscal intermediary chosen by the participant, must conduct reference checks and a criminal history screening through the Michigan State Police for each paid staff person who will be entering the participant's home. The MI Choice participant or fiscal intermediary must conduct the criminal history screening before authorizing the employee to furnish services in the participant's home. Waiver agencies must also check the Michigan Medicaid sanctioned provider list to determine if the provider is on the list; these providers must be excluded from providing any MI Choice services.

4. Provider Qualifications

   Providers of self-determined services must minimally:

   a. Be 18 years old.
   b. Be able to communicate effectively both orally and in writing and follow instructions.
   c. Be trained in universal precautions and blood-borne pathogens. The waiver agency must maintain a copy of the employees' training record in the participant's case file.
   d. Providers of self-determined services cannot also be the participant's spouse, guardian, legally responsible decision maker, or designated representative.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Minimum Operating Standards for MI Choice Waiver Program Services

III. SPECIFIC OPERATING STANDARDS FOR MI CHOICE WAIVER SERVICE PROVIDERS

The following pages describe specific operating standards for each waiver service. The standards apply only to the service being described within each section. Standards from one service are not to be construed to apply to other MI Choice services. Requirements that apply to all MI Choice services are explained in Sections I and II of this attachment. The standards apply to each provider interested in furnishing the specific service to MI Choice participants. The waiver agency must authorize the provision of each service to waiver participants. Waiver agencies will not use MI Choice funds to pay for services not specifically authorized in advance and included in the participant's PCSP.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Minimum Operating Standards for MI Choice Waiver Program Services

NAME	**Adult Day Health**
DEFINITION	Adult Day Health 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 PCSP, in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the participant. Meals provided as part of these services must 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 participant's residence and the Adult Day Health center is provided when it is a standard component of the service. Not all Adult Day Health Centers offer transportation to and from their facility. Additionally, some of those that offer transportation only offer this service in a specified area. When the center offers transportation, it is a component part of the Adult Day Health service. If the center does not offer transportation, or does not offer it to the participant's residence, the waiver agency may separately authorize transportation to and from the Adult Day Health Center.
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 waiver agency and provider S5102 = per diem
SERVICE DELIVERY OPTIONS	☑ Traditional/Agency-Based ☐ Self-Determination

Minimum Standards for Traditional Service Delivery

1. Each direct service provider must have written policies and procedures compatible with the "General Operating Standards for Waiver Agencies and Contracted Direct Service Providers", and minimally, Section B of the "General Operating Standards for MI Choice Waiver Providers."

2. Waiver agencies must only authorize Adult Day Health services for participants who meet at least one of the following criteria:

   a. Participants must require regular supervision to live in their own homes or the homes of a relative.

   b. Participants with caregivers must require a substitute caregiver while their regular caregiver is at work, in need of respite, or otherwise unavailable.

   c. Participants must have difficulty performing activities of daily living (ADLs) without assistance.

   d. Participants must be capable of leaving their residence with assistance to receive service.

   e. Participants are in need of intervention in the form of enrichment and opportunities for social activities to prevent or postpone deterioration that would likely lead to institutionalization.

3. A referral from a waiver agency for a MI Choice participant must replace any screening or assessment activities performed for other program participants. The adult day health service provider must accept copies of the MI Choice assessment and PCSP to eliminate duplicate assessment and service planning activities.

4. Each program must maintain comprehensive and complete files that include, at a minimum:

   a. Details of the participant's referral to the adult day health program,
   b. Intake records,
   c. A copy of the MI Choice assessment (and reassessments),
   d. A copy of the MI Choice PCSP,
   e. Listing of participant 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 participant,
   i. Notation of all releases of information about the participant, and
   j. A signed release of information form.

   Each program must keep all participant files confidential in controlled access files. Each program must use a standard release of information form that is time limited and specific as to the released information.

5. Each program must provide directly, or arrange for the provision of the following services. 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 must be in place. For MI Choice participants, the waiver agency must provide supports coordination.

   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. Participants attending from eight to fourteen hours per day must 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 must take into consideration participant choice, health, religious and ethnic diet preferences.
   d. Recreation: consisting of planned activities suited to the needs of the participant and designed to encourage physical exercise, maintain or restore abilities and skill, prevent deterioration, and stimulate social interaction.

6. Each program may provide directly, or arrange for the provision of the following optional services. 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 must be in place.

   a. Rehabilitative: Physical, occupational, speech, and hearing therapies provided by licensed professionals under order from a physician.
   b. Medical Support: Laboratory, X-ray, or pharmaceutical services provided by licensed professionals under order from a physician.
   c. Services within the scope of the Nursing Practice Act (PA 368 of 1978).
   d. Dental: Under the direction of a dentist.
   e. Podiatric: Provided or arranged for under the direction of a physician.
   f. Ophthalmologic: Provided or arranged for under the direction of an ophthalmologist.
   g. Health counseling.
   h. Shopping assistance/escort.

7. Each program must establish written procedures (reviewed and approved by a consulting Pharmacist, Physician, or Registered Nurse) that govern the assistance given by staff to participants taking their own medications while participating in the program. The policies and procedures must minimally address:

   a. Written consent from the participant or participant's representative, to assist in taking medications.
   b. Verification of the participant's medication regimen, including the prescriptions and dosages.
   c. The training and authority of staff to assist participants 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 participants.
   f. Disposal of unused medications for participants that no longer participate in the program.
   g. Instructions for entering medication information in participant files, including times and frequency of assistance.

8. Each provider must 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 must 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 must maintain a written agreement that clearly specifies the terms of the arrangement between the provider and other individual or organization.

9. The provider must require staff to participate in orientation training as specified in the General Operating Standards for Waiver Agencies and Contracted Direct Service Providers. Additionally, program staff must have basic first-aid training.

10. The provider must require staff to attend in-service training at least twice each year. The provider must design this training specifically to increase their knowledge and understanding of the program and participants, and to improve their skills at tasks performed in the provision of service. The provider must maintain records that identify the dates of training, topics covered, and persons attending.

11. If the provider operates its own vehicles for transporting participants to and from the program site, the provider must meet the following transportation minimum standards:

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

12. Each provider must have first-aid supplies available at the program site. The provider must make a staff person knowledgeable in first-aid procedures, including CPR, present at all times when participants are at the program site.

13. Each provider must post procedures to follow in emergencies (fire, severe weather, etc.) in each room of the program site. Providers must conduct practice drills of emergency procedures once every six months. The program must maintain a record of all practice drills.

14. Each day care center must have the following furnishings:

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

    The provider must maintain all equipment and furnishings used during program activities or by program participants in safe and functional condition.

15. Each day care center must 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.

Limitations:

1. Participants cannot receive Community Living Supports while at the Adult Day Health facility. Payment for Adult Day Health Services includes all services provided while at the facility. Community Living Supports may be used in conjunction with Adult Day Health services, but cannot be provided at the exact same time.
2. Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first.

3. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

4. HCPCS codes S5101 and S5102 are limited to one unit per day.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Minimum Operating Standards for MI Choice Waiver Program Services

NAME	Chore Services
DEFINITION	Chore Services are needed to maintain the home in a clean, sanitary, and safe environment. This service includes heavy household chores such as washing floors, windows, and walls, securing loose rugs and tiles, and moving heavy items of furniture in order to provide safe access and egress. Other covered services might include yard maintenance (mowing, raking and clearing hazardous debris such as fallen branches and trees) and snow plowing to provide safe access and egress outside the home. These types of services are allowed only in cases when neither the participant 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 proprietor, 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/Agency-Based ☑ Self-Determination

Minimum Standards for Traditional Service Delivery

1. Each direct service provider must have written policies and procedures compatible with the "General Operating Standards for Waiver Agencies and Contracted Direct Service Providers," and minimally, Section A of the "General Operating Standards for MI Choice Waiver Service Providers."

2. Waiver funds used to pay for chore services may include materials and disposable supplies used to complete the chore tasks. The waiver agency may also use waiver funds to purchase or rent the equipment or tools used to perform chore tasks for waiver participants.

3. Only properly licensed suppliers may provide pest control services.

4. Each waiver agency must develop working relationships with the Home Repair and Weatherization service providers, as available, in their program area to ensure effective coordination of efforts.

Minimum Standards for Self-Determined Service Delivery

1. Each chosen provider must minimally comply with Section C of the "General Operating Standards for MI Choice Waiver Service Providers."

2. Providers must have previous relevant experience and/or training for the tasks specified and authorized in the PCSP.

3. The waiver agency must deem the chosen provider capable of performing the required tasks.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Minimum Operating Standards for MI Choice Waiver Program Services

Service Limitations:

1. Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first.

2. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Minimum Operating Standards for MI Choice Waiver Program Services

NAME	**Community Health Worker**
DEFINITION	The Community Health Worker (CHW) works with participants who are re-enrolling in MI Choice, enrolling after a nursing facility or hospital discharge, or otherwise assists the participant with obtaining assistance in the community.
HCPCS CODES	**T2041** Supports brokerage, self-directed, waiver, per 15 minutes **G9012** Other specified case management services, not elsewhere classified
UNITS	T2041, per 15 minutes G9012, per service
SERVICE DELIVERY OPTIONS	☑ Traditional/Agency-Based ☑ Self-Determination

Minimum Standards for Service Delivery

1. The Community Health Worker (CHW) typically works with individuals who are re-enrolling in the MI Choice Waiver or are enrolled in the MI Choice waiver after nursing facility or hospital discharge. The CHW service is not limited to nursing facility or hospital transitions. The service is available to any participant who may benefit from additional hands-on support to obtain assistance in the community.

2. The CHW visits the participant at home within 3 days of hospital or facility discharge to review the discharge paperwork and any other documentation, reviews any medications received or orders that need to be filled, reminds the participant of the importance of filling the medications, and talks with the participant about the importance of following up with the physician. If needed, the CHW may make calls for medication to be filled, or to arrange for the follow-up appointment with the physician. The CHW also trains the participant about anything to be aware of and what to do if his/her condition worsens.

3. The CHW does another follow-up visit within 30 days to determine whether the participant followed up with the physician, took the prescribed medications, and followed any other discharge recommendations.

4. The CHW must thoroughly document what was discussed and discovered during the contacts with the participant, so the Supports Coordinator is aware of what occurred. If there are medication discrepancies, the CHW will follow up with the RN Supports Coordinator to get those issues addressed.

5. The CHW may also visit the individual in the nursing facility or hospital to ensure the staff knows who to contact to coordinate the discharge home. The CHW ensures the nursing facility or hospital staff has the contact of the Supports Coordinator with whom the discharge should be coordinated.

6. If the Supports Coordinator wishes and the participant agrees, the CHW will be in contact with the nursing facility if a participant goes from a hospital to a nursing facility for temporary rehab before returning to the Waiver. The CHW may assist with coordinating any supplies, services, etc., the participant requires at home after rehabilitation.

7. The CHW may perform the duties of a supports broker. They may provide assistance throughout the planning and implementation of the service plan and individual budget, assist the participant in making informed decisions about what works best for the participant, assist the participant to explore the availability of community services and supports, assist with access to housing and employment, and assist with making the necessary arrangements to link the participant with those identified supports.

8. CHW services offer practical skills training to enable individuals to remain independent, including the provision of information on recruiting, hiring and managing workers, effective communication skills, and problem solving.

9. The CHW may also coach participants in managing health conditions, assist with scheduling appointments, facilitate coordination between various providers, and assist the participants with completion of applications for programs for which they may be eligible.

10. The CHW must work in close collaboration with the participant's Supports Coordinator as the Supports Coordinator has ultimate responsibility for the participant's case.

11. Providers for the CHW service may be unlicensed, but must be trained in the duties of the job.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Minimum Operating Standards for MI Choice Waiver Program Services

NAME	Community Living Supports
DEFINITION	Community Living Supports facilitate an individual's independence and promote participation in the community. Community Living Supports can be provided in the participant's residence or in community settings. Community Living Supports include assistance to enable program participants to accomplish tasks that they would normally do for themselves if able. The services may be provided on an episodic or a continuing basis. The participant oversees and supervises individual providers on an on-going basis when participating in self-determination options. These services are provided only in cases when neither the participant nor anyone else in the household is capable of performing or financially paying for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision. When transportation incidental to the provision of community living supports is included, it must not also be authorized as a separate waiver service for the beneficiary.
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/Agency-Based ☑ Self-Determination

Minimum Standards for Traditional Service Delivery

1. Each direct service provider must have written policies and procedures compatible with the "General Operating Standards for Waiver Agencies and Contracted Direct Service Providers," and minimally, Section A of the "General Operating Standards for MI Choice Waiver Service Providers."

2. Community Living Supports (CLS) include:
   a. Assisting, reminding, cueing, observing, guiding and 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 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 from the participant's residence to community activities, among community activities, and from the community activities back to the participant'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 monitoring of medication administration

d. Staff assistance with preserving the health and safety of the individual in order that he or 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 or libraries, or volunteering.

f. Dementia support, including but not limited to redirection, reminding, modeling, socialization activities, and activities that assist the participant as identified in the individual's person-centered plan.

g. Observing and reporting to the supports coordinator any changes in the participant's condition and the home environment.

3. When the CLS services provided to the participant include tasks specified in 2.a.i, 2.a.ii, 2.a.iii, 2.a.v, 2.b.i, 2.b.iii, 2.b.v, 2.b.vi, 2.b.vii, 2.d, or 2g above, the individual furnishing CLS 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 experience with food preparation, safe food handling procedures, and reporting and identifying abuse and neglect are highly desirable.

4. When the CLS services provided to the participant include tasks specified in 2.a.iv, 2.b.ii, 2.c, 2.d, 2.e, 2.f, or 2.g above, the direct service providers furnishing CLS must also:

   a. Be supervised by a registered nurse (RN) licensed to practice nursing in the State. At the State's discretion, other qualified individuals may supervise CLS providers. For licensed residential settings, persons employed as facility owners or managers qualify to provide this supervision. The direct care worker's supervisor must be available to the worker at all times the worker is furnishing CLS services.

   b. Develop in-service training plans and assure all workers providing CLS services are confident and competent in the following areas before delivering CLS services to MI Choice participants, as applicable to the needs of that participant: safety, body mechanics, and food preparation including safe and sanitary food handling procedures.

   c. Provide an RN to individually train and supervise CLS workers who perform higher-level, non-invasive tasks such as maintenance of catheters and feeding tubes, minor dressing changes, and wound care for each participant who requires such care. The supervising RN must assure each workers confidence and competence in the performance of each task required.

   d. MDHHS strongly recommends each worker delivering CLS services complete a certified nursing assistant training course, first aid, and CPR training.

5. When the CLS services provided to the participant include transportation described in 2.b.iv the following standards apply:

a. Waiver agencies may not use waiver funds to purchase or lease vehicles for providing transportation services to waiver participants.

b. The Secretary of State must appropriately license and inspect all drivers and vehicles used for transportation supported all or in part by MI Choice funds. The vehicle owner must assure all vehicles used to transport participants have liability insurance.

c. All paid drivers for transportation providers supported entirely or in part by MI Choice funds must be physically capable and willing to assist persons requiring help to and from and to get in and out of vehicles. The provider must offer such assistance unless expressly prohibited by either a labor contract or insurance policy.

d. The provider must train all paid drivers for transportation programs supported entirely or in part by MI Choice funds to cope with medical emergencies, unless expressly prohibited by a labor contract or insurance policy.

e. Each provider must operate in compliance with P.A. 1 of 1985 regarding seat belt usage.

6. Waiver agencies authorize CLS when necessary to prevent the institutionalization of the participant served.

7. Individuals providing CLS must be at least 18 years old, able to communicate effectively both orally and in writing and follow instructions.

8. Members of a participant's family may provide CLS to the participant. However, waiver agencies must not directly authorize MI Choice funds to pay for services furnished to a participant by that person's spouse.

9. Family members who provide CLS must meet the same standards as providers who are unrelated to the individual.

10. The waiver agency or provider agency must train each worker to perform properly each task required for each participant the worker serves before delivering the service to that participant. The supervisor must assure that each worker competently and confidently performs every task assigned for each participant served.

11. Each direct service provider who chooses to allow staff to assist participants with self-medication, as described in 2.c above, must establish written procedures that govern the assistance given by staff to participants with self-medication. These procedures must be reviewed by a consulting pharmacist, physician, or RN and must include, at a minimum:

a. The provider staff authorized to assist participants 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 participant takes and its impact upon the participant.

b. Verification of prescription medications and their dosages. The participant must maintain all medications in their original, labeled containers.

c. Instructions for entering medication information in participant files.

d. A clear statement of the participant's and participant's family's responsibility regarding medications taken by the participant and the provision for informing the participant and the participant's family of the provider's procedures and responsibilities regarding assisted self-administration of medications.

12. CLS providers may only administer medications in compliance with Michigan Administrative Rule 330.7158:

a. A provider must 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 must assure that medication use conforms to federal standards and the standards of the medical community.

c. A provider must not use medication as punishment, for the convenience of the staff, or as a substitute for other appropriate treatment.

d. A provider must review the administration of a psychotropic medication periodically as set forth in the participant's individual PCSP and based upon the participant's clinical status.

e. If an individual cannot administer his or her own medication, a provider must ensure that medication is administered by or under the supervision of personnel who are qualified and trained.

f. A provider must record the administration of all medication in the recipient's clinical record.

g. A provider must ensure that staff report medication errors and adverse drug reactions to the participant's physician immediately and properly and record the incident in the participant's clinical record.

Additional Standards for Participants Who Reside in Licensed Settings

1. CLS provided in a licensed setting includes only those services and supports that are in addition to and must not replace usual and customary supports and services furnished to residents in the licensed setting.

2. Documentation in the participant's record must clearly identify the participant's need for additional supports and services not covered by licensure.

3. The PCSP must clearly identify the portion of the participant's supports and services covered by CLS.

4. Homemaking tasks incidental to the provision of assistance with activities of daily living may also be included in CLS but must not replace usual and customary homemaking tasks required by licensure.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Minimum Operating Standards for MI Choice Waiver Program Services

Minimum Standards for Self-Determined Service Delivery

1. When authorizing Community Living Supports for participants choosing the self-determination option, waiver agencies must comply with items 2, 5, 6, 7, 8, 9, and 12 of the Minimum Standards for Traditional Service Delivery specified above.

2. Each chosen provider must minimally comply with Section C of the "General Operating Standards for MI Choice Waiver Service Providers."

3. Each chosen provider furnishing transportation as a component of this service must have a valid Michigan driver's license.

4. When the CLS services provided to the participant include tasks specified in 2.a.i, 2.a.ii, 2.a.iii, 2.a.v, 2.b.i, 2.b.iii, 2.b.v, 2.b.vi, 2.b.vii, 2.d, or 2g above, the individual furnishing CLS 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 experience with food preparation, safe food handling procedures, and reporting and identifying abuse and neglect are highly desirable.

5. When the CLS services provided to the participant include tasks specified in 2.a.iv, 2.b.ii, 2.c, 2.d, 2.e, 2.f, or 2.g above, the individual furnishing CLS must also be trained in cardiopulmonary resuscitation. This training may be waived when the provider is furnishing services to a participant who has a "Do Not Resuscitate" order.

Limitations

1. Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first.

2. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

3. CLS does not include the cost associated with room and board.

4. When transportation incidental to the provision of CLS is included, the waiver agency must not also authorize transportation as a separate waiver service for the participant.

5. CLS services cannot be provided in circumstances where they would be a duplication of services available under the state plan or elsewhere.

6. CLS excludes nursing and skilled therapy services.

7. The phrase "These services are provided only in cases when neither the participant nor anyone else in the household is capable of performing or financially paying for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision" included in the definition of this service shall be interpreted as follows:

a. All informal supports must agree to provide the uncompensated (informal) services and supports to the participant as specified in the person-centered service plan. Specifically, the record must show the following:

    i. All persons providing informal services and supports included on the person-centered service plan are aware of and capable of performing the tasks assigned to them for the benefit of the participant as included in the person-centered service plan.

    ii. All informal supports agree to any financial liability related to the informal services and supports assigned to them on the person-centered service plan. This includes uncompensated or voluntary transportation of the participant.

    iii. Supports coordinators or other waiver agency staff did not arbitrarily assign the completion of services and supports that could otherwise be included as CLS to informal supporters. Rather, both the participant (or their responsible party) and the informal support agree in writing (by their signature on the person-centered service plan) to the provision of the identified services and supports as discussed during a person-centered planning meeting.

b. Relatives, caregivers, landlords, community or volunteer agencies, or other third-party payers have been contacted on behalf of the participant and agree to provide services and supports to the participant because they are both capable of and responsible for the provision of the identified services and supports. This agreement is noted by an authorized signature on the person-centered service plan from a representative of the entity identified as responsible for the services and supports.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Minimum Operating Standards for MI Choice Waiver Program Services

1.

NAME	**Community Transportation**
DEFINITION	The Community Transportation (CT) service combines non-emergency medical transportation and non-medical transportation into one transportation service. Community Transportation (CT) services are offered to enable waiver participants to access waiver and other community services, activities, and resources as specified in the individual plan of services. The CT service may also be utilized for expenses related to transportation and other related travel expenses determined necessary to secure medical examinations/appointments, documentation, or treatment for participants. Delivery services for medical items, such as medical supplies or prescriptions, should be utilized before authorizing CT services through the MI Choice program.
HCPCS CODES	**See List in Limitations section below**
UNITS	1 Mile; A0080, A0090, A0160, S0209, S0215 1 Leg of a trip; A0100, A0120, A0130, A0140, T2001, T2003, T2004, T2005 1 Meal; A0190, A0210 1 Overnight stay; A0180, A0200 ½ Hour; T2007 1 Day; A0110
SERVICE DELIVERY OPTIONS	☑ Traditional/Agency-Based ☑ Self-Determination

Minimum Standards for Traditional Service Delivery

1. Community Transportation includes expenses for transportation and other related travel expenses determined necessary to secure medical examinations, documentation, treatment, or non-medical community activities, outings and resources for a MI Choice participant. Waiver agencies will ensure MI Choice participants have access to transportation as needed to obtain medical services and other non-medical activities.

2. CT includes, but is not limited to, transportation to obtain the following medical services:
   a. Chronic and ongoing treatment,
   b. Prescriptions,
   c. Medical supplies and devices,
   d. One time, occasional and ongoing visits for medical care, and
   e. Services received at a Veteran Affairs hospital.

3. Travel expenses related to the provision of CT include:
   a. The cost of transportation for the MI Choice participant by wheelchair vans, taxis, bus passes and tickets, secured transportation containing an occupant protection system that

addresses safety needs of disabled or special needs individuals, and other forms of transportation,

b. Mileage reimbursement for individuals or volunteers with a valid driver's license utilizing personal vehicles to transport the MI Choice participant,
c. The cost of meals and lodging en route to and from medical care, and while receiving medical care,
d. The cost of an attendant to accompany the MI Choice participant, if necessary and not billed as a separate service,
e. The cost of the attendant's transportation, meals, and lodging, while assisting the participant who is traveling for medical care and
f. The attendant's salary, if the attendant is not a volunteer or a member of the MI Choice participant's family or reimbursed as a separate MI Choice service (such as CLS) provider.

4. Each direct service provider must have written policies and procedures compatible with the "General Operating Standards for Waiver Agencies and Contracted Direct Service Providers," and minimally, Section B of the "General Operating Standards for MI Choice Waiver Providers."

5. Waiver agencies may authorize CT as a MI Choice service for waiver participants. However, when possible, the waiver agency must utilize family, neighbors, friends, or community agencies that can provide this service without charge.

6. When authorizing CT, waiver agencies are to authorize the least expensive available means suitable to the participant's needs.

7. Waiver agencies may only authorize CT to provide transportation assistance to the participant. The participant must travel away from home to other locations within the community. CT does not include reimbursement for caregivers of the participant to run errands or otherwise travel on behalf of the participant.

8. The Secretary of State must appropriately license all drivers and vehicles used for CT. The provider must cover all vehicles used with insurance as required by law.

9. Each provider must operate in compliance with P.A. 1 of 1985 regarding seat belt usage.

10. Additionally, delivery services for medical items, such as medical supplies or prescriptions, should be utilized before authorizing CT through the MI Choice program.

11. Waiver agencies must use the SC modifier when billing for ancillary items that are only available for specific medically-related travel. This includes meals (A0190, A0210), lodging (A0180, A0200), and waiting time for air ambulances and non-emergency vehicles (T2007).

12. Waiver agencies may utilize a process to prior authorize requests for the following:

    a. All outstate travel that is non-borderland for medical treatment.
    b. Overnight stays if within 50 miles one-way from the participant's home for medical treatment.
    c. Overnight stays beyond five nights, including meals and lodging when traveling for medical treatment.

d. An attendant in addition to the driver of a wheelchair lift/medivan vehicle.
e. Mileage and meal expenses for daily long-distance trips for medical treatment.

Minimum Standards for Self-Determined Service Delivery

1. Each chosen provider must minimally comply with standards for Traditional Service Delivery specified above.

2. Volunteer drivers do not need to comply with standard 9 of the Minimum Standards for Traditional Service Delivery specified above. Volunteer drivers are those drivers who only seek reimbursement for mileage when furnishing CT.

Limitations

1. Where applicable, the participant must use other available payers or non-cost transportation first.

2. When the costs of transportation are included in the provider rate for another waiver service (e.g., Adult Day Health or CLS), there must be mechanisms to prevent the duplicative billing of CT.

3. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

4. Waiver agencies must not authorize MI Choice CT services to reimburse caregivers (paid or informal) to run errands for participants when the participant does not accompany the driver in the vehicle. The purpose of the CT service is to enable MI Choice participants to gain access to medical services and community activities/outings.

5. Reimbursement for CT **DOES NOT** include the following:

   a. Waiting time unless for an air ambulance or non-emergency vehicle. *exceptions apply – Refer to item 6
   b. Transportation for medical services that have already been provided
   c. Transportation costs to meet a participant's personal choice of provider for routine medical care outside the community when comparable care is available locally. Participants are encouraged to obtain medical care in their own community unless referred elsewhere by their local health care professional.
   d. Reimbursement for meals or lodging when the purpose of travel is not related to the receipt of Medicaid-covered medical services. Meals and lodging are only reimbursed when the participant and attendant are traveling to seek Medicaid-covered medical services.

6. Waiting times may be covered if built into the transportation reimbursement rate. Waiting times are also covered if the participant cannot wait for the transportation vehicle after outings due to medical conditions (i.e., cannot stay in wheelchair for long periods of time due to swelling or pain, etc.).

7. All paid drivers for transportation providers supported entirely or in part by MI Choice funds must be physically capable and willing to assist persons requiring help to and from and to get in and out of vehicles. The provider must offer such assistance unless expressly prohibited by either a labor contract or insurance policy.

8. The provider must train all paid drivers for transportation programs supported entirely or in part by MI Choice funds to cope with medical emergencies, unless expressly prohibited by a labor contract or insurance policy.

9. Each waiver agency and provider must attempt to receive reimbursement from other funding sources, as appropriate and available before utilizing MI Choice funds for transportation services. Examples include the American Cancer Society, Veterans Administration, MDHHS Field Offices, MDHHS Medical Services Administration, United Way, Department of Transportation programs, etc.

10. The following HCPCS codes are approved for use under the service definition:
    a. A0080, Non-emergency transportation, per mile - vehicle provided by volunteer (individual or organization), with no vested interest
    b. A0090, Non-emergency transportation, per mile - vehicle provided by individual (family member, self, neighbor) with vested interest
    c. A0100, Non-emergency transportation; taxi
    d. A0110, Non-emergency transportation and bus, intra- or inter- state carrier
    e. A0120, Non-emergency transportation: mini-bus, mountain area transports, or other transportation systems
    f. A0130, Non-emergency transportation: wheelchair van
    g. A0140, Non-emergency transportation and air travel (private or commercial) intra or inter state
    h. A0160, Non-emergency transportation: per mile - case worker or social worker
    i. A0170, Transportation ancillary: parking fees, tolls, other
    j. A0180, Non-emergency transportation: ancillary: lodging-recipient (requires SC modifier)
    k. A0190, Non-emergency transportation: ancillary: meals-recipient (requires SC modifier)
    l. A0200, Non-emergency transportation: ancillary: lodging escort (requires SC modifier)
    m. A0210, Non-emergency transportation: ancillary: meals-escort (requires SC modifier)
    n. S0209, Wheelchair van, mileage, per mile
    o. S0215, Non-emergency transportation; mileage, per mile
    p. T2001, Non-emergency transportation; patient attendant/escort
    q. T2002, Non-emergency transportation; per diem
    r. T2003, Non-emergency transportation; encounter/trip
    s. T2004, Non-emergency transport; commercial carrier, multi-pass
    t. T2005, Non-emergency transportation; stretcher van
    u. T2007, Transportation waiting time, air ambulance and non-emergency vehicle, one-half (1/2) hour increments (requires SC modifier)

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Minimum Operating Standards for MI Choice Waiver Program Services

NAME	Counseling Services
DEFINITION	Professional level counseling services seek to improve the participant's emotional and social well-being through the resolution of personal problems and/or change in an individual's social situation.
CPT CODE	**99510**, Home visit for individual, family, or marriage counseling
UNITS	One visit, regardless of duration.
SERVICE DELIVERY OPTIONS	☑ Traditional/Agency-Based ☐ Self-Determination

Minimum Standards for Traditional Service Delivery

1. Each direct service provider must have written policies and procedures compatible with the "General Operating Standards for Waiver Agencies and Contracted Direct Service Providers," and minimally, Section A of the "General Operating Standards for MI Choice Waiver Providers."

2. Waiver agencies must only authorize counseling services for participants within one of the following groups:
   a. Individuals who are experiencing emotional distress or a diminished ability to function; or

   b. Adults, children, spouses, or other responsible relatives (e.g. sibling, niece, or nephew) who are appropriate for family counseling to resolve the problems of the waiver participant.

3. Providers receiving waiver funds for counseling services must provide the following service components, at a minimum:
   a. Psychosocial evaluation to determine appropriateness of counseling options.

   b. Treatment plan that states goals and objectives, and projects the frequency and duration of service.

   c. Individual, family, and/or group counseling sessions.

   d. Home visits and on-site counseling.

   e. Case conferencing with a waiver supports coordinator at least once every six weeks with participant's release.

4. Persons providing counseling services must have:
   a. A master's degree in social work, psychology, psychiatric nursing, or counseling, or

   b. A bachelor's degree in one of the above areas and be under the supervision of a mental health professional with a master's degree, AND

   c. Be licensed in the State of Michigan to provide counseling under MCL 333.17201, MCL 333.18101, MCL 333.18201, or MCL 333.18501.

5. Each waiver agency will verify the licensure of each prospective counselor.

6. Counselors must maintain ongoing case files for each participant, recording the needs assessed, a treatment plan, and the progress achieved at each session.

Limitations

1. Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first. This includes mental health treatment and therapy available through community mental health agencies. Under no circumstances does MI Choice counseling replace therapeutic treatments available through the local community mental health agency.

2. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Minimum Operating Standards for MI Choice Waiver Program Services

NAME	**Environmental Accessibility Adaptations**
DEFINITION	Environmental Accessibility Adaptations (EAA) includes physical adaptations to the home required by the participant's PCSP that are necessary to ensure the health and welfare of the participant or that enable the participant to function with greater independence in the home, without which the participant would require institutionalization. Assessments and specialized training needed in conjunction with the use of such environmental adaptations are included as a part of the cost of the service.
HCPCS CODE	**S5165**, Home modifications, per service
UNITS	One modification or adaptation
SERVICE DELIVERY OPTIONS	☑ Traditional/Agency-Based ☑ Self-Determination

Minimum Standards for Traditional Service Delivery

1. All providers of EAA must meet the licensure requirements as outlined in MCL 339.601, MCL 339.2401, and/or MCL 339.2412, as appropriate.

2. Each direct service provider must have written policies and procedures compatible with the "General Operating Standards for Waiver Agencies and Contracted Direct Service Providers," and minimally, Section B of the "General Operating Standards for MI Choice Waiver Providers."

3. Adaptations may include:
   a. The installation of ramps and grab bars;
   b. Widening of doorways;
   c. Modification of bathroom facilities;
   d. Modification of kitchen facilities;
   e. Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the participant; and
   f. Environmental control devices that replace the need for paid staff and increase the participant's ability to live independently, such as automatic door openers.

4. The case record must contain documented evidence that the adaptation is the most cost-effective and reasonable alternative to meet the participant's need. An example of a reasonable alternative, based on the results of a review of all options, may include changing the purpose, use, or function of a room within the home or finding alternative housing.

5. Each waiver agency must develop working relationships with the weatherization, chore, and housing assistance service providers, as available in the program area to ensure effective coordination of efforts.

6. The participant, with the direct assistance of the PAHP supports coordinator when necessary, must make a reasonable effort to access all available funding sources, such as housing commission grants, Michigan State Housing Development Authority (MSHDA) and community development block grants. The participant's record must include evidence of efforts to apply for alternative funding sources and

the acceptances or denials of these funding sources. The MI Choice waiver is a funding source of last resort.

7. Under the EAA service, waiver agencies may use MI Choice funds to purchase materials and labor used to complete the modifications to prevent or remedy a sub-standard condition or safety hazard. The direct service provider must provide equipment or tools needed to perform modifications or adaptations, unless another source can provide the tools or equipment at a lower cost or free of charge and the provider agrees to use such equipment or tools. The waiver agency may purchase supplies for the modification or adaptation, such as grab bars, lumber, or plumbing supplies, and provide them to the direct service provider at their discretion.

8. The waiver agency may not approve EAA for rental property without close examination of the rental agreement and the proprietor's responsibility (including both legal and monetary) to furnish such adaptations.

9. Adaptations may be made to rental properties when the lease or rental agreement does not indicate the landowner is responsible for such adaptations, and the landowner agrees to the adaptation in writing. A written agreement between the landowner, the participant, and the PAHP must specify any requirements for restoration of the property to its original condition if the occupant moves.

10. The waiver agency must obtain a written agreement with the participant residing in each domicile to be modified that includes, at a minimum; a) a statement that the domicile is occupied by and is the permanent residence of the participant, and b) a description of the planned modifications.

11. The waiver agency must document approval of all EAA in the participant's record. This documentation must minimally include dates, tasks performed, materials used, and cost.

12. The direct service provider must check each domicile for compliance with local building codes.

13. The waiver agency may not approve repairs, modifications, or adaptations to a condemned structure.

14. The PAHP must assure there is a signed contract or bid proposal with the builder or contractor prior to the start of an EAA.

15. It is the responsibility of the PAHP to work with the participant and builder or contractor to ensure the work is completed as outlined in the contract or bid proposal.

16. All services must be provided in accordance with applicable state or local building codes.

17. The environmental adaptation must incorporate reasonable and necessary construction standards, excluding cosmetic improvements. The adaptation cannot result in valuation of the structure significantly above comparable neighborhood real estate values

18. Within fourteen calendar days or ten working days of completion, each waiver agency must utilize a job completion procedure which includes, at a minimum:

a. Verification that the work is complete and correct.
b. Verification by a local building inspector(s) that the work satisfies building codes (as appropriate).
c. Acknowledgment by the participant that the work is acceptable.

Minimum Standards for Self-Determined Service Delivery

1. When authorizing EAA for participants choosing the self-determination option, waiver agencies must comply with item 1 and items 3 through 17 of the Minimum Standards for Traditional Service Delivery specified above.

2. Each chosen provider must minimally comply with Section C of the "General Operating Standards for MI Choice Waiver Service Providers," except item 4.c regarding universal precautions and blood-borne pathogens.

Limitations

1. Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first.

2. Before approving MI Choice payment for each modification or adaptation, each waiver agency must determine whether a participant is eligible to receive services through a program supported by other funding sources. If it appears that another resource can serve the participant, the waiver agency must make an appropriate referral.

3. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

4. 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 participant or homeowner; and
    c. Are not of direct medical or remedial benefit to the participant.
    d. Examples of exclusions include, but are not limited to, carpeting, roof repair, sidewalks, driveways, heating, central air conditioning (unless minimum standard #4 as described above is met), garages, raised garage doors, storage and organizers, hot tubs, whirlpool tubs, swimming pools, landscaping and general home repairs.

5. Environmental adaptations must exclude costs for improvements exclusively required to meet local building codes.

6. 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.

7. 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 a participant's home.

8. The existing structure must have the capability to accept and support the proposed changes.

9. The MI Choice waiver does not cover general construction costs in a new home or additions to a home purchased after the participant is enrolled in the waiver. If a participant or the participant's family purchases or builds a home while receiving waiver services, it is the participant's or family's responsibility to assure the home will meet basic needs, such as having a ground floor bath or bedroom if the participant has mobility limitations. However, MI Choice waiver 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.

10. If modifications are needed to a home under construction that require special adaptation to the plan (e.g. roll-in shower), the MI Choice waiver may be used to fund the difference between the standard fixture and the modification required to accommodate the participant's need.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Minimum Operating Standards for MI Choice Waiver Program Services

NAME	Fiscal Intermediary Services
DEFINITION	Fiscal Intermediary services assist participants in self-determination in acquiring and maintaining services defined in the participant's PCSP, controlling a participant's budget, and choosing staff authorized by the waiver agency. The fiscal intermediary helps a participant manage and distribute funds contained in an individual budget. Funds are used to purchase waiver goods and services authorized in the participant's PCSP. Fiscal Intermediary services include, but are not limited to, the facilitation of the employment of MI Choice service providers by the participant (including federal, state, and local tax withholding or payments, unemployment compensation fees, wage settlements), fiscal accounting, tracking and monitoring participant directed budget expenditures and identifying potential over- and under-expenditures, and assuring compliance with documentation requirements related to management of public funds. The fiscal intermediary may also perform other supportive functions that enable the participant to self-direct needed services and supports. These functions may include verification of provider qualifications, including reference and criminal history review checks, and assisting the participant to understand billing and documentation requirements.
HCPCS CODE	**T2025**, Waiver Services, not otherwise specified.
UNITS	As specified in the contract between the Fiscal Intermediary and the waiver agency, usually a monthly or bi-weekly fee.
SERVICE DELIVERY OPTIONS	☐ Traditional/Agency-Based ☑ Self-Determination

Minimum Standards for Self-Determined Service Delivery

1. Each Fiscal Intermediary (FI) agency must satisfactorily pass a readiness review conducted by a waiver agency, as specified in Attachment N of the MI Choice contract and meet all criteria sanctioned by the state.

2. Each FI must be bonded and insured. The insured amount must exceed the total budgetary amount the FI is responsible for administering.

3. 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.

4. Each FI must demonstrate competence in managing budgets and performing other functions and responsibilities of a fiscal intermediary.

5. Each FI will provide four basic areas of performance:

    a. Function as the employer agency for participants 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 participants, and contracting for other authorized goods 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 participant and waiver agency; and
d. Offer supportive services to enable participants to self-determine and direct the services and supports they need.

6. The waiver agency and FI must abide by the principles set forth in the Self-Determination Technical Advisory "Choice Voucher System" available at:

   www.hcbs.org/moreInfo.php/doc/2928

7. Participants choosing self-determination and utilizing the Agency with Choice option do not have to utilize a fiscal intermediary. Participants using the Agency with Choice option may choose to have the agency perform the functions outlined in standard #5 above.

Limitations

1. Fiscal Intermediary services are only available to those participants choosing the self-determination option for service delivery.

2. Providers of other covered services to the participant, family, or guardians of the participant may not provide FI services to the participant.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Minimum Operating Standards for MI Choice Waiver Program Services

NAME	Goods and Services
DEFINITION	Goods and services are services, equipment, or supplies not otherwise available through the MI Choice waiver or the Medicaid State Plan that address an identified need in the individual PCSP, including improving and maintaining the participant's opportunities for full membership in the community.
HCPCS CODE	**T2041**, Supports brokerage, self-directed, waiver per 15 minutes **T5999**, Supply, not otherwise specified.
UNITS	T2041 = per 15 minutes T5999 = one unit per item
SERVICE DELIVERY OPTIONS	☐ Traditional/Agency-Based ☑ Self-Determination

Minimum Standards for Self-Determined Service Delivery

1. Each chosen provider must minimally comply with Section C of the "General Operating Standards for MI Choice Waiver Service Providers."

2. Waiver agencies 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 waiver agency must assure the item purchased meets the service standards. The waiver agency may choose to open a business account with a retail store for such purchases. The waiver agency must maintain the original receipts and maintain accurate systems of accounting to verify the specific participant who received the purchased item.

3. Each item specified in the PCSP as Goods and Services must meet the following requirements:

   a. The item or service would decrease the need for other Medicaid services; or
   b. Promote inclusion in the community; or
   c. Increase the participant's safety in the home environment; and,
   d. The participant does not have the funds to purchase the item or service or the item or service is not available through another source.

4. The item or service must be designed to meet the participant's functional, medical, or social needs and advance the desired outcomes in the participant's individual PCSP.

5. Self-directed Goods and Services are purchased from the participant-directed budget.

6. Participants choosing the self-determination model for service delivery may also choose to utilize a supports broker to assist with developing the person-centered plan and securing other services (regardless of payer source) that may contribute to the participant's success in home and community-based living and improvements in their quality of life. Supports coordinators should inform all participants of this option and may assist the participant with selecting a supports broker, as needed.

Limitations

1. This service is only available to those participants choosing self-determination.

2. Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first.

3. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

4. This service excludes experimental or prohibited treatments.

5. Federal or State Medicaid or other statues and regulations, including the State's Procurement Requirement, may not prohibit the services or items authorized for purchase.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Minimum Operating Standards for MI Choice Waiver Program Services

NAME	**Home Delivered Meals**
DEFINITION	Home Delivered Meals (HDM) is the provision of one to two nutritionally sound meals per day to a participant who is unable to care for their own nutritional needs. The unit of service is one meal delivered to the participant's home or to the participant's selected congregate meal site that provides a minimum of one-third of the current dietary reference intake (DRI) allowances for the age group as established by the Food and Nutritional Board of the Institute of Medicine of the National Academy of Sciences. Allowances must be made in HDMs for specialized or therapeutic diets as indicated in the participant's PCSP. Home Delivered Meals cannot constitute a full nutritional regimen.
HCPCS CODE	**S5170**, Home delivered meals, including preparation, per meal.
UNITS	One delivered meal
SERVICE DELIVERY OPTIONS	☑ Traditional/Agency-Based ☐ Self-Determination

Minimum Standards for Traditional Service Delivery

The standards identified below apply only to individuals for whom the MI Choice waiver program is purchasing home delivered or congregate meals. Waiver agencies authorize MI Choice payment of meals for qualified participants.

General Requirements

1. Each direct service provider must have written policies and procedures compatible with the "General Operating Standards for Waiver Agencies and Contracted Direct Service Providers," and minimally, Section A of the "General Operating Standards for MI Choice Waiver Providers."

2. All congregate meals providers must meet the MDHHS Aging and Adult Services Agency requirements for congregate meals providers and be an approved provider of congregate meals by the local Area Agency on Aging.

3. Each waiver agency must have written eligibility criteria for persons receiving home delivered or congregate meals authorized through the waiver program which include, at a minimum:

    a. The participant must be unable to consistently obtain food or prepare meals for themselves because of:
        i. A disabling condition, such as limited physical mobility, cognitive or psychological impairment, or sight impairment, **or**
        ii. A lack of knowledge or skill to select and prepare nourishing and well-balanced meals, **or**
        iii. A lack of means to obtain or prepare nourishing meals, **or**
        iv. A lack of incentive to prepare and eat a meal alone, **or**
        v. A lack of informal supports who are both willing and able to perform the services needed, **or**
        vi. A need to supplement the informal supports available with additional meals.
    b. The participant does not have a paid caregiver that is able and willing to prepare meals for the participant.

c. The provider can appropriately meet the participant's special dietary needs as defined by the most current version of the US Department of Agriculture "Dietary Guidelines for Healthy Americans".
d. The participant must be able to feed him or herself.
e. The participant must agree to be home when meals are delivered, or contact the program when absence is unavoidable.

4. Each provider must have written policies and procedures that integrates person centered planning into the home delivered and congregate meals program. This includes allowing participants to attend congregate meals sites when they have transportation or help to the site and providing diet modifications, as requested by the participant when the provider is able to do so while following established nutritional guidelines.

5. Federal regulations prohibit the MI Choice program from providing three meals per day to waiver participants. Providers must vary the level of meal service for an individual in response to varying availability of help from allies and formal caregivers, and changes in the participant's status or condition. When MI Choice provides home delivered meals less than seven days per week, the waiver agency must identify and document in the case record, the usual source of all meals for the participant that are not provided by the program.

6. Each home delivered or congregate meals provider must have the capacity to provide three meals per day, which together meet the DRI 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.

7. The provider may offer liquid meals to participants when ordered by a physician. The regional dietitian must approve all liquid meals products used by the provider. The provider or supports coordinator must provide instruction to the participant, the participant's caregiver, and participant's family in the proper care and handling of liquid meals. The waiver agency and provider must meet the following requirements when liquid meals are the sole source of nutrition:

   a. Diet orders must include participant weight and specify the required nutritional content of the liquid meals.
   b. The supports coordinator must ensure the participant's physician renews the diet orders every three months, and
   c. The MI Choice RN supports coordinator and participant must develop the PCSP for participant receiving liquid meals in consultation with the participant's physician.

8. The provider may supply liquid nutritional supplements ordered by a supports coordinator where feasible and appropriate. When liquid nutrition supplements a participant's diet, the supports coordinator must ensure the physician renews the order for liquid nutritional supplements every six months. However, liquid nutritional supplements are classified as a specialized medical supply for purposes of the MI Choice program and must be billed accordingly.

9. The supports coordinator or provider must verify and maintain records that indicate each participant can provide safe conditions for the storage, thawing, and reheating of frozen foods. Frozen foods should be kept frozen at 0 degrees Fahrenheit thawing for consumption. Unless otherwise preferred by the participant, providers must not furnish more than a two-week supply of frozen meals to a participant during one home delivery visit.

10. Each provider must develop and have available written plans for continuing services in emergencies such as short-term natural disasters (e.g., snow and/or ice storms), loss of power, physical plant malfunctions, etc. The provider must train staff and volunteers on procedures to follow in the event of severe weather or natural disasters and the county emergency plan. The emergency plan shall address, but not be limited to:

    a. Uninterrupted delivery of meals to HDM participants, including, but not limited to use of families and friends, volunteers, shelf-stable meals and informal support systems;
    b. Provision of at least two, and preferably more, shelf-stable meals and instructions on how to use for participants. Every effort should be made to assure that the emergency shelf-stable meals meet the nutrition guidelines. If it is not possible, shelf-stable meals will not be required to adhere to the guidelines.
    c. MI Choice participants may receive two emergency meals.
    d. Back-up plan for food preparation if usual kitchen facility is unavailable;
    e. Agreements in place with volunteer agencies, individual volunteers, hospitals, long-term care facilities, other nutrition providers, or other agencies/groups that could be on standby to assist with food acquisition, meal preparation, and delivery;
    f. Communications system to alert congregate and home-delivered meals participants of changes in meal site/delivery;
    g. The plan shall cover all the sites and participants for each provider, including sub-contractors of the provider.

11. A record of the menu actually served each day shall be maintained for each fiscal year's operation.

12. Monthly nutrition education sessions must be offered at each meal site and as appropriate to home-delivered meal participants. Emphasis should focus on giving the participant the information and tools to make food choices in relation to health and wellness, and to any chronic diseases they may have, including making choices at the meal site, at home, and when they eat out.

    Topics shall include, but not be limited to, food, nutrition, and wellness issues. Nutrition education materials must come from reputable sources. Questions pertaining to appropriateness of materials and presenters are to be directed to the staff dietitian, regional dietitian or Dietetic Technician, Registered (DTR). Program materials distributed must take into consideration the level of literacy, living alone status, caregiver support and translation of materials as appropriate for older adults with limited English proficiency. At least once per year, the following topics must be covered:

    - How food choices affect chronic illnesses
    - Food safety at home and when dining out
    - Food choices at home
    - Emergency preparedness- what to have on hand

13. Each provider must operate according to the Michigan Food Code and must have a copy of the most recent version of the Code available for reference.

14. Complaints from participants should be referred to the provider that hosts the site or manages the HDMs. Each provider shall have a written procedure for handling complaints. The provider and

waiver agency must develop a plan for what type of complaints need to be referred to the waiver agency.

15. Home Visit Safety. Assessors, HDM drivers, delivery people and other staff are not expected to be placed in situations that they feel unsafe or threatened. Providers must work with their waiver agency to create a "Home Visit Safety Policy" that addresses verbal and physical threats made to the assessor(s), drivers or other program persons, by participants, family members, pets (animals) or others in the home during the assessment. This policy should include, but is not limited to:
    a. Definition of a verbal or physical threat;
    b. How a report should be made/who investigates the report;
    c. What actions should be taken by the assessor or driver if they are threatened;
    d. What warnings should be given to the participant;
    e. What actions should be taken for repeated behaviors;
    f. What information gets recorded in the chart; and
    g. Situations requiring multiple staff/volunteers.

Nutrient Analysis Guidelines

1. When developing menus, MDHHS encourages every attempt to include key nutrients and to follow other dietary recommendations that relate to lessening chronic disease and improving the health of MI Choice participants. Diabetes, hypertension, and obesity are three prevalent chronic conditions among all adults in Michigan. Providers should pay special attention to nutritional factors that can help prevent and manage these and other chronic conditions.

2. Develop menu standards to sustain and improve a participant's health through the provision of safe and nutritious meals using specific guidelines.

3. Each meal served by the provider must meet the current U.S. Department of Agriculture/ Health and Human Services Dietary Guidelines and minimally contain 33 1/3 percent of the current DRI as established by the Food and Nutrition Board of the National Academy of Science, National Research Council.

4. The provider must offer meal components meeting the 33 1/3 percent of the DRI if the provider serves one meal per day. If the provider serves two meals per day, the provider must offer meal components meeting 66 2/3 percent of the DRI. If the provider serves three meals per day, the provider must offer meal components with 100 percent of the DRI.

5. Providers must design menu planning to:

    a. Include a variety of foods, especially fruits, vegetables, and whole grains;
    b. Increase the use of fresh or frozen fruits and vegetables, especially those high in potassium;
    c. Avoid too much total fat, saturated fat, trans fat, and cholesterol. Encourage mono- and polyunsaturated fats;
    d. Include foods with adequate complex carbohydrates and fiber;
    e. Avoid too much refined carbohydrates and added sugars;
    f. Encourage nutrient dense foods;

g. Avoid too much sodium by using salt free herbs and spices, cooking from scratch, and using less processed and manufactured foods; and
h. Provide an appropriate number of calories to help maintain ideal body weight.

6. Providers must use person-centered planning principles when doing menu planning. Examples of person-centered menu planning include offering rather than serving food and providing choices of food as often as possible.

7. Providers should track the nutrients in the chart below on a daily basis and may average them weekly. The target value represents 1/3 of the DRI for a >70 year old male, and is the minimum amount. Compliance range represents acceptable minimum and maximum values as specified by the State to allow flexibility and participant satisfaction. Use fortified foods to meet Vitamin B12 needs.

Nutrient	**Target Values (Minimum)**	**Compliance Values Averaged over one week**
Calories	700	600-850
Protein	19 grams per meal	>=19 grams per meal
Total Fat Saturated Fat Trans Fat	<30% of calories <10% of calories No trans fat	<30% of calories No meal > 35% fat As low as possible
Fiber	10 grams	7 grams or higher
Calcium	400 mg	400 mg or higher
Magnesium (suggested food sources: bananas, raisins, legumes, nuts, whole grains, oatmeal, vegetables, milk, and milk products)	116 mg	116 mg or higher
Vitamin B6 (suggested food sources: fish, beef liver and other organ meats, potatoes and other starchy vegetables, fruit (excluding citrus), and fortified cereals)	0.6 mg	0.6 mg or higher
Vitamin B12 (suggested food sources: fish, red meat, poultry, eggs, milk and milk products, and fortified cereals)	0.8 mcg	0.8 mcg or higher
Vitamin C	30 mg	25 mg or higher
Sodium	800-1,200 mg	1,200 mg or less

8. These nutrients have been targeted for tracking because older adults frequently do not get enough of these nutrients, which affect bone and muscle health. Deficiencies can lead to balance problems and exacerbate existing chronic conditions.

9. Special Menus: To the extent practicable, adjust meals to meet any special dietary needs of the participants for health reasons, ethnic and religious preference, and to provide flexibility in designing meals that are appealing to participants.

10. Providers must be able to produce a nutrient analysis for a meal when requested by MDHHS, the waiver agency, a participant, a participant's family, or a medical provider. The provider does not have to list nutrient analysis on the menu.

11. Key recommendations from the USDA Dietary Guidelines for Americans (DGA) to consider when planning meals:

    a. Consume a healthy eating pattern that accounts for all foods and beverages within an appropriate calorie level.

i. A variety of vegetables from all of the sub-groups- dark green, red and orange, legumes (beans and peas), starchy, and other.
ii. Fruits, especially whole fruits
iii. Grains, at least half of which are whole grains
iv. Fat-free, or low-fat dairy, including milk, yogurt, and cheese
v. A variety of protein foods, including seafood, lean meats and poultry, eggs, legumes, nuts and seeds.
vi. Oils

b. Nutrient dense meals shall be planned using preparation and delivery methods that preserve the nutritional value of foods.
   i. Consume less than 10% of calories per day from added sugars
   ii. Consume less than 10% of calories per day from saturated fats
   iii. Consume less than 2300 grams of sodium per day (This may be averaged in your meal plans)

c. The target for carbohydrate per meal is 75 grams. If the provider is following one of the suggested meal patterns from the Dietary Guidelines for Americans, the CHO grams should follow that pattern.

Meal Planning Guidelines

1. The provider may serve vegetarian meals as part of the menu cycle or as an optional menu choice. Vegetarian meals must include a variety of flavors, textures, seasonings, colors, and food groups in the same meal.

2. Breakfast meals may include any combination of foods that meet the meal planning guidelines.

3. Providers may present hot, cold, frozen, or shelf-stable meals as long as the meals conform to the meal planning guidelines.

4. Each meal should include the following food groups: bread or bread alternative, vegetables, fruit, dairy, and meat or meat alternatives. The provider should refer to http://www.choosemyplate.gov for serving sizes of each meal component.

5. Each program shall utilize a menu development process, which places priority on healthy choices and creativity, and includes, at a minimum:
   a. Use of written or electronic standardized recipes.
   b. Provision for review and approval of all menus by one of the following: a registered dietitian (R.D.), or, an individual who is dietitian registration eligible, or a DTR.
   c. Posting of menu to be served in a conspicuous place at each meal site, and at each place food is prepared. The provider must be able to provide information on the nutrition content of menus upon request; and
   d. Modified diet menus may be provided, where feasible and appropriate, which take into consideration participant choice, health, religious and ethnic diet preferences.

6. Each provider shall use standardized portion control procedures to ensure that each meal served is uniform. At the request of a participant, standard portions may be altered or less may be served than the standard serving size. A participant may refuse one or more items. Less than standard portions shall not be served in order to 'stretch' available food to serve additional persons.

   a. **Bread or Bread Alternatives** may include, but is not limited to:

Muffin	Cornbread	Biscuit	Waffle	French toast
English muffin	Tortilla	Pancakes	Bagel	Crackers
Granola	Graham Cracker	Dressing	Stuffing	Pasta
Sandwich bun	Cooked cereal	Bread, all types		

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

   b. **Vegetables** include traditional vegetables and dried beans, peas, lentils, 100% vegetable juice, raw leafy vegetables, and other beans.

   c. **Fruits** include traditional fruits; chopped, cooked, or canned fruit; 100% fruit juice; fresh, frozen, freeze-dried, juice, or canned fruit.

   d. **Milk or Milk Alternatives** include traditional milk products and may include, but is not limited to:

Buttermilk	Low-fat chocolate milk	Lactose-free milk
Powdered milk	Evaporated milk	Yogurt
Cottage cheese	Tofu	Calcium fortified soy, rice, or almond milk
Natural or processed cheese		

   e. **Meat or Meat Alternatives** include traditional meat products and may include, but is not limited to:

Eggs	Nuts	Cheese	Cottage Cheese	Dried beans
Dried lentils	Tofu	Nut butter	Tempeh	

   A meat or meat alternative may be served in combination with other high protein foods. Avoid serving dried beans, nut butter, nuts, or tofu for consecutive meals or on consecutive days, except to meet cultural or religious preferences or for emergency meals.

   Imitation cheese is made from vegetable oil, not from milk or milk products, and may not be served as a meat alternative.

   Consider serving cured and processed meats (ham, smoked or Polish sausage, corned beef, dried beef) no more than once per week to limit sodium content of the meals.

   f. **Accompaniments**
   Include traditional meal accompaniments as appropriate, e.g., condiments, spreads, and garnishes. Examples include mustard or mayonnaise with a meat sandwich; tartar sauce with fish; salad dressing with tossed salad; margarine with bread or rolls. Whenever feasible, provide 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, trans fats, and cholesterol.

g. **Desserts**
Serving a dessert is encouraged, but optional. Dessert suggestions include, but are not limited to fruit, fruit crisps with whole grain toppings, pudding with double milk, gelatin with fruit, low-fat frozen yogurt, and Italian ices. Limit the use of baked, commercial desserts to once per week.

h. **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.

Congregate:	Milk and water must be offered with every meal. Coffee and/or tea, or other beverages, are optional.
Home Delivered:	Milk, or a milk substitute, must be offered with every meal. If requested, water shall be provided.

Milk may be skim, 1%, 2%, full-fat or chocolate. It should be available to participants but is not required.

Limitations

1. Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first.

2. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

3. The meals authorized under this service must not constitute a full nutritional regimen.

4. Providers must not solicit donations from waiver participants.

5. Providers must not use waiver funds to purchase dietary supplements such as vitamins and minerals.

6. When the participant has informal supports or paid caregivers available during meal times, the case record must clearly document the need for a home delivered meal.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Minimum Operating Standards for MI Choice Waiver Program Services

NAME	**Nursing Services**
DEFINITION	MI Choice Nursing Services are covered on an intermittent (separated intervals of time) basis for a participant who requires nursing services for the management of a chronic illness or physical disorder in the participant's home and are provided by a registered nurse (RN) or a licensed practical nurse (LPN) under the direct supervision of a registered nurse (RN). MI Choice Nursing Services are for participants who require more periodic or intermittent nursing than available through the Medicaid State Plan or other payer resources for the purpose of preventive interventions to reduce the occurrence of adverse outcomes for the participant such as hospitalizations and nursing facility admissions. MI Choice Nursing Services must not duplicate services available through the Medicaid State Plan or third payer resources.
HCPCS CODE	**T1002**, RN Services, up to 15 minutes **T1003**, LPN/LVN services, up to 15 minutes
UNITS	15 minutes
SERVICE DELIVERY OPTIONS	☑ Traditional/Agency-Based ☑ Self-Determination

Minimum Standards for Traditional Service Delivery

1. Each direct service provider must have written policies and procedures compatible with the "General Operating Standards for Waiver Agencies and Contracted Direct Service Providers", and minimally, Section A of the "General Operating Standards for MI Choice Waiver Providers."

2. When the participant's condition is unstable, could easily deteriorate, or when significant changes occur, MI Choice covers nurse visits for observation and evaluation. The purpose of the observation and evaluation is to monitor the participant's condition and report findings to the participant's physician or other appropriate health care professional to prevent additional decline, illness, or injury to the participant.

3. The supports coordinator must communicate with both the nurse providing this service and the participant's health care professional to assure the nursing needs of the participant are being addressed.

4. Participants 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 participant-recorded blood sugar levels, to assist with effective pre-diabetes or diabetes management.

    d. Require professional assessment of the participant'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 participant'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 participant'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 participant's physician or other health care professional.

5. 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 the participant cannot self-administer (as defined under Michigan Complied Law (MCL) 333.7103(1)).

   b. Setting up medications according to physician orders.

   c. Monitoring participant adherence to their medication regimen.

   d. Applying dressings that require prescribed medications and aseptic techniques.

   e. Providing refresher training to the participant 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.

Minimum Standards for Self-Determined Service Delivery

1. Each chosen provider must minimally comply with Section C of the "General Operating Standards for MI Choice Waiver Service Providers."

2. When authorizing Nursing Services for participants choosing the self-determination option, waiver agencies must comply with items 2, 3, 4, and 5, of the Minimum Standards for Traditional Service Delivery specified above.

Limitations

1. Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first.

2. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

3. This service is limited to no more than two hours per visit, unless a reason for a longer visit is clearly documented in the participant's record (such as requiring three hours to complete a complicated dressing change).

4. Participants receiving Private Duty Nursing services are not eligible to receive MI Choice Nursing Services.

5. All providers furnishing this service must be licensed as either a Registered Nurse or a Licensed Practical Nurse in the State of Michigan.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Minimum Operating Standards for MI Choice Waiver Program Services

NAME	**Personal Emergency Response System**
DEFINITION	A Personal Emergency Response System (PERS) is an electronic device that enables a participant to summon help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is often connected to the participant's phone and programmed to signal a response center once a "help" button is activated. This service also includes installation, upkeep, and maintenance of devices.
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/Agency-Based ☐ Self-Determination

Minimum Standards for Traditional Service Delivery

1. Each direct service provider must have written policies and procedures compatible with the "General Operating Standards for Waiver Agencies and Contracted Direct Service Providers," and minimally, Section A of the "General Operating Standards for MI Choice Waiver Providers."

2. 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.

3. The provider may offer this service for cellular or mobile phones and devices. The device must meet industry standards. The participant must reside in an area where the cellular or mobile coverage is reliable. When the participant uses the device to signal and otherwise communicate with the PERS provider, the technology for the response system must meet all other service standards.

4. 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.

5. The response center must maintain the monitoring capacity to respond to all incoming emergency signals.

6. 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.

7. The provider will furnish each responder with written instructions and provide training, as appropriate.

8. The provider will verify the responder and contact names for each participant on a semi-annual basis to assure current and continued participation.

9. The provider will assure at least monthly testing of each PERS unit to assure continued functioning.

10. The provider will furnish ongoing assistance, as necessary, to evaluate and adjust the PERS instrument or to instruct participants and caregivers in the use of the devices, as well as to provide performance checks.

11. The provider will maintain individual client records that include the following:

    a. Service order,
    b. Record of service delivery, including documentation of delivery and installation of equipment, participant/caregiver orientation, and monthly testing,
    c. List of emergency responders for each participant, and
    d. A case log documenting participant and responder contacts.

Limitations

1. Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first.

2. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

3. PERS does not cover monthly telephone charges associated with phone service.

4. PERS is limited to persons who either live alone or who are left alone for significant periods on a routine basis and who could not summon help in an emergency without this device.

5. Waiver agencies may authorize PERS units for persons who do not live alone if both the waiver participant and the person with whom they reside would require extensive routine supervision without a PERS unit in the home. For example, if one or both spouses are waiver participants and both are frail and elderly, the waiver agency may authorize a PERS unit for the waiver participant(s). Supports coordinators must clearly document in the case record the reason for the provision of a PERS unit when the participant does not live alone or is not left alone for significant lengths of time.

6. Waiver agencies may provide a purchased unit like a PERS device. This type of unit does not require an installation or monthly fee but is a one-time cost. These units are covered under the Specialized Medical Equipment and Supplies service. Participants should not have both a purchased and a rented unit.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Minimum Operating Standards for MI Choice Waiver Program Services

NAME	**Private Duty Nursing/Respiratory Care**
DEFINITION	Private Duty Nursing/Respiratory Care (PDN/RC) services are skilled nursing or respiratory care interventions provided to a participant age 21 and older on an individual and continuous basis to meet health needs directly related to the participant's physical disorder. PDN/RC includes the provision of nursing assessment, treatment and observation provided by licensed nurses within the scope of the State's Nurse Practice Act, consistent with physician's orders and in accordance with the participant's PCSP. To be eligible for PDN/RC services, the waiver agency must find the participant meets either Medical Criteria I or Medical Criteria II, and Medical Criteria III. Regardless of whether the participant meets Medical Criteria I or II, the participant must also meet Medical Criteria III. The participant's PCSP must provide reasonable assurance of participant safety. This includes a strategy for effective back-up in the event of an absence of providers. The back-up strategy must include informal supports or the participant's capacity to manage his or her care and summon assistance. PDN/RC for a participant between the ages of 18-21 is covered under the Medicaid State Plan.
HCPCS CODE	**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 G0237, Therapeutic procedures to increase strength or endurance of respiratory muscles, face to face, one on one, each 15 minutes (includes monitoring) G0238, Therapeutic procedures to improve respiratory function other than described by G0237, face to face, one on one, per 15 minutes (includes monitoring) G0239, Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, two or more individuals (includes monitoring)
UNITS	Up to 15 minutes
SERVICE DELIVERY OPTIONS	☑ Traditional/Agency-Based ☑ Self-Determination

Medical Criteria

Medical Criteria I – The participant is dependent daily on technology-based medical equipment to sustain life. "Dependent daily on technology-based medical equipment" means:

1. Mechanical rate-dependent ventilation (four or more hours per day), or assisted rate-dependent respiration (e.g., some models of Bi-PAP); or

2. Deep oral (past the tonsils) or tracheostomy suctioning eight or more times in a 24-hour period; or

3. Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility; or

4. Total parenteral nutrition delivered via a central line, associated with complex medical problems or medical fragility; or

5. 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 requirement 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 and 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.

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:
1. "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.

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

3. "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.

4. "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.

5. "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.

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

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

Definitions:
1. "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.

2. "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:

    a. 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;

    b. Managing mechanical rate-dependent ventilation or assisted rate-dependent respiration (e.g., some models of Bi-PAP) that is required by the beneficiary four or more hours per day;

    c. Deep oral (past the tonsils) or tracheostomy suctioning;

    d. 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);

    e. Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility;

    f. Total parenteral nutrition delivered via a central line and care of the central line;

    g. 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 and 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;

    h. 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 to MI Choice participants must meet licensure requirements and practice the standards found under MCL 333.17201-17242 and maintain a current State of Michigan nursing license.

2. All Respiratory Therapists providing respiratory care to MI Choice participants must meet licensure requirements and practice standards found in MCL 333.18701-333.18713 and maintain a current State of Michigan respiratory therapist/care license.

3. Each direct service provider must have written policies and procedures compatible with the "General Operating Standards for Waiver Agencies and Contracted Direct Service Providers," and minimally, Section A of the "General Operating Standards for MI Choice Waiver Providers."

4. Through a person-centered planning process, the waiver agency must determine the length and duration of services provided.

5. The direct service provider must maintain close contact with the authorizing waiver agency to promptly report changes in each participant's condition and/or treatment needs upon observation of such changes.

6. The direct service provider must send case notes to the supports coordinator on a regular basis, preferably monthly, but no less than quarterly, to update the supports coordinator on the condition of the participant.

7. This service may include medication administration as defined under MCL 333.7103(1).

8. The waiver agency 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/RC services. However, the waiver agency is responsible for assuring the PDN/RC provider has a copy of these orders and delivers PDN/RC services according to the orders.

9. The waiver agency must maintain a copy of the physician orders in the case record.

Minimum Standards for Self-Determined Service Delivery

1. Each chosen provider must minimally comply with Section C of the "General Operating Standards for MI Choice Waiver Service Providers."

2. When authorizing PDN/RC for participants choosing the self-determination option, waiver agencies must comply with items 1, 3, 4, 5, 6, 7, and 8 of the Minimum Standards for Traditional Service Delivery specified above.

Limitations

1. Participants receiving MI Choice Nursing Services are not eligible to receive Private Duty Nursing/Respiratory Care Services.

2. All PDN/RC services authorized must be medically necessary as indicated through the MI Choice assessment and meet the medical criteria described above.

3. The participant's physician, physician's assistant, or nurse practitioner must order PDN/RC services and work in conjunction with the waiver agency and provider agency to assure services are delivered according to that order.

4. Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first.

5. The waiver agency and direct service provider must explore and utilize all other sources of funding before using MI Choice funds for PDN/RC services.

6. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

7. Services paid for with MI Choice funds must not duplicate nor replace services available through the Michigan Medicaid state plan. Waiver agencies and direct service providers can find state plan coverage online in the Medicaid Provider Manual at http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf.

8. PDN is limited to persons aged 21 or older. PDN is a Medicaid State Plan benefit for persons under the age of 21 who qualify for the service.

9. It is not the intent of the MI Choice program to provide PDN/RC services on a continual 24 hours per day, 7 days per week basis. MI Choice services are intended to supplement informal support services available to the participant. Only under extreme circumstances should 24/7 PDN/RC be authorized for a participant. These circumstances must be clearly described in the participant's case record and approved by MDHHS.

10. 24/7 PDN/RC services cannot be authorized for persons who cannot direct their own services and supports, make informed decisions for themselves, or engage their emergency back-up plan without assistance. These persons must have informal caregivers actively involved in providing some level of direct services to the participant on a routine basis.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Minimum Operating Standards for MI Choice Waiver Program Services

NAME	**Respite (*provided at the participant's home or in the home of another*)**
DEFINITION	Respite services are provided to participants unable to care for themselves and are furnished on a short-term basis due to the absence of, or need of relief for, those individuals normally providing services and supports for the participant. This standard addresses respite provided in the participant's home or in the home of another. Respite does not include the cost of room and board. Respite can only be provided in the home of another when the participant is using the self-determination option for service delivery.
HCPCS CODE	**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/Agency-Based ☑ Self-Determination

Minimum Standards for Traditional Service Delivery

1. Each direct service provider must have written policies and procedures compatible with the "General Operating Standards for Waiver Agencies and Contracted Direct Service Providers," and minimally, Section A of the "General Operating Standards for MI Choice Waiver Providers."

2. Participants choosing this method of service delivery **may not** choose to have respite furnished in the home of another.

3. Each waiver agency must establish and follow written eligibility criteria for in-home respite that include, at a minimum:

    a. Participants 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. Participants have difficulty performing or are unable to perform activities of daily living without assistance.

4. Respite services include:

    a. Attendant care (participant is not bed-bound) such as companionship, supervision, and/or assistance with toileting, eating, and ambulation.

    b. Basic care (participant 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 appropriate portions of the assessment conducted by the waiver agency before initiating service. The assessment information must include a recommendation made by the assessing RN describing the respite support services the participant

needs. Each waiver agency or direct service provider must ensure the skills and training of the respite care worker assigned coincides with the condition and needs of the participant.

6. With the assistance of the participant or participant's caregiver, the waiver agency or direct service provider must determine an emergency notification plan for each participant, pursuant to each visit.

7. Each direct service provider must establish written procedures that govern the assistance given by staff to participants with self-medication. These procedures must be reviewed by a consulting pharmacist, physician, or registered nurse and must include, at a minimum:

   a. The provider staff authorized to assist participants 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 participant takes and its impact upon the participant.

   b. Verification of prescription medications and their dosages. The participant must maintain all medications in their original, labeled containers.

   c. Instructions for entering medication information in participant files.

   d. A clear statement of the participant's and participant's family's responsibility regarding medications taken by the participant and the provision for informing the participant and the participant's family of the provider's procedures and responsibilities regarding assisted self-administration of medications.

8. Each direct service provider must employ a professionally qualified supervisor that is available to staff during their shift while providing respite care.

9. Members of a participant's family who are not the participant's regular caregiver may provide respite for the regular caregiver. However, waiver agencies must not authorize MI Choice funds to pay for services furnished to a participant by that person's spouse.

10. Family members who provide respite services must meet the same standards as providers who are unrelated to the individual.

11. The waiver agency must not authorize respite services to relieve a caregiver that receives waiver funds to provide another service to the waiver participant. For example, if the waiver agency has authorized a niece to provide 30 hours per week of community living supports to the participant and pays for this service with waiver funds, the waiver agency must not also authorize additional hours of respite to relieve that niece of her caregiver duties. Rather, the waiver agency should decrease the niece's paid hours and authorize another caregiver to provide the needed services and support to the participant.

    This requirement may be waived if:

    a. The case record demonstrates the participant has a medical need for services and supports in excess of the authorized amount of MI Choice services (i.e. in the example above the participant has a medical need for 50 hours per week of services); **and**

b. The case record demonstrates the paid caregiver furnishes unpaid services and supports to the participant (i.e. the niece is paid for 30 hours per week, but actually delivers 50 hours per week of services); **and**

c. The paid caregiver is requesting respite for the services and supports not usually authorized through the MI Choice program (i.e. for all or part of the 20 hours of medically necessary, but unpaid services the niece regularly furnishes).

Minimum Standards for Self-Determined Service Delivery

1. Each chosen provider must minimally comply with Section C of the "General Operating Standards for MI Choice Waiver Service Providers."

2. Participants choosing this method of service delivery may choose to have respite services delivered in the home of another.

3. When authorizing Respite services for participants choosing the self-determination option, waiver agencies must comply with items 2, 3, 5, 8, 9, and 10 of the Minimum Standards for Traditional Service Delivery specified above.

Limitations

1. MDHHS does not intend to furnish respite services on a continual basis. Respite services should be utilized for the sole purpose of providing temporary relief to an unpaid caregiver. When a caregiver is unable to furnish unpaid medically necessary services on a regular basis, waiver agencies should work with the participant and caregiver to develop a PCSP that includes other MI Choice services, as appropriate.

2. Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first.

3. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

4. The costs of room and board are not included.

5. Waiver agencies cannot authorize respite services on a continual daily basis. Waiver agencies may authorize respite services on a daily basis for a short period, such as when informal supports are on vacation.

6. Respite should be used on an intermittent basis to provide scheduled relief of informal caregivers.

7. The waiver agency must not authorize waiver funds to pay for respite services provided by the participant's usual caregiver.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Minimum Operating Standards for MI Choice Waiver Program Services

NAME	**Respite *(provided outside of the home)***
DEFINITION	Respite services are provided to participants unable to care for themselves and are furnished on a short-term basis due to the absence of, or need of relief for, those individuals normally providing services and supports for the participant. This standard addresses respite provided outside of the home. When provided in a Medicaid-certified hospital or a licensed Adult Foster Care facility, this type of respite may include the cost of room and board.
HCPCS CODE	**H0045**, Respite services not in the home, per diem
UNITS	H0045 = per day
SERVICE DELIVERY OPTIONS	☑ Traditional/Agency-Based ☐ Self-Determination

Minimum Standards for Traditional Service Delivery

1. Each direct service provider must have written policies and procedures compatible with the "General Operating Standards for Waiver Agencies and Contracted Direct Service Providers," and minimally, Section B of the "General Operating Standards for MI Choice Waiver Providers."

2. Out of home respite providers must also adhere to parts 5 and 6 of Section A of the "General Operating Standards for MI Choice Waiver Providers."

3. Each out of home respite service provider must be either a Medicaid certified hospital or a licensed group home as defined in MCL 400.701 ff, which includes adult foster care homes and homes for the aged. Properly licensed nursing facilities may be providers of out of home respite services.

4. Each waiver agency must establish and follow written eligibility criteria for out-of-home respite that include, at a minimum:

    a. Participants 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. Participants have difficulty performing or are unable to perform activities of daily living without assistance.

5. Respite services include:

    a. Attendant care (participant is not bed-bound) such as companionship, supervision and/or assistance with toileting, eating, and ambulation.

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

6. The direct service provider must obtain a copy of the assessment conducted by the waiver agency before initiating service. The assessment information must include a recommendation made by the assessing RN describing the respite support services the participant needs.

7. Each direct service provider must demonstrate a working relationship with a hospital and/or other health care facility for the provision of emergency health care services, as needed. With the assistance of the participant or participant's caregiver, the waiver agency or direct service provider must determine an emergency notification plan for each participant, pursuant to each visit.

8. Each direct service provider must establish written procedures to govern the assistance given by staff to participants with self-medications. These procedures must be reviewed by a consulting pharmacist, physician, or registered nurse and must include, at a minimum:

    a. The provider staff authorized to assist participants 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 participant takes and its impact upon the participant.

    b. Verification of prescription medications and their dosages. The participant must maintain all medications in their original, labeled containers.

    c. Instructions for entering medication information in participant files.

    d. A clear statement of the participant's and participant's family's responsibility regarding medications taken by the participant while at the facility and the provision for informing the participant and the participant's family of the program's procedures and responsibilities regarding assisted self-administration of medications.

9. Each direct service provider must employ a professionally qualified program director that directly supervises program staff.

Limitations

1. MDHHS does not intend Respite services to be furnished on a continual basis. Respite services should be utilized for the sole purpose of providing temporary relief to an unpaid caregiver. When a caregiver is unable to furnish unpaid medically necessary services on a regular basis, waiver agencies should work with the participant and caregiver to develop a PCSP that includes other MI Choice services, as appropriate.

2. Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first.

3. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

4. For each participant, the waiver agency must not authorize MI Choice waiver payment for more than 30 days of out of home respite service per calendar year. Calendar years consist of any 365-day period.

5. Waiver agencies cannot authorize respite services on a continual daily basis. Waiver agencies may authorize respite services on a daily basis for a short period, depending upon the needs of the participant and the participant's caregivers, such as when informal supports are on vacation.

6. Respite should be used on an intermittent basis to provide scheduled relief of informal caregivers.

7. The waiver agency must not authorize waiver funds to pay for respite services provided by the participant's usual caregiver.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Minimum Operating Standards for MI Choice Waiver Program Services

NAME	Specialized Medical Equipment and Supplies
DEFINITION	Specialized Medical Equipment and Supplies includes devices, controls, or appliances that enable participants 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. This service excludes those items that are not of direct medical or remedial benefit to the participant. Durable and non-durable medical equipment and medical supplies not available under the State Plan that are necessary to address the participant's functional limitations may be covered by this service. Medical equipment and supplies furnished under the State Plan must be procured and reimbursed through that mechanism and not through MI Choice. All items must be specified in the participant's PCSP. All items must meet applicable standards of manufacture, design and installation. Coverage includes training the participant or caregiver(s) in the operation and maintenance of the equipment or the use of a supply when initially purchased. Waiver funds may also be used to cover the maintenance costs of equipment.
HCPCS CODES	Please see list included in item #10 under minimum standards.
UNITS	Per item, unless otherwise specified.
SERVICE DELIVERY OPTIONS	☑ Traditional/Agency-Based ☐ Self-Determination

Minimum Standards for Traditional Service Delivery

1. Each direct service provider must enroll in Medicare and/or Medicaid as a Durable Medical Equipment provider, pharmacy, etc., as appropriate.

2. Waiver agencies may obtain some items directly from a retail store that offers the item to the public (i.e. Wal-Mart, K-mart, Meijer, Costco, etc.). When utilizing retail stores, the waiver agency must assure the item purchased meets the service standards. The waiver agency may choose to open a business account with a retail store for such purchases. The waiver agency must maintain the original receipts and maintain accurate systems of accounting to verify the specific participant who received the purchased item.

3. Each direct service provider must have written policies and procedures compatible with the "General Operating Standards for Waiver Agencies and Contracted Direct Service Providers," and minimally, Section B of the "General Operating Standards for MI Choice Waiver Providers."

4. The waiver agency and/or direct service provider must pursue payment by Medicare, Medicaid state plan, or other entities, as applicable before the waiver agency authorizes MI Choice payment.

5. The waiver agency must document the medical or remedial benefit the equipment or supply provides to the participant in the participant's case record.

6. Where feasible, the waiver agency or direct service provider must seek affirmation of the need for the item provided from the participant's physician.

7. The waiver agency may not authorize MI Choice payment for prescription medications not found on the Medicaid prescription drug formulary. If a participant requires a medication not found on the formulary, the waiver agency, participant, or pharmacy must seek prior authorization of payment through the state plan. Regardless of approval or denial of state plan prior authorization, MI Choice funds must not pay for the medication.

8. The waiver agency may provide liquid nutritional supplements as a specialized medical supply. The participant's physician or other health care professional must first order liquid nutritional supplements as described in the home delivered meals service standards. When liquid nutrition supplements a participant's diet, the supports coordinator must ensure the physician or other health care professional renews the order for liquid nutritional supplements every six months.

9. The waiver agency must not authorize MI Choice payment for herbal remedies or other over-the-counter medications for uses not authorized by the FDA.

10. The following HCPCS codes are approved for use under the Specialized 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 waiver agency 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. **E0629**, Separate seat lift mechanism for use with patient owned furniture, non-electric
    r. **E0745** Neuromuscular stimulator, electronic shock unit

s. **E1639**, Scale, each
t. **S5162**, Emergency response system; purchase only
u. **S5199**, Personal care item, NOS, each
    i. Use this code for items that the participant uses to perform ADLs or IADLs, or that assist the participant in the performance of ADLs or IADLs.
    ii. This category must exclude items such as shampoo, soap, toothpaste, toothbrushes, dent-tips, shaving cream, and razors.
    iii. The waiver agency must include a description of this item in the appropriate loop for approval of a claim.
    iv. Standardized remarks are available.
v. **T1999**, Misc. Therapeutic items & supplies, retail purchases, NOC, identify product in “remarks”
    i. Items in this category have a therapeutic use for the participant.
    ii. The waiver agency must include a description of this item in the appropriate loop for approval of a claim.
    iii. Standardized remarks are available.
w. **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 waiver agency must include a description of this item in the appropriate loop for approval of a claim.
    iv. Standardized remarks are available.
x. **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 waiver agency must include a description of this item in the appropriate loop for approval of a claim.
    iv. Standardized remarks are available.
y. **T2039**, Vehicle Modifications, waiver, per service
z. **T4537**, Incontinence product, protective underpad, reusable, bed size, each
aa. **T4540**, Incontinence product, protective underpad, reusable, chair size, each
bb. **V5268**, Assistive listening device, telephone amplifier, any type
cc. **V5269**, Assistive listening device, alerting, any type
dd. **V5270**, Assistive listening device, television amplifier, any type

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Minimum Operating Standards for MI Choice Waiver Program Services

NAME	**Supports Coordination**
DEFINITION	Supports Coordination is provided to assure the provision of supports and services needed to meet the participant's health and welfare needs in a home and community-based setting. Without these supports and services, the participant would otherwise require institutionalization. The supports coordination functions to be performed and the frequency of face-to-face and other contacts are specified in the participant's PCSP. The frequency and scope of supports coordination contacts must take into consideration health and safety needs of the participant. Supports Coordination does not include the direct provision of other Medicaid services.
HCPCS CODE	**T2022**, Case management, per month
UNITS	One unit per month
SERVICE DELIVERY OPTIONS	☑ Traditional/Agency-Based ☐ Self-Determination

Minimum Standards for Traditional Service Delivery

1. Each direct service provider must have written policies and procedures compatible with the "General Operating Standards for Waiver Agencies and Contracted Direct Service Providers," and minimally, Section A of the "General Operating Standards for MI Choice Waiver Providers."

2. Each supports coordinator must have a valid Michigan license as a registered nurse or a licensed social worker and be trained and knowledgeable about the program requirements for MI Choice as well as other available community resources.

3. Functions performed by a supports coordinator include:

    a. Assure the participant meets the Nursing Facility Level of Care per MDHHS policy.

    b. Conduct the initial assessment and periodic reassessments.

    c. Facilitate person-centered planning that is focused on the participant's preferences, includes family and other allies as determined by the participant, identifies the participant's goals, preferences and needs, provides information about options, and engages the participant in monitoring and evaluating services and supports.

    d. Develop a PCSP, including revisions to the PCSP at the participant's initiation, or as changes in the participant's circumstances may warrant.

    e. Communication with the participant is a requirement and must be incorporated into the person-centered service plan.

    f. Make referrals to and coordinate with providers of services and supports, including non-Medicaid services and informal supports. This may include providing assistance with access to entitlements or legal representation.

g. Monitor MI Choice waiver services and other services and supports necessary for achievement of the participant's goals. Monitoring includes providing opportunities for the participant to evaluate the quality of services received and indicate whether those services achieved desired outcomes. This activity includes the participant and other key sources of information as determined by the participant.

h. Provide social and emotional support to the participant and allies to facilitate life adjustments and reinforce the participant's sources of support. This may include arranging services to meet those needs.

i. Provide advocacy to support the participant's access to benefits, assure the participant's rights as a program beneficiary, and support the participant's decisions.

j. Maintain documentation of the above listed activities to ensure successful support of the participant, comply with Medicaid and other relevant policies, and meet the performance requirements delineated in the waiver agency's contract with MDHHS.

4. Additional requirements and standards for performing the functions required of a supports coordinator are defined in the document "Supports Coordination Service Performance Standards and MI Choice Program Operating Criteria" which is Attachment K of the contract between the waiver agency and MDHHS.

Limitations

1. Participant must need and agree to accept at least one additional MI Choice service every 30 days to qualify for the program.
2. Supports coordinators must not also provide Transition Navigation services.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Minimum Operating Standards for MI Choice Waiver Program Services

NAME	**Training**
DEFINITION	Training services consist of instruction provided to a MI Choice participant or caregiver(s) in either a one-to-one situation or a group basis to teach a variety of independent living skills, including the use of specialized or adaptive equipment or medically related procedures required to maintain the participant in a community-based setting. The training needs must be identified in the comprehensive assessment or in a professional evaluation and included in the participant's PCSP. Training is covered for areas such as activities of daily living, adjustment to home or community living, adjustment to mobility impairment, adjustment to serious impairment, management of personal care needs, the development of skills to deal with service providers and attendants, and effective use of adaptive equipment. For participants self-directing services, Training services may also include the training of independent supports brokers, developing and managing individual budgets, staff hiring, training, and supervision, or other areas related to self-direction.
HCPCS CODES	**S5110**, Home care training, family, per 15 minutes **S5115**, Home care training, non-family, per 15 minutes
UNITS	S5110 = 15 minutes S5115 = 15 minutes
SERVICE DELIVERY OPTIONS	☑ Traditional/Agency-Based ☐ Self-Determination

Minimum Standards for Traditional Service Delivery

1. Each direct service provider must have written policies and procedures compatible with the "General Operating Standards for Waiver Agencies and Contracted Direct Service Providers," and minimally, Section A of the "General Operating Standards for MI Choice Waiver Providers."

2. Direct service providers must possess credentials required by Michigan laws or federal regulations, including:

   a. MCL 333.17801…333.17831 (physical therapist),
   b. MCL 333.18301…333.18311 (occupational therapist),
   c. MCL 333.18501…333.18518 (social worker), and/or
   d. MCL 333.17201…333.17242 (nursing)

3. The waiver agency must identify the training needs in the comprehensive assessment or in a professional evaluation and include them in the PCSP. The waiver agency must provide a description of these needs to the direct service provider.

4. The waiver agency must maintain verification of training provided to self-determined workers in the participant's case record.

Limitations:

1. Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first.

2. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Minimum Operating Standards for MI Choice Waiver Program Services

DEFINITION OF TERMS

Acronym or Term	Definition
ACA	Affordable Care Act
ADLs	Activities of Daily Living
CHAMPS	Community Health Automated Medicaid Payment System, Michigan's MMIS, the software Michigan uses to process Medicaid claims and encounter data.
CLS	Community Living Supports
CMS	The Centers for Medicare and Medicaid Services, a division of the Federal Health and Human Services Department
CT	Community Transportation
DRI	Deficit Reduction Act
Direct Service Provider (DSP)	A business, agency, company or other entity under subcontract with a waiver agency to provide MI Choice services to participants. This term also includes individuals hired by MI Choice participants to deliver self-determined services.
EAA	Environmental Accessibility Adaptations
FDA	Food and Drug Administration
FI	Fiscal Intermediary
FFP	Federal Financial Participation, the federal government's share of approved Medicaid expenses.
MI Choice	Michigan's home and community based services for the elderly and disabled Medicaid waiver program. This is a combination 1915b/c waiver.
MCL	Michigan Compiled Laws
MDHHS	The Michigan Department of Health and Human Services
MDHHS Field Office	Formerly the Department of Human Services, this section of MDHHS receives applications and authorizes assistance programs including Medicaid and SNAP.
MMIS	The Medicaid Management Information System, the software MDHHS uses to process claims for Medicaid reimbursement and encounter data.
NEMT	Non-Emergency Medical Transportation
NFT	Nursing Facility Transition, the services and supports offered to a nursing facility resident to transition that resident to the community, with or without the support of enrollment in the MI Choice program upon discharge from the facility.
PAHP	Pre-paid Ambulatory Health Plan, an agency that administers the MI Choice Waiver program for MDHHS.
Participant	A person enrolled in the MI Choice program.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Minimum Operating Standards for MI Choice Waiver Program Services

PCP	Person-Centered Planning. A highly individualized process designed to respond to the expressed needs and desires of the individual.
Person-Centered Service Plan (PCSP)	An individualized, comprehensive document developed by participants and supports coordinators using a person-centered approach that identifies each participant's strengths, weaknesses, needs, goals, outcomes, and planned interventions. This document includes all services provided to or needed by the participant, regardless of funding source.
PDN	Private Duty Nursing
PERS	Personal Emergency Response System
PSA	Provider Service Area
Waiver Agency	An entity, under contract with MDHHS to administer the MI Choice program in a specific PSA.

Service Name	Assistive Devices and Technologies
Service Number	B-9
Service Category	In-Home
Service Definition	A service that provides assistive devices and technologies which enable individuals to live independently in the community according to their preferences, choices and abilities.
Unit of Service	One device, plus installation and training as appropriate, provided to a program participant.
Service Description	This service helps individuals to learn about and acquire devices, equipment and supporting technologies that assist in the conduct of activities of daily living. Such devices may include, but are not limited to: Personal Emergency Response Systems (PERS), wheel chairs, walkers, lifts, medication dispensers, etc.

Minimum Standards

1. Each program must coordinate with other appropriate service providers in the community in order to avoid an unnecessary duplication of services.

2. All devices installed must conform to local building codes, as applicable, and meet respective UL® safety standards.

3. Funds awarded for assistive devices and technologies may be used for labor costs and to purchase devices to be installed.

4. With regard to Personal Emergency Response Systems (PERS), the following additional requirements must be met:

    a. Equipment used must be approved by the Federal Communication Commission and must meet UL® safety standards specifications for Home Health Signaling Equipment.
    b. Response center must be staffed 24 hours/day, 365 days/year with trained personnel. Response center will provide accommodations for persons with limited English proficiency.
    c. Response center must maintain the monitoring capacity to respond to all incoming emergency signals.
    d. Response center must be able to accept multiple signals simultaneously. Calls must not be disconnected for call-back or put in a first call, first serve basis.
    e. Provider will furnish each responder with written instructions and provide training as appropriate.

f. Provider will verify responder and contact names semi-annually to assure current and continued participation.
g. Provider will assure at least monthly testing of the PERS unit to assure continued functioning.
h. Provider will furnish ongoing assistance, as necessary, to evaluate and adjust the PERS instrument or to instruct participants and responders in the use of the devices, as well as to provide for performance checks.
i. Provider will maintain individual participant records that include the following:
    i. Service order.
    ii. Record of service delivery, including documentation of delivery and installation of equipment, participant orientation, and monthly testing.
    iii. List of emergency responders.
    iv. Case log documenting participant and responder contacts.

Service Name	Medication Management
Service Number	B-7
Service Category	In-Home
Service Definition	• Direct assistance in managing the use of both prescription and over the counter (OTC) medication. Allowable program components include: • Face-to-face review of client's prescription, OTC medication regimen, and use of herbs and dietary supplements. • Regular set-up of medication regimen (Rx pills, Rx injectables, and OTC medications). • Monitoring of compliance with medication regimen. • Cueing via home visit or telephone call. • Communicating with referral sources (physicians, family members, primary care givers, etc.) regarding compliance with medication regimen. • Family, caregiver and client education and training.
Unit of Service	Each 15 minutes (.25 hours) of component activities performed.

updated 3-17-06

Minimum Standards

1. Each program shall employ a registered nurse (RN) who supervises program staff and is available to staff when they are in a client's home or making telephone reminder calls. Each program shall employ program staff who are appropriately licensed, certified, trained, oriented and supervised.

2. The supervising nurse shall review and evaluate the medication management care plan and the complete medication regimen, including prescription and OTC medications, dietary supplements and herbal remedies, with each client and appropriate caregiver.

   Each program shall implement a procedure for notifying the client's physician(s) of all medications being managed.

3. The program shall be operated within the three basic levels of service as follows:

   Level 1: Telephone reminder call/cueing with maintenance of appropriate documentation. Program staff performing this level of service shall be delegated by the supervising nurse.

Level 2: In-home monitoring visit/cueing with maintenance of appropriate documentation. Program staff performing level 2 services shall be delegated by the supervising nurse.

Level 3: In-home medication set up, instructions, and passing and/or assistance with medications (e.g., putting in eye drops, giving pills and injections). Program staff performing level 3 services shall be delegated by the supervising nurse.

4. The program shall maintain an individual medication log for each client that contains the following information:

   a. Each medication being taken.
   b. The dosage for each medication.
   c. Label instructions for use for each medication.
   d. Level of service provided and initials of person providing service.
   e. Date and time for each time services are provided.

5. The program shall report any change in a client's condition to the client's physician(s) immediately.

Service Name	Respite Care
Service Number	B-10
Service Category	In-Home
Service Definition	Provision of companionship, supervision and/or assistance with activities of daily living for persons with mental or physical disabilities and frail older persons in the absence of the primary care giver(s). Respite care may be provided at locations other than the client's residence.
Unit of Service	Each hour of respite care provided.

updated 3-17-06

Minimum Standards

1. Each program must establish written eligibility criteria which include at a minimum:

   a. That clients must require continual supervision in order to live in their own homes or the home of a primary care giver, or require a substitute care giver while their primary care giver is in need of relief or otherwise unavailable; and/or
   b. That clients may have difficulty performing or be unable to perform activities of daily living (ADLs) without assistance as a result of physical or cognitive impairment.

2. Respite care services include:

   a. Attendant care (client is not bed-bound) - companionship, supervision and/or assistance with toileting, eating and ambulation; and,
   b. Basic care (client may or may not be bed-bound) - assistance with ADLs, routine exercise regimen, and assistance with self-medication.
   c. Respite care may also include chore, homemaking, home care assistance, home health aide, meal preparation and personal care services. When provided as a form of respite care, these services must also meet the requirements of that respective service category.

3. Each program shall ensure that the skills and training of the respite care worker to be assigned coincides with the service plan of the client, client needs, and client preferences. Client needs may include, through are not limited to, cultural sensitivity, cognitive impairment, mental illness, and physical limitation.

4. An emergency notification plan shall be developed for each client, in conjunction with the client's primary caregiver.

5. Each program shall establish written procedures to govern the assistance to be given participants in taking medications, which includes at a minimum:

a. Who is authorized to assist participants 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 to be taken and its impact upon the client.
b. Verification of prescriptions and dosages. All medications shall be maintained in their original, labeled containers.
c. Instructions for entering medications information in client files, including times and frequency of assistance.
d. A clear statement of the client's and client's family responsibility regarding medications to be taken by the client while participating in the program and provision for informing the client and client's family of the program's procedures and responsibilities regarding assisted self-administration of medications.

Attachment E

Northeast Michigan Community Service Agency, Inc.
BUSINESS ASSOCIATE AGREEMENT

This Agreement is entered into by and between Northeast Michigan Community Service Agency, Inc. (hereafter referred to as NEMCSA) and _____ (hereinafter referred to as the Business Associate) to set forth the terms and conditions under which protected health information, as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Regulations set forth by the U.S. Department of Health and Human Services (HHS) enacted thereunder, and amended by the Health Information Technology for Economic and Clinical Health Act (HITECH Act) created or received by the Business Associate, on behalf of NEMCSA may be used or disclosed.

Whereas, to provide such services, the Business Associate must have access to certain protected health information as defined in the Standards for Privacy of Individually Identifiable Health Information (Privacy Rule) and the standards for the Security of Electronic Protected Health Information (Security Rule)

Whereas, to comply with the requirements of the HIPAA, the HITECH Act, the Privacy Rule and the Security Rule, NEMCSA must enter into this Business Associate Agreement with the Business Associate.

The Business Associate shall not use nor further disclose protected health information from NEMCSA other than as permitted by this Agreement or as required by law.

This Agreement shall commence on October 1, 2019, and the obligations herein shall continue in effect so long as the Business Associate uses, discloses, creates or otherwise possesses any protected health information created or received on behalf of NEMCSA, and until all protected health information created or received by the Business Associate on behalf of NEMCSA is destroyed or returned to NEMCSA pursuant to Paragraph 21 herein.

1. NEMCSA and the Business Associate hereby agree that the Business Associate shall be permitted to use and/or disclose protected health information created, maintained or received on behalf of NEMCSA for any one or combinations of the following purpose(s):

    a. completing and submitting health care claims to health plans and other third party payers (i.e. billing);
    b. providing services;
    c. emergency and contingency planning;
    d. providing participant information for reporting purposes; or
    e. as necessary to perform service set for in the services agreement
    f. none.

2. The Business Associate may use and disclose protected health information created or received by the Business Associate on behalf of NEMCSA if necessary for the proper management and administration of the Business Associate or to carry out the Business Associate's legal responsibilities, provided that any disclosure is:

    a. required by law; or
    b. the Business Associate obtains reasonable assurances from the person to whom the protected health information is disclosed that (1) the protected health information will be

held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person; and (2) the Business Associate will be notified of any instances of which the person is aware in which confidentiality of the informed is breached; or

c. the Business Associate may use protected health information to report violations of law to appropriate Federal and State authorities.

3. The Business Associate hereby agrees to maintain the security and privacy of all protected health information in a manner consistent with Michigan and federal laws and regulations including the Health Insurance Portability and Accountability Act of 1996 and Regulations thereunder, including the Privacy Rule, the Security Rule, the HITECH Act, and all other applicable laws.

4. Except as otherwise limited in this Agreement, the Business Associate may use protected health information to provide data aggregation services to NEMCSA.

5. The Business Associate further agrees not to use or disclose protected health information except as expressly permitted by this Agreement, applicable law, or for the purpose of managing the Business Associate's own internal business processes consistent with Paragraph 2 herein.

6. The Business Associate is required to implement appropriate safeguards to prevent unauthorized use or disclosure of the information, including implementing requirements of HIPAA Security Rule and the HITECH Act with regard to electronic protected information. The Business Associate agrees to use appropriate safeguards to prevent use and disclosure of protected health information and electronic health information. Further, the Business Associate agrees to implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the protected information that it creates, receives, maintains or transmits on behalf of NEMCSA. "Appropriate Safeguards" include, but are not limited to, physical, administrative and technical safeguards such as locking cabinets or rooms where protected information is stored, using computer passwords or other security measures to prevent unauthorized access to protected information in electronic format; providing encryption for electronic protected health information at rest and in motion, implementing policies and procedures describing access and use for Business Associate's workforce; and human resource policies and procedures to enforce these rules.

7. The Business Associate is directly liable to the government for fines and other sanctions imposed by HHS, and the State Attorney General for non-compliance.

8. The Business Associate is required to report to NEMCSA any use or disclosure of the information not provided for this this contract, including incidents that constitute breaches of unsecured protected health information. The Business Associate is also required to report breaches to HHS in accordance with stipulations provided under the HIPAA and the HITECH Act.

9. The Business Associate shall not disclose protected health information to any member of its workforce unless the Business Associate has advised such person of the Business Associate's privacy and security obligations under this Agreement, including the consequences for violation of such obligations. The Business Associate shall take appropriate disciplinary action against any member of its workforce who uses or discloses protected health information in violations of this Agreement and applicable law.

10. The Business Associate shall not disclose protected health information created or received by the Business Associate on behalf of NEMCSA to a person, including any agent or subcontractor of the Business Associate, but not limited to a member of the Business Associate's own workforce, until such person agrees in writing to be bound by the provisions of this Agreement and applicable Michigan or federal law.

11. The Business Associate agrees to use appropriate safeguards to prevent use or disclosure of protected health information not permitted by this Agreement or applicable law.

12. The Business Associate agrees to maintain a record of all disclosures of protected health information, including disclosures not made for the purposes of this Agreement. Such record shall include the date of the disclosure, the name and, if known, the address of the recipient of the protected health information, the name of the individual who is the subject of the protected health information, a brief description of the protected health information disclosed, and the purpose of the disclosure. The Business Associate shall make such record available to an individual who is the subject of such information or NEMCSA within five (5) days of a request.

13. The Business Associate agrees to report to NEMCSA any unauthorized use or disclosure of protected health information by the Business Associate or its workforce or subcontractors, and the remedial action taken or proposed to be taken with respect to such use or disclosure. The Business Associate must conduct a risk analysis to ensure future incidence of unauthorized use or disclosure is minimized. Results of such risk analysis shall be provided to NEMCSA and HHS as required.

14. The Business Associate agrees to make its internal practices, books, and records relating to the use and disclosure of protected health information received from NEMCSA, or created or received by the Business Associate on behalf of NEMCSA available to the Secretary of the United States Department of Health and Human Services, for purposes of determining the Covered Entity's compliance with the HIPAA and the HITECH Act.

15. The Business Associate will make available to NEMCSA such information as NEMCSA may require to fulfill its obligations to provide access to, copies of, or an accounting of uses and disclosures of protected health information as a Covered Entity under HIPAA. Within thirty (30) days of a written request by NEMCSA, the Business Associate shall allow a person who is the subject of protected health information, such person's legal representative, or NEMCSA to have access to and to copy such person's protected health information in the format requested by such person, legal representative, or practitioner unless it is not readily producible in such format, in which case it shall be produced in standard hard copy format. The Business Associate shall notify NEMCSA of such a request.

16. The Business Associate shall not request from NEMCSA, or provide to any third party or other entity in connection with any of its permitted uses and/or disclosures of protected health information, more information or protected health information than the minimum amount necessary to carry out its obligations, functions, or services on behalf of NEMCSA.

17. To the extent the Business Associate now or in the future conducts any transaction defined as an Electronic Transaction using protected health information of NEMCSA, the Business Associate shall ensure that such transaction is conducted in full compliance with applicable Electronic Transaction Standards. Moreover, to the extent the Business Associate transmits, receives, or stores protected health information electronically, irrespective of whether any such transmission or

reception constitutes an Electronic Transaction, the Business Associate agrees to conduct such transmissions, receptions, and storage of protected health information in a manner so as to be in full compliance with federal and state law, including, but not limited to, the final Security Standards under HIPPA and the HITECH Act.

18. The Business Associate agrees to amend, pursuant to a request by NEMCSA, protected health information maintained and created or received by the Business Associate on behalf of NEMCSA. The Business Associate further agrees to complete such amendment within thirty (30) days or a written request by NEMCSA, and to make such amendment as directed by NEMCSA.

19. In the event the Business Associate fails to perform the obligations under this Agreement, NEMCSA may, at its option:
    a. require the Business Associate to submit a plan of compliance, including monitoring by NEMCSA and reporting by the Business Associate, as NEMCSA in its sole discretion, determines necessary to maintain compliance with this Agreement and applicable law. Such plan shall be incorporated by the unauthorized amendment thereto; and/or
    b. require the Business Associate to mitigate any loss occasioned by the unauthorized disclosure or use of protected health information; and/or
    c. immediately discontinue providing protected health information to the Business Associate with or without written notice to the Business Associate.

20. NEMCSA may immediately terminate this Agreement and related agreements if NEMCSA determines that the Business Associate has breached a material term of this Agreement. Alternatively, NEMCSA may choose to: (1) provide the Business Associate with ten (10) days written notice of the existence of an alleged material breach; and (2) afford the Business Associate an opportunity to cure said alleged material breach to the satisfaction of NEMCSA within ten (10) days. The Business Associate's failure to cure shall be grounds for immediate termination of this Agreement. The Business Associate's remedies under this Agreement are cumulative, and the exercise of any remedy shall not preclude the exercise of any other.

21. Upon termination of this Agreement, the Business Associate shall return or destroy all protected health information received from NEMCSA, or created or received by the Business Associate on behalf of NEMCSA, and that the Business Associate maintains in any form, and shall retain no copies of such information. If the parties mutually agree that return or destruction of protected health information is not feasible, the Business Associate shall continue to maintain the security and privacy of such protected health information in a manner consistent with the obligations of this Agreement and as required by applicable law, and shall limit further use of the information to those purposes that make the return or destruction of the information infeasible. The duties hereunder to maintain the security and privacy of protected health information shall survive the discontinuance of this Agreement.

22. NEMCSA may amend this Agreement by providing ten (10) days prior written Notice to the Business Associate in order to maintain compliance with Michigan or federal law. Such amendment shall be binding upon the Business Associate at the end of the ten (10) day period and shall not require the consent of the Business Associate. The Business Associate may elect to discontinue the Agreement within the ten (10) day period, but the Business Associate's duties hereunder to maintain the security and privacy of protected health information shall survive such discontinuance. NEMCSA and the Business Associate may otherwise amend this Agreement by mutual written agreement.

23. The Business Associate shall, to the fullest extent permitted by law, protect, defend, indemnify and hold harmless NEMCSA and its employees and directors from and against any and all losses costs, claims, penalties, fines, demands, liabilities, legal actions, judgments, and expenses of every kind (including reasonable attorney's fees, including at trial and on appeal) asserted or imposed against any indemnities arising out of the acts or omissions of the Business Associate or any subcontractor of or consultant of the Business Associate or any of the Business Associate's employees, directors, or agents related to the performance of this Agreement.

24. The Business Associate shall make itself, and any subcontractors, employees or agents assisting the Business Associate in the performance of its obligations under this Agreement, available to NEMCSA, at no cost to NEMCSA, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against NEMCSA, its directors, offices, or employees based upon a claimed violation of HIPAA, the HIPAA regulations, HITECH, or other laws relating to security and privacy, except where the Business Associate or its subcontractors, employees, or agents are named as an adverse party.

25. The Business Associate agrees that the terms and conditions of this Business Associate Agreement shall be construed as a general confidentiality agreement binding upon the Business Associate even if it is determined that the Business Associate is not a business associate as that term is used in the Privacy Rule and/or Security Rule.

26. This Business Associate Agreement shall not be modified or amended except if done so in a written agreement and signed by both parties.

27. This Business Associate Agreement is not assignable or able to be delegated to another party.

28. The provision of this Business Associate Agreement supersedes all prior agreements regarding the same subject matter.

NEMCSA, Inc.	*Date*
Business Associate	*Date*

Please be sure to return the following items to renew contracts for fiscal years 2020-2022:

- ☐ Completed Contract Document
- ☐ Completed Business Associate Agreement
- ☐ Completed False Claims Act Policy
- ☐ Certificate of Insurance with NEMCSA **listed as an additional insured**
- ☐ Copy of Any Required Licensure
- ☐ Vendor View / Vendor Billing Enrollment Form
- ☐ Vendor Billing Certification (one form completed for each person submitting invoices)
- ☐ Copy of In Home Journal for NEMCSA Approval (including EVV systems)
- ☐ Evidence of Person Centered Planning Training
- ☐ Evidence of Fraud, Waste and Abuse Training

If you have questions regarding the Contract, contact:

Gina Bey
Associate AAA Director
beyg@nemcsa.org
989/356-3474, ext 282

Yvette Smigelski
Business/Financial Resources Manager – Aging
smigelskiy@nemcsa.org
989/356-3474, ext 213

Any potential new contractors additionally must submit copies of the following policies/procedures, as applicable:

1. Participant Confidentiality
2. Participant Appeals/Grievances
3. Participant Feedback/Evaluation
4. Participant Rights/Responsibilities
5. Emergencies in Participants Home
6. Personnel Policies
7. Recruitment, Training and Supervision
8. Reference Checks
9. Reporting of Abuse, Neglect or Other Critical Incidences
10. Criminal History Screens
11. Verification of Driver's License & Insurance
12. TB Testing
13. CPR Certification
14. Current Nursing License on File
15. Supervisory Visits
16. Written Procedures to Govern Administration of Medications (both Prescription and Over-the-Counter)
17. Policy/Procedure for Notifying NEMCSA Care Managers of:
    - changes in participant's condition or status
    - non-service due to: participant not at home, death, institutionalization, hospitalization, personal choices
    - upcoming appointments the participant may have
    - when paid staff fail to show up at the participants home as scheduled
18. Records Retention Policy
19. Privacy Practices
20. Fraud, Waste and Abuse Policy
21. Orientation Schedule

NORTHEAST MICHIGAN COMMUNITY SERVICE AGENCY, INC.
REGION 9 AREA AGENCY ON AGING
CARE MANAGEMENT AND MI CHOICE WAIVER PROGRAM
FOR THE ELDERLY AND DISABLED

MINIMUM SERVICE STANDARDS AND DEFINITIONS FOR ALL SERVICES

The following Minimum Service Standards are considered mandatory for all Service Provider entities who will participate in the Northeast Michigan Community Service Agency, Inc. (NEMCSA) Care Management Program or MI Choice Home and Community Based Waiver Program for the Elderly and Disabled. Each contracted Service Provider shall adhere to the following standards for each category of service. Failure to comply with these requirements may be grounds for termination of the purchase agreement and may require the Service Provider to repay all funds remitted during the time in which the Provider failed to meet these requirements.

Contract requirements and Service Standards are based on standards established by the Michigan Aging and Adult Services Agency (AASA), the Medical Services Administration (MSA), the Michigan Department of Health and Human Services (MDHHS), and the Centers for Medicare and Medicaid Services (CMS).

GENERAL PROGRAM REQUIREMENTS

As a condition of entering into the purchase of service contract, Service Providers shall provide assurance of compliance with all applicable federal, state, and local laws and regulations.

Agencies seeking first-time enrollment into NEMCSA's direct service purchase pool must satisfactorily pass an on-site NEMCSA/AAA pre-contract visit, which assesses and establishes initial verification of the agency's ability to meet all of the following standards.

All contracted Providers will be periodically monitored to verify compliance with program standards and requirements. Monitoring visits will be conducted by NEMCSA staff, by the State of Michigan and/or representatives from the Centers for Medicare and Medicaid Services. As a routine component of Provider monitoring visits, NEMCSA shall review the Service Provider's policies, participant records and personnel documentation to validate that all required contract elements are met.

PARTICIPANT ELIGIBILITY CRITERIA

1. NEMCSA Supports Coordinator (SC) staff shall be solely responsible for establishing eligibility for participation in the NEMCSA Care Management or MI Choice Waiver Program and for establishing the need to receive the services as defined herein. This includes the provision of a comprehensive medical and financial assessment; development of a plan of

care which includes the establishment of service frequency, duration, and delivery time; reassessment; and monitoring of the program participant's status.

2. Financial eligibility for the MI Choice Waiver Program shall be determined by the MDHHS Field Offices.

3. Services shall be provided to persons age 18 or older. Note: This age limitation differs from those established through the Federal Older Americans Act and the State Older Michiganians Act and applies to services purchased by the NEMCSA Care Management Program staff.

4. Participants eligible to receive services through existing community resources shall be referred to those programs by Care Management staff. All third party reimbursement resources will be sought and pursued before any Care Management direct service purchasing resources are used, unless otherwise directed by the State of Michigan.

NEMCSA, as an agent for MDHHS, will coordinate procedures with the appropriate MDHHS Field Offices to insure that direct service purchasing resources are not used to provide personal care service or other in-home service to program participants when such services could be provided or paid for through other programs administered by the Department of Health and Human Services.

SERVICE AUTHORIZATIONS AND REIMBURSEMENT

The Service Provider shall use the written service authorizations and adjustments provided by NEMCSA for the provision of service.

1. NEMCSA Support Coordinators will contact the Provider's designated contact person to formally request service provision. The call shall be followed up by a service authorization specifying the frequency and duration of service delivery as well as specification related to the service provision.

2. By using Vendor View, each Provider is able to review and accept service authorizations. The acceptance of each service authorization will be complete when the request is archived by the Provider. The date, time and user identification are attached to each authorization when archived.

3. Service Providers are required to formally acknowledge acceptance of the service request within twenty-four (24) hours of receipt of a service authorization.

4. The Service Provider's employees shall have NEMCSA Care Management service authorizations and/or adjustments reviewed with them by their supervisor prior to beginning care for the individual to assure that the employee is fully aware of the participant's needs and expectations prior to arrival at the participant's home.

5. Services are not reimbursable without a properly executed service authorization.

6. The Service Provider shall not increase the provision of service units without prior authorization from NEMCSA. Such increases without prior authorization are not reimbursable by the State of Michigan or NEMCSA, and are not billable to the participant.

7. Any decrease in frequency, time or duration as requested by the participant or the family must be reported to NEMCSA immediately. NEMCSA shall be responsible for contacting the participant and re-evaluating needs.

8. In the event a participant (or representative) discharges the Provider's employee prior to the conclusion of the shift as indicated on the work order, the Provider may bill for only that portion of the shift where service delivery occurred.

9. Should the Provider opt to leave the participant's home prior to the completion of the requested shift, documentation must indicate why and the exact departure time. Failure to comply will result in a recoupment of resources paid for service delivery.

10. The Provider's inability to fulfill a service request must be reported immediately to the SC team.

11. If the Provider is a certified provider of Medicare or Medicaid, and intends to bill either source for services provided to MI Choice Program participants, the SC staff must be notified.

12. When in a participant's home, the Service Provider staff shall report any changes in a participant's condition or situation to their supervisor immediately. The supervisor shall notify NEMCSA of the changes. NEMCSA Support Coordinators will re-evaluate the participant to determine what changes may be required in the service plan.

13. NEMCSA cannot reimburse a Service Provider for time spent traveling to a participant's home. Therefore, prior to making each home visit, Service Provider staff is strongly urged to call the participant and confirm the visit. If for any reason a visit is not made as a result of the advance phone call, the Provider must contact the SC to report the visit was not made and indicate the reason. For example, the participant refuses service delivery, participant not at home due to hospitalization, participant has family available to provide service that day, etc. Providers must report activation of back-up plans.

PARTICIPANT RECORDS

Service Providers shall maintain comprehensive and complete participant records, which shall be kept confidential in a controlled access file. Files shall be made available upon request to NEMCSA staff, authorized representatives of NEMCSA, the State of Michigan, and the Center for Medicare and Medicaid Services. Participant records must be maintained for a period of ten (10) years post audit. At a minimum, the records shall contain:

1. A copy of the NEMCSA assessment and reassessment.

2. A copy of the NEMCSA participant-approved PCSP, Service Authorization and corresponding adjustments.

3. A copy of the participant's Emergency Back-Up Plan.

4. A current and duly executed Release of Information form.

5. Progress notes for documenting communications and relevant case information.

6. Provider records must specifically identify participants being served through the purchase agreement with NEMCSA and have a separate audit trail from the Provider's other business activities.

7. Records must contain the date of service, time service was rendered (start and stop time), a summary of services and tasks performed, specific notes in response to participant, family, and agency contacts pertaining to the agency's provision of service to each participant, signature of staff person performing the service and signature of participant confirming service was provided. Such records shall be reviewed as the official billing documentation for payment of service delivery and for audit purposes. Employee time sheets are not acceptable documentation for reimbursement purposes.

Any requests made for information about a NEMCSA participant to the Service Provider shall be referred directly to NEMCSA. If the release of information is determined valid and appropriate by NEMCSA, the SC team shall secure the appropriate authorization signatures and provide the Service Provider with a copy of the release.

STAFF SUPERVISION AND TRAINING

1. The Service Provider shall conduct in-home supervision of program staff no less frequently than two (2) times each fiscal year as part of its normal operation. A qualified professional must conduct the supervisory visit. Documentation must be maintained indicating the dates of on-site supervision, the person and title doing the supervising, the staff person supervised, and the location of the in-home supervision. The name of the participant shall not be used in the documentation. Participant ID and home address may be used; however, a notation of the supervisory visit in the In-Home Journal is also recommended.

2. Such in-home supervision shall not be considered a separate, billable service, but must be included in the overall unit bid developed by the Service Provider as an administrative cost. Visits shall be for the sole purpose of supervising the agency employee and not for the purpose of conducting an assessment or reassessment of the participant.

3. Provider forms serving dual purpose for staff supervision and participant evaluation for "private duty" participants, which will also be used for NEMCSA participants, shall clearly have "N/A" written in those areas designed for participant evaluation.

4. Service Providers shall assure that all employees participate in relevant in-service trainings at least two (2) times per year. Suggested training topics include Universal Precautions, safety, sanitation, household maintenance, proper lifting techniques, cooking, boundaries, professional etiquette and appearance, CPR, and first aid.

5. Person-Centered Planning or Person-Centered Thinking is required for each employee and shall be part of each employee's orientation process. Confidentiality and privacy (HIPAA/HITECH) is required at orientation and is strongly encouraged annually. Fraud, waste and abuse training is required at the time of hire and annually.

USE OF VOLUNTEERS

Service Providers who utilize volunteers to meet service order requests must notify NEMCSA of such, both in terms of completing the unit bid for the service definition and when using volunteer services for a specific participant. All volunteer documentation must be maintained in an appropriate personnel file.

CONFIDENTIALITY (See attached Business Associate Agreement)

Service Providers shall have written procedures in place to protect the confidentiality of participant information. No information shall be disclosed, other than to the NEMCSA staff, without the prior informed consent of the individual or his/her legal representative.

Disclosure of information may be allowed by court order, or for program monitoring by authorized Federal, State, or local agencies so long as access to information is in conformity with the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Protection of information is required for all data maintained in paper and electronic files. Ongoing staff training must be evident in training logs and meet the frequency requirements set forth in the Health Insurance Portability and Accountability Act of 1996.

Any breach of confidentiality must be mitigated to the extent possible and reported to NEMCSA in writing. Appropriate notice must also be provided to the Office of Civil Rights and individuals affected as mandated by the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH).

INSURANCE

Required insurance is detailed in the contract document. Additionally, cyber insurance is recommended.

CONTRIBUTIONS

No contributions, donations, or additional fees may be sought by Service Providers from participants when Care Management is purchasing the service. In addition, no paid or volunteer staff person of a Service Provider may offer for sale any type of merchandise or service, or seek to encourage the acceptance of any particular belief or philosophy by any program participant.

Contracted Providers agree to accept the agreed upon unit rate for all services ordered by NEMCSA staff. Service Providers must accept MI Choice payments for services as payment in full for such services. Exception: MI Choice Waiver participants may be billed for that portion of the ordered service that the participant agrees to pay as established in the NEMCSA Person-Centered Service Plan.

Contracted Service Providers shall not require program participants to sign any document or agreement guaranteeing exclusivity. Unless otherwise stipulated in the provider service authorization, NEMCSA shall be responsible for reimbursing the provider for all services delivered to the program participants. Such activity shall be grounds for termination of the Purchase of Service Agreement.

PARTICIPANT SATISFACTION / COMPLAINT RESOLUTION

Service Providers shall have procedures established to assure participants are able to express their opinions or grievances and/or complaints regarding services rendered by the Provider.

Service Providers shall have written grievance resolution procedures, which can be used by program participants. NEMCSA Care Management must be notified immediately when grievances are filed.

FALSE CLAIMS ACT

Service Providers agree to comply with all provisions under the Deficit Reduction Act of 2005 including the Federal False Claims Act (*31 U.S.C. §3729 et seq.)* and the State of Michigan's Medicaid False Claims Act (*M.C.L. 400.601 et seq.).* Providers are required to educate all employees, providers and volunteers with information regarding federal and state false claims laws, administrative remedies under those laws, whistle-blower protections to employees who report incidents of false claims, and methods for detecting and preventing fraud, waste and abuse in Medicaid programs. Documentation of said education must be maintained in the agency's records to be reviewed upon request.

DEPARTMENT OF LABOR FAIR LABOR STANDARDS ACT

Service Providers agree to comply with all labor laws as defined by the United States Department of Labor and the Fair Labor Standards Act. These provisions include but are not limited to the Home Care Final Rule *(29 CFR 522.3 et. seq.),* including overtime and minimum wage protections for home care workers and third party liability provisions.

CRITICAL INCIDENT REPORTING REQUIREMENTS

In general, NEMCSA supports the provision of service in the least restrictive manner as possible and does not condone nor encourage the use of physical and/or chemical restraints or isolation of program participants. Providers must inform NEMCSA of any discovery of the use of physical restraints or isolation of program participants. In addition, any evidence or suspicion of abuse, neglect, or exploitation must be reported to MDHHS Central Intake at 1-855-444-3911.

MDHHS has instituted a Critical Incident Reporting System, which requires providers and Supports Coordinators to report the following incidents that bring harm or potential harm to MI Choice participants:

a. Exploitation
b. Illegal Activity in the home with potential to cause serious or major negative event
c. Neglect
d. Physical Abuse
e. Provider no shows (particularly when participant is bed-bound or critical need)
f. Sexual Abuse
g. Theft
h. Verbal Abuse
i. Worker consuming drugs/alcohol on the job
j. Suspicious or unexpected death
k. Medication Error which resulted in death or loss of limb or function or risk there of
l. Suicide Attempt
m. Use of Restraints or Seclusion

Providers must ensure that any of the above situations are reported to NEMCSA staff within two days. This can be accomplished via telephone and/or Vendor View.

MARKETING AND ADVERTISING

Contracted Providers are prohibited from making references to, or using NEMCSA's name or the MI Choice Waiver Program, in any printed or any other form of advertising or agency promotion.

ATTACHMENT G

HCPCS/ CPT Code	HCPCS/ CPT Modifier	HCPCS/ CPT Code Description	Standardized Remark	Comment
99510		Home visit for individual, family, or marriage Counseling		
A0080	SC	Non-emergency transportation, per mile - vehicle provided by volunteer (individual or organization), with no vested interest	7003 Volunteer Transportation	NEMT
A0090	SC	Non-emergency transportation, per mile - vehicle provided by individual (family member, self, neighbor) with vested interest	7002 Private Transportation	NEMT
A0090	SC	Non-emergency transportation, per mile - vehicle provided by individual (family member, self, neighbor) with vested interest	7003 Volunteer Transportation	NEMT
A0100	SC	Non-emergency transportation; taxi	7001 Public Transportation	NEMT
A0110	SC	Non-emergency transportation and bus, intra or inter state carrier	7001 Public Transportation	NEMT
A0120	SC	Non-emergency transportation: mini-bus, mountain area transports, or other transportation systems	7001 Public Transportation	NEMT
A0130		Non-emergency transportation; wheel chair van; per trip	7001 Public Transportation	
A0130	SC	Non-emergency transportation; wheel chair van; per trip	7001 Public Transportation	NEMT
A0130		Non-emergency transportation; wheel chair van; per trip	7002 Private Transportation	
A0130	SC	Non-emergency transportation; wheel chair van; per trip	7002 Private Transportation	NEMT
A0130		Non-emergency transportation; wheel chair van; per trip	7003 Volunteer Transportation	
A0130	SC	Non-emergency transportation; wheel chair van; per trip	7003 Volunteer Transportation	NEMT
A0140	SC	Non-emergency transportation and air travel (private or commercial) intra or inter state	7001 Public Transportation	NEMT
A0140	SC	Non-emergency transportation and air travel (private or commercial) intra or inter state	7002 Private Transportation	NEMT
A0160	SC	Non-emergency transportation: per mile - case worker or social worker	7002 Private Transportation	Medical transportation only. Must have SC modifier
A0170	SC	Transportation ancillary: parking fees, tolls, other		NEMT
A0180	SC	Non-emergency transportation: ancillary: lodging-recipient		Medical transportation only. Must have SC modifier
A0190	SC	Non-emergency transportation: ancillary: meals-recipient		Medical transportation only. Must have SC modifier
A0200	SC	Non-emergency transportation: ancillary: lodging escort		Medical transportation only. Must have SC modifier
A0210	SC	Non-emergency transportation: ancillary: meals-escort		Medical transportation only. Must have SC modifier
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

Modifiers:
BO=Orally administered Nutrition
SC=Medically necessary service use for NEMT
TD=RN
TE=LPN

ATTACHMENT G

HCPCS/ CPT Code	HCPCS/ CPT Modifier	HCPCS/ CPT Code Description	Standardized Remark	Comment
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		
E0629		Separate seat lift mechanism for use with patient owned furniture - nonelectric		
E0745		Neuromuscular stimulator, electronic shock unit		per unit
E1639		Scale, each		
G0237		Therapeutic procedures to increase strength or endurance of respiratory muscles, face to face, one on one, each 15 minutes (includes monitoring)		Respiratory Care
G0238		Therapeutic procedures to improve respiratory function other than described by G0237, face to face, one on one, per 15 minutes (includes monitoring)		Respiratory Care
G0239		Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, two or more individuals (includes monitoring)		Respiratory Care
G9012		Other specified case management services, not elsewhere classified		Use for Community Health Worker
H0045		Respite services not in the home, per diem	7500 Adult Foster Care	
H0045		Respite services not in the home, per diem	7501 Hospital	
H0045		Respite services not in the home, per diem	7502 Nursing Facility	
H2015		Comprehensive community support services, per 15 minutes	5501 Includes transportation	Use for CLS services.
H2015		Comprehensive community support services, per 15 minutes	5502 Does not include transportation	Use for CLS services.
H2016		Comprehensive community support services, per diem	5501 Includes transportation	Use for CLS services.
H2016		Comprehensive community support services, per diem	5502 Does not include transportation	Use for CLS services.
S0209		Wheelchair van, mileage, per mile	7001 Public Transportation	
S0209	SC	Wheelchair van, mileage, per mile	7001 Public Transportation	NEMT
S0209		Wheelchair van, mileage, per mile	7002 Private Transportation	
S0209	SC	Wheelchair van, mileage, per mile	7002 Private Transportation	NEMT
S0209		Wheelchair van, mileage, per mile	7003 Volunteer Transportation	

Modifiers:
BO=Orally administered Nutrition
SC=Medically necessary service use for NEMT
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ATTACHMENT G

HCPCS/ CPT Code	HCPCS/ CPT Modifier	HCPCS/ CPT Code Description	Standardized Remark	Comment
S0209	SC	Wheelchair van, mileage, per mile	7003 Volunteer Transportation	NEMT
S0215		Non-emergency transportation, mileage, per mile	7001 Public Transportation	
S0215	SC	Non-emergency transportation, mileage, per mile	7001 Public Transportation	NEMT
S0215		Non-emergency transportation, mileage, per mile	7002 Private Transportation	
S0215	SC	Non-emergency transportation, mileage, per mile	7002 Private Transportation	NEMT
S0215		Non-emergency transportation, mileage, per mile	7003 Volunteer Transportation	
S0215	SC	Non-emergency transportation, mileage, per mile	7003 Volunteer Transportation	NEMT
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	
S5110		Home care training, family; per 15 minutes	6501 Chronic Disease Self-Management Program	
S5110		Home care training, family; per 15 minutes	6502 Diabetes Self-Management Program	
S5110		Home care training, family; per 15 minutes	6503 Chronic Pain Self-Management Program	
S5110		Home care training, family; per 15 minutes	6504 Arthritis Self-Management Program	
S5110		Home care training, family; per 15 minutes	6505 Better Choices Better Health	
S5110		Home care training, family; per 15 minutes	6506 Matter of Balance	
S5110		Home care training, family; per 15 minutes	6507 Healthy Moves	
S5110		Home care training, family; per 15 minutes	6508 Physical Activity Programs	
S5110		Home care training, family; per 15 minutes	6509 Creating Confident Caregivers	
S5110		Home care training, family; per 15 minutes	6510 T-Care	
S5110		Home care training, family; per 15 minutes	6511 Occupational Therapy	
S5110		Home care training, family; per 15 minutes	6512 Dietician	
S5115		Home care training, non family; per 15 minutes	6501 Chronic Disease Self-Management Program	
S5115		Home care training, non family; per 15 minutes	6502 Diabetes Self-Management Program	
S5115		Home care training, non family; per 15 minutes	6503 Chronic Pain Self-Management Program	
S5115		Home care training, non family; per 15 minutes	6504 Arthritis Self-Management Program	
S5115		Home care training, non family; per 15 minutes	6505 Better Choices Better Health	
S5115		Home care training, non family; per 15 minutes	6506 Matter of Balance	
S5115		Home care training, non family; per 15 minutes	6507 Healthy Moves	
S5115		Home care training, non family; per 15 minutes	6508 Physical Activity Programs	
S5115		Home care training, non family; per 15 minutes	6509 Creating Confident Caregivers	
S5115		Home care training, non family; per 15 minutes	6510 T-Care	
S5115		Home care training, non family; per 15 minutes	6511 Occupational Therapy	

Modifiers:
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ATTACHMENT G

HCPCS/ CPT Code	HCPCS/ CPT Modifier	HCPCS/ CPT Code Description	Standardized Remark	Comment
S5115		Home care training, non family; per 15 minutes	6512 Dietician	
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	

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HCPCS/ CPT Code	HCPCS/ CPT Modifier	HCPCS/ CPT Code Description	Standardized Remark	Comment
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 Participant's home	
S5151		Unskilled Respite Care, not Hospice, per diem	7502 Home of another	
S5151		Unskilled Respite Care, not Hospice, per diem	7503 Participant'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		Specialized DME Category
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	

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HCPCS/ CPT Code	HCPCS/ CPT Modifier	HCPCS/ CPT Code Description	Standardized Remark	Comment
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		Non PDN Nursing Services
T1003		LPN/LVN services, up to 15 minutes		Non PDN Nursing Services
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	
T2001	SC	Non-emergency transportation; patient attendant/escort		Medical transportation only. Must have SC modifier

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ATTACHMENT G

HCPCS/ CPT Code	HCPCS/ CPT Modifier	HCPCS/ CPT Code Description	Standardized Remark	Comment
T2002	SC	Non-emergency transportation; per diem	7001 Public Transportation	NEMT
T2002	SC	Non-emergency transportation; per diem	7002 Private Transportation	NEMT
T2002	SC	Non-emergency transportation; per diem	7003 Volunteer Transportation	NEMT
T2003		Non-Emergency Transportation; per encounter/trip	7001 Public Transportation	
T2003	SC	Non-Emergency Transportation; per encounter/trip	7001 Public Transportation	NEMT
T2003		Non-Emergency Transportation; per encounter/trip	7002 Private Transportation	
T2003	SC	Non-Emergency Transportation; per encounter/trip	7002 Private Transportation	NEMT
T2003		Non-Emergency Transportation; per encounter/trip	7003 Volunteer Transportation	
T2003	SC	Non-Emergency Transportation; per encounter/trip	7003 Volunteer Transportation	NEMT
T2004		Non-emergency Transportation, commercial carrier, multi-pass	7001 Public Transportation	
T2004	SC	Non-emergency Transportation, commercial carrier, multi-pass	7001 Public Transportation	NEMT
T2004		Non-emergency Transportation, commercial carrier, multi-pass	7002 Private Transportation	
T2004	SC	Non-emergency Transportation, commercial carrier, multi-pass	7002 Private Transportation	NEMT
T2004		Non-emergency Transportation, commercial carrier, multi-pass	7003 Volunteer Transportation	
T2004	SC	Non-emergency Transportation, commercial carrier, multi-pass	7003 Volunteer Transportation	NEMT
T2005	SC	Non-emergency transportation; stretcher van	7001 Public Transportation	NEMT
T2005	SC	Non-emergency transportation; stretcher van	7002 Private Transportation	NEMT
T2007	SC	Transportation waiting time, air ambulance and non-emergency vehicle, one-half (1/2) hour increments	7001 Public Transportation	Medical transportation only. Must have SC modifier
T2007	SC	Transportation waiting time, air ambulance and non-emergency vehicle, one-half (1/2) hour increments	7002 Private Transportation	Medical transportation only. Must have SC modifier
T2022		Case management, per month		Supports Coordination
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	

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HCPCS/ CPT Code	HCPCS/ CPT Modifier	HCPCS/ CPT Code Description	Standardized Remark	Comment
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	Use 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, NOS, waiver	0423 Over-tub 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	

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HCPCS/ CPT Code	HCPCS/ CPT Modifier	HCPCS/ CPT Code Description	Standardized Remark	Comment
T2039		Vehicle Modifications, waiver, per service		
T2041		Supports brokerage, self-directed, waiver per 15 minutes		
T4537		Incontinence product, protective underpad, reusable, bed size, each		
T4540		Incontinence product, protective underpaid, reusable, chair size, each		
T5999 is to be used for Goods and Services and is only available for those persons choosing the Self-Determination Option for service delivery				
T5999		Supply, NOS	9001 Water Heater	
T5999		Supply, NOS	9002 Equipment Repair	
T5999		Supply, NOS	9003 Hand Control Unit for Hospital Bed	
T5999		Supply, NOS	9004 Power Converter Pack	
T5999		Supply, NOS	9005 Wheel Chair Accessories	If not medically necessary
T5999		Supply, NOS	9006 Appliance	
T5999		Supply, NOS	9007 Personal Hygiene Item	
T5999		Supply, NOS	9008 Masseuse	Per 15 minutes
T5999		Supply, NOS	9009 Household Supplies	
T5999		Supply, NOS	9010 Moving Expenses	
T5999		Supply, NOS	9011 Repair Service	
T5999		Supply, NOS	9012 Water Therapy	Per 15 minutes
T5999		Supply, NOS	9013 Utility Services	
T5999		Supply, NOS	9014 Furniture	
T5999		Supply, NOS	9015 Groceries	In emergencies only
T5999		Supply, NOS	9016 Roof Repair	If no other funding source
T5999		Supply, NOS	9017 Safety Gate	
T5999		Supply, NOS	9018 Smoke Alarm	
T5999		Supply, NOS	9019 Electric Fan	
T5999		Supply, NOS	9020 Financial Management	Per 15 minutes
T5999		Supply, NOS	9021 Clothing	
~~T5999~~		~~Supply, NOS~~	~~9022 Interpreter~~	Effective 10/1/2018 Interpreter is /administrative expense
T5999		Supply, NOS	9023 Emergency Meal	
T5999		Supply, NOS	9024 Protective Apron	
T5999		Supply, NOS	9025 Step Stool	
T5999		Supply, NOS	9026 Fire Extinguisher	
~~T5999~~		~~Supply, NOS~~	~~9027 Ferry cost to/from particpant's home~~	10/1/2018 - Use A0170 instead
T5999		Supply, NOS	9028 Magnifier	
T5999		Supply, NOS	9029 Court Fees for Conservator/Guardian	
T5999		Supply, NOS	9030 Carbon monoxide detector	

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T5999		Supply, NOS	9031 Specialty Camp	
T5999		Supply, NOS	9032 MDCH prior authorized premium payment	Requires MDHHS prior auth.
T5999		Supply, NOS	9033 SD advertisement for workers	
T5999		Supply, NOS	9034 SD one-time payment for workers	
T5999		Supply, NOS	9035 Social Isolation Remedy	
V5268		Assistive listening device, telephone amplifier, any type		
V5269		Assistive listening device, alerting, any type		
V5270		Assistive listening device, television amplifier, any type		

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HOME & COMMUNITY BASED SERVICES WAIVER FOR THE ELDERLY & DISABLED	NEMCSA Use Only
SUBCONTRACTOR AGREEMENT	Contract Begin Date: 10/01/2019
	Contract End Date: 09/30/2022

(If private individual please provide First Name, Middle Initial and Last Name)
ALL FIELDS ARE MANDATORY – IF NOT APPLICABLE MARK N/A

PROVIDER NAME:		
STREET ADDRESS		P.O. BOX
CITY:	STATE:	ZIP CODE PLUS 4
PHONE NUMBER:	FAX NUMBER:	TOLL FREE NUMBER:
TYPE OF AGENCY: ☐ Nonprofit Corporation ☐ For-profit Corporation ☐ General Purpose Government or Agency thereof		
CONTACT PERSON NAME AND TITLE:	CONTACT E-MAIL ADDRESS:	
DUNS NUMBER:		
EIN NUMBER, IF APPLICABLE:	SOCIAL SECURITY NUMBER, IF APPLICABLE:	
MEDICAID ID NUMBER, IF APPLICABLE:	NATIONAL PROVIDER ID (NPI): required if providing nursing services	
SERVICE AREA: (Counties or Cities)		

This Agreement is between Northeast Michigan Community Service Agency (NEMCSA), and _____, hereinafter referred to as Provider Agency, to promote the development of a comprehensive and coordinated service delivery system to meet the needs of those individuals who are “medically eligible” for institutional placement as established by the Michigan Department of Health and Human Services under the guidelines of the Federal Home and Community-Based Services Waiver for the Elderly and Disabled.

This Agreement provides a mechanism for the creation of an individualized network of community resources on a participant by participant basis, through the NEMCSA Care Management Program and the Home and Community Based Waiver Program.

OBJECTIVES

- To promote the mutual goal of maximizing independent functioning of eligible adults through Supports Coordination.

- To maintain a climate of cooperation and consultation with and between agencies in order to achieve maximum efficiency and effectiveness among all agencies serving waiver clients through Supports Coordination.

- To avoid and/or reduce service duplication and fragmentation in the service area.

- To share information and resources, and advocate for the development of comprehensive community-based long-term care services in the area.

The parties of the Agreement will, whenever possible, provide technical assistance and consultation to each other on matters pertaining to actual service delivery; will share, as appropriate, the findings of research and results of service delivery; share relevant needs assessment information and activities so that the resources of concerned agencies may be maximized.

TERMS OF AGREEMENT

NEMCSA shall:

1. Provide comprehensive Supports Coordination services to individuals who are medically eligible for institutionalization, and determined eligible for Supports Coordination/Care Management intervention.

   The responsibilities of NEMCSA shall include:

   A. screen all individuals referred for supports coordination/care management intervention;

   B. participant assessment, using assessment tool provided by the Michigan Department of Health and Human Services;

   C. care plan development, in consultation with the participant's physician, family and inclusive of a determination of frequency and duration of all services required under the care plan;

   D. service negotiation, including the arrangement of all health and human services as outlined in the care plan that maximize all reimbursement sources available;

   E. care plan monitoring, to track participant progress, through direct observational visits; and

   F. participant reassessment and appropriate care plan modification.

2. Provide technical assistance to Provider Agency, as requested and available.

3. Use screening and assessment tools developed and required by the Michigan Department of Health and Human Services, for use by NEMCSA Supports Coordination staff.

4. Offer the Provider Agency information regarding the service utilization patterns of care management/waiver participants.

As a result of the Agreement the Provider Agency shall:

1. Accept and serve on a priority basis Care Management participants referred to it by the NEMCSA Care Management Program. Where openings do not exist in the Provider Agency caseload, the Provider Agency agrees to negotiate alternative arrangements with NEMCSA and Supports Coordination staff in order to meet the needs of the participant.

2. Accept the comprehensive assessment as completed by the NEMCSA Supports Coordination staff and refrain from conducting duplicative assessment or reassessment activities.

3. Provide service delivery as prescribed in the directions received from the NEMCSA Supports Coordination staff during service requisition.

4. Provide the NEMCSA Supports Coordination staff with regular, on-going feedback regarding participant referred to it for services.

5. Inform the NEMCSA staff of the appropriate Provider Agency contact person to be notified in care plan development and modification.

6. Immediately notify the NEMCSA Supports Coordination staff if, for any reason, the Provider Agency is unable to provide service to the Care Management/Waiver participant, as negotiated, or if a service is not provided as agreed.

7. Comply with all licensing standards as may be prescribed, to assure quality of services delivered to Care Management/Waiver participant, to comply with all service standards and definitions as established by the Department of Health and Human Services and/or NEMCSA. (Private providers must submit copies of current license with this signed agreement.)

8. Follow the NEMCSA Care Management prescreening criteria when referring individuals who may be eligible for Care Management intervention.

9. Indemnify, save and hold harmless NEMCSA and the Michigan Department of Health and Human Services against expense or liability of any kind arising out of service delivery performed by the Provider Agency, and to immediately notify the NEMCSA Supports Coordination staff if the Provider Agency becomes involved in, or is threatened with litigation related to any NEMCSA Care Management/Waiver participant.

10. Maintain, in effect at all times during the course of this Agreement, insurance coverage as indicated and required by the Michigan Department of Health and Human Services, which includes NEMCSA as an additional named insured. (Provider Agency must provide NEMCSA a copy of an additional named insured certificate with this signed agreement, and must provide a copy of the insurance policy upon request.)

11. Protect participant confidentiality, and agree to not identify NEMCSA Care Management/ Waiver participants by name or otherwise, in any reports, without prior consent from the participant, and approval by the NEMCSA and the Department of Health and Human Services. (See Business Associate Agreement for providers receiving protected health information)

    A. Legal limitations exist on both the Provider Agency and the NEMCSA Supports Coordination staff regarding the disclosure of information about a participant. The law treats all

communication received from the participant as confidential, whether oral, written or electronic, including records derived from those communications.

12. Accept from and share any information that may be necessary to better serve the participant that may be viewed as confidential, upon receipt of a copy of the general release of information signed by the participant, and avoid requiring the signing of additional release by the participant.

This Agreement will be reviewed annually, and amended if necessary, for the purpose of focusing the provisions herein to more specifically address the agreed upon interactions between the parties.

Periodic review will include amending the Agreement to appropriately reflect pertinent agreements that may be developed between NEMCSA and other federal, state and local agencies.

Termination may be used, at the discretion of NEMCSA, with or without prior probation or suspension, for serious violations of the Contract, which are not deemed by the NEMCSA to be correctible or which are likely to recur, as well as lack of availability of funding. For adequate cause, the NEMCSA may immediately terminate this Contract prior to the end of an approved budget year or prior to the end of the contracted period.

The Subcontractor may terminate the subcontract upon **THIRTY** (30) days written notice to NEMCSA at any time prior to the completion of the subcontract, for adequate cause.

ADDENDUM A - Addendum A contains the purchase of service agreement.

ADDENDUM B - Addendum B includes the Provider Agency's assurance that its employees meet the minimum standards developed by the Department of Health and Human Services and NEMCSA.

ADDENDUM C - Addendum C includes the assurance that the Provider Agency will comply with Section 504 of the Rehabilitation Act of 1973, as amended.

ADDENDUM D - Addendum D includes the assurance that the Provider Agency will comply with the Department of Health and Human Services Regulations under Title VI of the Civil Rights Act of 1964, Michigan Handicappers Civil Rights Act of 1976, and the Elliot-Larsen Civil Rights Act of 1976.

ADDENDUM E - Business Associate Agreement, if applicable.

Provider signature on all Agreements and Assurances is binding for the term of the Agreement.

SIGNATURES

Signature of NEMCSA Representative	Representative Signature of Provider Agency
Laurie L. Sauer	
Typed Name	Typed Name
NEMCSA-AAA Director	
Title	Title
Date	Date

ADDENDUM A

HOME & COMMUNITY BASED SERVICES WAIVER FOR THE ELDERLY & DISABLED	NEMCSA USE ONLY
	Begin Date: 10/01/2019
PURCHASE OF SERVICE AGREEMENT	End Date: 09/30/2022

This Agreement, effective October 1, 2019, negotiated between Northeast Michigan Community Service Agency, NEMCSA, and _____ the Provider Agency, outlines the services that may be purchased from the latter party.

SERVICES TO BE RENDERED

NEMCSA may purchase services from the Provider Agency, if selected from the Direct Service Purchasing pool. Services are purchased at the levels specified in the Care Management/Waiver Plan of Care on a per participant basis as developed by the NEMCSA Supports Coordinators. Provider activities must meet service definitions and all standards presented in the Service Definitions and Standards, as established by the Department of Health and Human Services.

PAYMENT AND REPORTING

The Provider Agency will receive payment for approved services delivered through a ***MONTHLY*** reimbursement method. Checks are made payable to the Provider Agency each month upon receipt and approval of billing voucher by NEMCSA. Bill vouchers received after the 15th day of the month will be processed with the next month's vouchers. No voucher will be accepted that is more than 3 months following the month of service. Services provided without a written service authorization from NEMCSA staff are not reimbursable.

The amount to be reimbursed is established from the charge or bid presented in this Agreement. The Provider Agency must establish accessible record systems to verify that all programmatic and fiscal information reported and make such records available for review by the NEMCSA staff and/or Department of Health and Human Services.

COST PER UNIT (inclusive of all costs) If more lines are required, use separate sheet of paper.

SERVICE	# Participants You Anticipate You Can Serve	PER UNIT BID PRICE
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

LENGTH OF AGREEMENT

Fiscal Years 2020-2022: Approved Period: From October 1, 2019 through September 30, 2022

SIGNATURES

Signature of NEMCSA Representative	Signature of Provider Agency Representative
NEMCSA-AAA Director	
Title	Title
Date	Date

ADDENDUM B

HOME & COMMUNITY BASED SERVICES WAIVER FOR THE ELDERLY & DISABLED	NEMCSA USE ONLY
MINIMUM STANDARDS ASSURANCE	Begin Date: 10/01/2019 End Date: 09/30/2022

Any service purchased by NEMCSA must be in compliance with the Department of Health and Human Services and NEMCSA service definitions, unit definition, and minimum standards of operation.

As a Provider Agency for NEMCSA, _____

HEREBY ASSURES the persons involved in implementing the Subcontractor Agreement have read the minimum standards for each of the services for which service may be purchased by NEMCSA from the Provider Agency.

FURTHERMORE, the Provider Agency assures that it is completely in compliance with all standards for the following services and will maintain compliance with these standards throughout the term of this Agreement. (List all services for which the Provider Agency is proposing to make available for purchase by NEMCSA).

1. 6.
2. 7.
3. 8.
4. 9.
5. 10.

FURTHERMORE, the Provider Agency assures that it possesses insurance coverage as required by the Department of Health and Human Services in the Service Standards/Definitions, that **NEMCSA is listed as an additional insured under such insurance coverage, and that a Certificate indicating that NEMCSA is an additional insured under such insurance coverage is included as an appendix to this agreement. The Provider Agency understands that service purchasing cannot begin until such time as NEMCSA has in its possession such a Certificate of Insurance.**

This assurance is given in consideration of and for the purpose of obtaining Federal or State funds though a purchase of service arrangement with NEMCSA. The Provider agency recognizes and agrees that any approved financial assistance will be extended based on agreements made in this assurance and that NEMCSA shall have the right to seek enforcement of this assurance.

This assurance is binding on the Provider Agency, its successors, transferees, and assignees.

SIGNATURES

Signature of NEMCSA Representative	Signature of Provider Agency Representative
NEMCSA-AAA Director Title	Title
Date	Date

ADDENDUM C

HOME & COMMUNITY BASED SERVICES WAIVER FOR THE ELDERLY & DISABLED	NEMCSA USE ONLY
ASSURANCE OF COMPLIANCE WITH SECTION 504 OF THE REHABILITATION ACT OF 1973, AS AMENDED	Begin Date: 10/01/2019
	End Date: 09/30/2022

_____, the Provider Agency, who receives funds from the Michigan Department of Health and Human Services, HEREBY AGREES THAT it will comply with Section 504 of the Rehabilitation Act of 1973, as amended (29, USC 794), all requirements imposed by the applicable Health and Human Services regulations (45 CFR, Part 84) and all guidelines and interpretations issued pursuant thereto.

Pursuant to 84.5(a) of the regulation (45 CFR 84.5(a)) the Provider Agency gives this Assurance in consideration of, and for the purpose of, obtaining any and all grants, loans, contracts (except procurement contracts and contracts of insurance or guaranty), property, discounts, or other financial assistance extended by the above noted Department after the date of this assurance, including payment of other assistance made after such date on application for financial assistance that were approved before such date. The Provider Agency recognizes and agrees that such financial assistance will be extended in reliance on the representations and agreements made in this Assurance and that the above noted Department will have the right to enforce this Assurance through lawful means. This Assurance is binding on the Provider Agency, its successors, transferees, and assignees, and the person or persons whose signature appears below as authorized to sign this Assurance on behalf of the Provider Agency.

This Assurance obligates the Provider Agency for the period during which federal financial assistance is extended to be the above noted Department of the State of Michigan, or, where the assistance is in the form of real or personal property, for the period in 84.5(b) of the regulation.

I CERTIFY THAT THE ABOVE STATED INFORMATION IS COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

_____

Signature of Provider Agency Representative

_____

Title

_____

Date

ADDENDUM D

HOME & COMMUNITY BASED SERVICES WAIVER FOR THE ELDERLY & DISABLED	NEMCSA USE ONLY
ASSURANCE OF COMPLIANCE WITH HEALTH AND HHS REGULATIONS	Begin Date: 10/01/2019
	End Date: 09/30/2022

_____, the Provider Agency who receives funds from the Michigan Department of Health and Human Services, HEREBY AGREES THAT it will comply with Title VI of the Civil Rights Act of 1964 (P.A. 88-352), the Michigan Handicappers Civil Rights Act of 1976 (P.A. 220), and the Elliot-Larsen Civil Rights Act of 1976 (P.A. 453, Section 209) and will comply with the requirements imposed by, or pursuant to, the Regulation of the Department of Health and Human Services (45 CFR Part 80) issued pursuant to that Title to the end that, in accordance with Title VI of the Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Provider Agency received federal or state financial assistance from NEMCSA, and HEREBY GIVES ASSURANCE that it will immediately take measures necessary to effectuate this agreement.

If any real property or structure thereon is provided or improved with the aid of federal or state financial assistance extended to the Provider Agency by NEMCSA, this Assurance shall obligate the Provider Agency for the period during which said property or structure is used for a purpose for which federal and state financial assistance is extended. This Assurance further certifies that the Provider Agency has no other commitments or obligations that are inconsistent with compliance of these and any other pertinent federal or state regulations and policies, and that any other agency, organization, or party that participated in this project shall have not such commitments or obligations, and all activities shall not run counter to the purpose and intent of the Agreement.

This Assurance is given in consideration of, and for the purpose of, obtaining any and all grants, loans, contracts, property, discounts, or other financial assistance extended after the date of this assurance that were approved before such date. The Provider Agency recognizes and agrees that such financial assistance will be extended in reliance on the representations and agreements made in this Assurance and that the above noted Department will have the right to enforce this Assurance through lawful means. This Assurance is binding on the Provider Agency, its successors, transferees, and assignees, and the person or persons whose signature appears below as authorized to sign this Assurance on behalf of the Provider Agency.

_____

Signature of Provider Agency Representative

_____

Title

_____

Date

HOME & COMMUNITY BASED SERVICES WAIVER FOR THE ELDERLY & DISABLED	NEMCSA USE ONLY
SUBCONTRACTOR ENROLLMENT AGREEMENT Michigan Department of Health and Human Services	Eligibility Begin Date: 10/01/2019
	Eligibility End Date: 09/30/2022

This form is to be completed by all providers who wish to receive payment from the Medicaid-enrolled Pre-paid Ambulatory Health Plan (PAHP) for services provided under the Home & Community Based Services Waiver for the Elderly and Disabled. An original payment agreement must be submitted for **each** eligible provider.

COMPLETION INSTRUCTIONS **PLEASE TYPE OR PRINT CLEARLY**

- Individual providers must enter their last name, first name and middle initial. All other applicants (e.g., a licensed business) must enter the complete business name as licensed/certified.
- If the applicant is employed/contracted by a business, or in partnership, enter the name of the business you are employed by, affiliated with, contracted with, or in partnership with.
- Proof of the EIN number (federal tax number) is **REQUIRED.**
- Providers must attach a copy of their licensure/certification, as applicable.
- The SSN is required for an individual and is confidential to be used only for the administration of the program.

APPLICANT INFORMATION

1. PROVIDER'S NAME (SEE INSTRUCTIONS)	2. PROFESSIONAL TITLE, IF APPLICABLE
3. EMPLOYER'S NAME (SEE INSTRUCTIONS)	4. EIN NUMBER (SEE INSTRUCTIONS)
5. STATE LICENSE NUMBER (SEE INSTURCTIONS)	6. APPLICANT SOCIAL SECURITY NUMBER

BUSINESS LOCATION

7. STREET ADDRESS (NUMBER & STREET)			P. O. BOX
CITY	STATE	ZIP CODE PLUS 4	PHONE NUMBER

MEDICAL ASSISTANCE (MEDICAID) PROVIDER PAYMENT AGREEMENT CONDITIONS

1. All information furnished on this payment agreement form is true and complete.
2. I consent that, upon request and at a reasonable time and place, I will permit authorized agents of the State of Michigan or the federal government to inspect, and copy, any records related to my delivery of goods or services to, or on behalf of, a participant under the Medicaid Program.
3. I am not currently suspended, terminated, or excluded from any state Medicaid Program or by the U.S. Department of Health and Human Services.
4. I agree to accept the Michigan Medicaid payment as payment in full for the services rendered. Except for patient liability as determined by the Michigan Medicaid Program including applicable co-payments, I will not seek nor accept additional or supplemental payment from the participant, his/her family, or representative(s).
5. I may be prosecuted under applicable federal or state criminal and civil laws for submitting false claims, concealing material facts, misrepresentation, falsifying data, other acts or misrepresentation, or conspiracy to engage therein.
6. I agree to comply with the MDHHS policies and procedures for the Medical Assistance Program and the Home and Community Based Services for the Elderly and Disabled contained in manuals, manual updates, provider bulletins, and other program notifications.

As a condition of receiving payment from the Michigan Medicaid Program for services provided to an eligible participant, I certify and/or agree to all of the conditions listed above. I certify that the undersigned has the authority to execute this agreement.

APPLICANT'S SIGNATURE	TITLE	DATE

The Michigan Department of Health and Human Services will not discriminate against any individual or group because of race, religion, age, national origin, marital status, political beliefs, or disability.

GRIEVANCE FORM

MI CHOICE WAIVER & CARE MANAGEMENT PROGRAMS

REGION 9 AREA AGENCY ON AGING
A DIVISION OF NEMCSA

Participant Name: _____ **Date:** _____

Person Reporting: _____ **Phone:** _____

Relationship to Participant: _____

Description of Grievance:
Suggested Resolution of Grievance:
AAA Office Use Only
Supervisor Responding to Grievance: _____ **Date:** _____
Director Notified: ☐ **Yes** **Date:** _____ ☐ **No** **Why Not:** _____
Resolution:
Finding Communicated to: _____ **Date:** _____
☐ **Phone** ☐ **Letter** ☐ **E-mail** ☐ **Site Visit** ☐ **Other:** _____ **Date:** _____
Director Review: _____ **Date:** _____

Written grievances may be submitted to:
Laurie Sauer, Director
Region 9 Area Agency on Aging
2375 Gordon Rd.
Alpena, MI 49707

IN - HOME JOURNAL FOR RESIDENTIAL SERVICES

PROVIDER:	
Participant Name:	Phone Number: ( ) -
Address:	City/State/Zip

Date:	EMPLOYEE SIGNATURE:	SERVICES PROVIDED:	COMMENTS:
Total Service Hours Provided for Day:	PARTICIPANT SIGNATURE:		

Date:	EMPLOYEE SIGNATURE:	SERVICES PROVIDED:	COMMENTS:
Total Service Hours Provided for Day:	PARTICIPANT SIGNATURE:		

Date:	EMPLOYEE SIGNATURE:	SERVICES PROVIDED:	COMMENTS:
Total Service Hours Provided for Day:	PARTICIPANT SIGNATURE:		

Date:	EMPLOYEE SIGNATURE:	SERVICES PROVIDED:	COMMENTS:
Total Service Hours Provided for Day:	PARTICIPANT SIGNATURE:		

Date:	EMPLOYEE SIGNATURE:	SERVICES PROVIDED:	COMMENTS:
Total Service Hours Provided for Day:	PARTICIPANT SIGNATURE:		

REVISED 9/5/2013

REGION 9
AREA AGENCY ON AGING
A DIVISION OF NEMCSA

Serving the counties of:
Alcona - Alpena - Arenac - Cheboygan - Crawford - Iosco
Montmorency - Ogemaw - Oscoda - Otsego - Presque Isle - Roscommon

2375 Gordon Road Alpena, Michigan 49707 Phone: 989-356-3474 Fax: 989-358-6604 Toll Free: 800-219-2273 www.nemcsa.org

September 10, 2020

The following are **maximum** rates that will be paid for Fiscal Year 2021:

HCPC and Description	Unit Rate
H2015 Community Living Supports, mileage included	$4.90
H2015 Community Living Supports, no mileage	$4.45
S5120 Chore Service	$5.25
S5150 In-Home Respite	$4.45
S5170 Home Delivered Meals	$6.15
S0215 Non-Medical Transportation	IRS Rate
T1000 Private Duty Nursing, TD RN	$12.50
T1000 Private Duty Nursing, TE LPN	$10.00
T1002 RN Services	$12.50
T1003 LPN Services	$10.00
S5101 Day Care Services, Adult, per half Day	$49.00

MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 14-31

Distribution: Home Help Providers, MI Choice Waiver Agencies

Issued: July 31, 2014

Subject: Personal Care Provider Criminal History Screening

Effective: September 1, 2014

Programs Affected: Medicaid, Healthy Michigan Plan

This bulletin provides additional information about the Michigan Department of Community Health's (MDCH) implementation of Medicaid provider screening and enrollment requirements of Sections 6201, 6401, and 6501 of the Affordable Care Act (ACA) and state policy as reflected in the General Information for Providers Chapter, Section 2 – Provider Enrollment, in the Michigan Medicaid Provider Manual. Section 1128(a) of 42 U.S.C.1320a-7 (the Social Security Act) prohibits individuals or entities from participating in programs funded under the Act if they have been convicted of any of the Mandatory Exclusion offenses outlined below. The Act permits the State to apply additional permissive restrictions; however those will be covered in a subsequent bulletin. This policy applies to all providers of personal care services that are delivered through the Michigan Medicaid Home Help program and the MI Choice waiver program.

For the purposes of this policy, a provider is any individual providing a direct or indirect program service to a beneficiary or enrollee of the Home Help or MI Choice programs that is reimbursed by Medicaid. This applies to both independent providers of service as well as employees of service agencies. The criminal history screen will be conducted either by MDCH through the provider registration process or as assigned by contract with the MI Choice waiver agencies. Screenings under this policy will not require fingerprinting of the individual being screened and will be conducted though available public record databases.

Mandatory Exclusions: Providers (any individual or entity) MUST be screened for and, as required by the State of Michigan, MUST disclose the following excludable convictions. Any applicant or provider found to meet one of these four categories is prohibited from participating as a service provider for Medicaid or the Home Help program. The mandatory exclusion categories are:

1. Any criminal convictions related to the delivery of an item or service under Medicare (Title XVIII), Medicaid (Title XIX) or other state health care programs (e.g., Children's Special Health Care Services, Healthy Kids), (Title V, Title XX, and Title XXI)
2. Any criminal convictions under federal or state law, relating to neglect or abuse of patients in connection with the delivery of a health care item or service
3. Felony convictions **occurring after August 21, 1996**, relating to an offense, under federal or state law, in connection with the delivery of health care items or services or with respect to any act or omission in a health care program (other than those included in number 1 above) operated by or financed in whole or in part by any federal, state, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct
4. Felony convictions **occurring after August 21, 1996,** under federal or state law, related to unlawful manufacture, distribution, prescription, or dispensing of a controlled substance

For the purposes of the laws mentioned above, an individual or entity is considered to have been convicted of a criminal offense when:

- A judgment of conviction has been entered against the individual or entity by a federal, state, or local court, regardless of whether there is an appeal pending or whether the judgment of conviction or other record relating to criminal conduct has been expunged,
- A finding of guilt against the individual or entity by a federal, state, or local court,
- A plea of guilty or nolo contendere by the individual or entity has been accepted by a federal, state, or local court, or
- An individual or entity that has entered into participation in a first offender, deferred adjudication, or other arrangement or program where judgment of conviction has been withheld.

Criminal History Screening: All current and potential providers covered under this policy must agree to a criminal history screening. Such approval will be indicated through the submission of a signed MSA-4678 Medical Assistance Home Help Provider Agreement, a properly submitted online program provider application, or other authorized application approved by the department. Valid identifying information, including name, home address, date of birth, and Social Security Number, must be provided by all providers and applicants. The screening must be completed and passed before a provider will be allowed to provide services under a Medicaid program. Subsequent screening will be administered as described below. Approved and existing individual providers will be periodically reviewed and rescreened by MDCH.

Program-approved provider agencies are required to assure that a criminal history screening of all individuals in their employment providing in-home services has been conducted. Such agencies are also required to provide similar screenings on the following agency personnel:

- Any individual with an ownership interest in the agency,
- Any individual providing services on behalf of the agency or individual who has direct access to a client, patient or resident or to a client's, patient's or resident's property, financial information, medical records, treatment information, or any other identifying information, or
- Any person providing services to client, patient or resident for which the agency is reimbursed under Medicaid.

All providers will be required to revalidate their Medicaid enrollment information for the purposes of subsequent criminal history screenings a minimum of once every three years, or more often if requested by MDCH. MDCH will notify providers when revalidation is required. **Providers are reminded that they must notify MDCH within 10 business days of any change to their enrollment information. Failure to do so will result in termination of provider enrollment.**

Exclusions: For any provider found to be in violation of any of the four mandatory exclusions listed above, MDCH shall terminate or deny enrollment in the Michigan Medicaid program. Although the Social Security Act stipulates a minimum exclusionary period for these offenses under of 42 U.S.C.1320a-7(c)(3)(B), the exclusionary period under this policy will be consistent with that set for other types of Medicaid providers under MCL 333.20173. Termination of enrollment means a provider's billing privileges have been revoked and all appeal rights have been exhausted or the timeline for appeal has expired. Denial of enrollment means the provider agreement will not be approved for participation in the Medicaid program. The basis for termination or denial of enrollment includes, but is not limited to:

- Failure to submit timely and accurate information,
- Failure to cooperate with MDCH screening methods,
- Any criminal convictions related to the delivery of an item or service under Medicare (Title XVIII), Medicaid (Title XIX) or other state health care programs (e.g., Adult Benefit's Waiver, County Health Plan, Children's Special Health Care Services, Healthy Kids), (Title V, Title XX, and Title XXI),
- Termination on or after January 1, 2011, under Medicare or the Medicaid program or Children's Health Insurance Program (CHIP) of any other state,
- Falsification of information provided on the provider agreement, or
- Inability to verify a provider applicant's identity.

In addition to the above, approved or applying Home Help agency providers will be terminated or denied enrollment under for the following:

- Billing for services provided by individuals who have a criminal conviction listed under Section 1128(a) of the Social Security Act,
- Having owners or disclosed individuals with convictions listed under Section 1128(a) of the Social Security Act,
- Failing to provide MDCH upon request with proof that any individual subject to criminal history screening has a completed screen not older than twelve months, or
- Failing to notify MDCH of a conviction listed under Section 1128(a) of the Social Security Act of an individual covered by this policy.

MDCH shall suspend payments to a provider after determining there is a credible allegation of fraud for which an investigation is pending under the Medicaid program. An allegation of fraud may be from any source including fraud hotline complaints, claims data mining and patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indications of reliability and the state Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis. Providers will be notified within 90 days of initiation of a payment suspension. The notification will include the general allegations as to the nature of the suspension action, the period of suspension, and the circumstances under which the suspension will be terminated. Providers may submit written evidence for consideration through the administrative appeal process. All payment suspensions will include referral to the Office of Health Services Inspector General.

Notifications: MDCH will notify applicants or providers within 10 business days of conducting an ineligible criminal history screening. The department will concurrently notify all affected program beneficiaries and necessary Department of Human Services (DHS) staff.

Reviews and Appeals: Provider applicants and enrolled providers may request an administrative redetermination of the criminal history screening process if the criminal history record is inaccurate. Such a request must be made in writing to the department and must identify the specific information being challenged as well as what the individual feels to be the correct information. Negative actions based on an accurate criminal history are not subject to appeal, except as provided below.

Providers who are providing services to a client prior to the effective date of this policy may appeal a decision to terminate or deny enrollment. Denial of enrollment due to a temporary enrollment moratorium is appealable, but the scope of review is limited to whether the temporary moratorium applies to the provider appealing the denial. The basis for imposing a temporary moratorium is not subject to review. After termination from the Medicaid program, the provider must contact MDCH to request re-enrollment as a Medicaid provider and reinstatement of billing privileges. Providers whose enrollment has been denied are not prohibited from submitting a request for subsequent re-enrollment.

Manual Maintenance

Retain this bulletin until the information has been incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Stephen Fitton

Stephen Fitton, Director
Medical Services Administration

MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 14-40

Distribution: Home Help Provider Agencies, MI Choice Waiver Agencies, Program of All-Inclusive Care for the Elderly (PACE) Programs, Prepaid Inpatient Health Plans (PIHPs), Integrated Care Organizations

Issued: September 2, 2014

Subject: Excludable Convictions for Medicaid Home Help Program Personal Care Service Providers

Effective: October 2, 2014

Programs Affected: Home Help

The Michigan Department of Community Health (MDCH) intends to utilize the authority extended to the state through 42 USC 1396t(k)(4) to meet the requirements under 42 CFR 441.570 to assure that "[n]ecessary safeguards have been taken to protect the health and welfare of enrollees." This bulletin extends the Medicaid provider criminal history screening and enrollment requirements to individuals who offer personal care services through the Medicaid Home Help program. Additionally, it augments the list of excludable convictions as outlined in Bulletin MSA 14-31 to include permissive exclusions as defined below. The screening requirements described in this bulletin are to apply to all providers of Medicaid Home Help personal care services. The requirements apply to both individual providers and to those providing services as an employee of a provider agency.

As used in this bulletin, "personal care services" include services provided to a Medicaid beneficiary to assist the beneficiary with completing their Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) while the beneficiary is in a home or community-based setting. ADLs include eating, bathing, dressing, toileting, transferring, mobility, walking, and personal hygiene. IADLs include financial management, shopping, telephone use, transportation, housekeeping, meal preparation, and managing medications.

Compliance Timeline: Beginning October 2, 2014, all new provider applicants must fully meet the provisions of this bulletin before being enrolled to provide services. Providers must be properly enrolled prior to being authorized, approved, or reimbursed to provide personal care services through the Medicaid Home Help program.

All currently enrolled providers must be fully compliant with the provisions of this policy by March 31, 2015. Screenings, updates, enrollments, and notifications to currently enrolled providers will be done on a timeline to be established by MDCH, but will be completed no later than the March 31, 2015 deadline.

Excludable Convictions: Excludable convictions fall into two general categories. Mandatory exclusions, as discussed in Bulletin MSA 14-31, are those set forth in the Social Security Act (42 USC 1320a-7[a]) and shown in the first bullet below. Permissive exclusions are allowed under part (b) of that section. The Act (42 USC 1396t[f][1][A]) states that "[n]othing in the Act shall be construed as preventing States from imposing requirements that are more stringent than the requirements published or developed by the Secretary." Finally, 42 CFR 441.570 requires the State to assure that "[n]ecessary safeguards have been taken to protect the health and welfare of enrollees." Permissive exclusions within the context of this policy are reflected in the second bullet and sub-bullets below. Based on these guidelines and subject to the Personal Choice and Acknowledgement of Provider provision, the Medicaid Home Help program shall not employ, independently contract with, or otherwise authorize or reimburse for services any individual who has direct access to or provides direct services to program participants if the individual has received a criminal history screening from MDCH that indicates one or more of the following:

- Convictions associated with program-related fraud and patient abuse, health care fraud, and felony controlled substance crimes. These exclusions are mandated and defined under 42 USC 1320a-7 and articulated in Bulletin MSA 14-31.
- Conviction of crimes directly relatable to neglect, physical and sexual abuse, financial exploitation, inappropriate involuntary restraint, providing unqualified health care services and other crimes identified by MDCH. The list of specific crimes shall be the same as those defined for nursing facilities, county medical care facilities, hospices, and other long term service and support providers as set out and defined in the Public Health Code Act 368 of 1978, specifically Public Act 28 Sec. 20173a(1) (MCL333.20173a[1]). This list includes, but is not limited to crimes that:

    - Involve the intent to cause death or serious impairment of a body function;
    - Result in death or serious impairment of a body function;
    - Involve the use of force or violence;
    - Involve the threat of force or violence;
    - Involve cruelty or torture;
    - Involve criminal sexual conduct;
    - Involve abuse or neglect;
    - Involve the use of a firearm or a dangerous weapon;
    - Involve larceny, theft, or embezzlement;
    - Involve a felony Driving Under The Influence (DUI);
    - Involve an assault, battery, or the threat thereof;
    - Involve a crime against a "vulnerable adult";
    - Involve retail fraud; or
    - State that the conviction is a felony reduced to a misdemeanor.

For the purposes of the laws mentioned above, an individual or entity is considered to have been convicted of a criminal offense when:

- A judgment of conviction has been entered against the individual or entity by a federal, state, or local court, regardless whether an appeal is pending or whether the judgment of conviction or other record relating to criminal conduct has been expunged;
- A finding of guilt by judge or jury against the individual or entity by a federal, state, or local court; or
- A plea of guilty or nolo contendere by the individual or entity has been accepted by a federal, state, or local court.

The criminal history screening will be conducted by MDCH through a reputable and reliable data source. Screenings for any provider may be updated on a schedule set by the MDCH or as deemed necessary for the protection of a Medicaid beneficiary.

Provider Application or Agreement: Any individual wishing to provide personal care services through the Medicaid Home Help program, including those providing such services as an employee of a provider agency, must submit a properly formatted and approved application or service agreement form to MDCH that:

- Provides notification that a criminal history screening will be performed on the applicant or provider;
- Identifies the general categories of convictions that will be screened;
- Provides adequate information as determined by MDCH to conduct such a screening;
- Notifies the applicant or provider that the results of the screening will be shared with the applicant, pertinent program participants, and pertinent program staff; and
- Is signed by the applicant or provider.

Providers are reminded that they must notify MDCH within 10 days of any change to their enrollment information. Failure to do so will result in termination of provider enrollment.

Notifications: MDCH will notify applicants or providers within 10 business days of an ineligible criminal history screening. The department will concurrently notify all affected program participants and Department of Human Services (DHS) staff of all criminal history information discovered through the screening process. The notice shall include a statement that the applicant or provider has a right to appeal the information relied upon by MDCH in making its decision regarding his or her employment eligibility based on the criminal history screening. The notice shall also include information describing the appellate procedures.

Placement in Provider Referral System: Names and contact information for all individuals successfully passing a criminal history screening will be placed in a provider referral system database administered and operated by MDCH. Individuals identified with an excludable conviction through the screening process CANNOT be placed in the provider referral database. Any individual in the provider referral database will have the option to:

- Update their personal and contact information;
- Indicate their work preferences or otherwise restrict their availability; and
- Indicate that they are not available for referrals to provide services to additional participants.

The database will be used to make referrals to Home Help program participants who are in need of personal care services. Providers are not required to accept service referrals made through the referral system. Similarly, program participants are not required to accept services from providers listed in any given referral. Providers serving through a personal choice selection as described below may not be placed in the provider referral database and cannot be given any additional participant referrals through that process.

Personal Choice and Acknowledgement of Provider Selection: A participant receiving personal care services through the Medicaid Home Help program may select any family member or other individual to provide such services subject to the following restrictions:

- The provider does not have a disqualifying conviction that is one of the four Mandatory Exclusions under 42 USC 1320a-7.
- The provider is not legally responsible for the participant.
- The provider is capable of providing the required services and is otherwise qualified to do so.
- The provider has successfully undergone a criminal history screening conducted by MDCH and has received notification of a successful determination.

A participant may request to select a provider who has been determined ineligible as a result of a Permissive Exclusion identified through the criminal history screening process. The request must be submitted on a form specified by MDCH. The participant must provide a signed acknowledgement that indicates receipt of notification of the criminal offense(s) which prompted the exclusion and must indicate their selection of that provider to deliver services. The selection shall not be considered effective until the signed acknowledgement has been received, processed, and recorded by MDCH and communicated to DHS.

A personal choice selection may not be applied to the federally mandated exclusions that are described under 42 USC 1320a-7. A personal choice selection may be applied to permissive exclusions for the limited purpose of providing Home Help services to the specific individual identified in the request.

A personal choice selection through this section shall not be construed as approval, authorization or permission to provide services to other participants or through other programs. Providers selected through the personal choice provisions of this section will be registered in the Community Health Automated Medicaid Processing System (CHAMPS) and other systems for the purposes of monitoring, contacting, and generating payments, however, such individuals shall be prohibited from either being placed in the provider referral database or receiving referrals for additional clients through that process.

Reviews and Appeals: Individuals may request an administrative redetermination of the criminal history screening, but such a review is limited solely to the accuracy of the information used for the screening. Negative actions based on accurate criminal history are not subject to appeal, except as provided below. A review will not be granted to contest the merits of the court findings.

Providers who are authorized to furnish services for a program participant prior to the effective date of this policy may appeal a decision to terminate or deny their provider enrollment. Denial of provider enrollment due to a temporary enrollment moratorium is appealable, but the scope of review is limited to whether the temporary moratorium applies to the provider appealing the denial. The basis for imposing a temporary moratorium is not subject to review. After termination from the Medicaid program, the provider must contact MDCH to request re-enrollment as a Medicaid provider and reinstatement of billing privileges. Providers whose enrollment has been denied are not prohibited from submitting a request for subsequent re-enrollment.

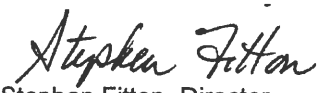
Manual Maintenance

Retain this bulletin until the information has been incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved



Stephen Fitton, Director
Medical Services Administration

NORTHEAST MICHIGAN COMMUNITY SERVICE AGENCY, INC.
Region 9 Area Agency on Aging
Care Management / MI Choice Waiver Program
Satellite Office Locations and Staff
Fiscal Year 2021

Main Office Address (all correspondence for Alpena Annex Staff should go the MAIN Office address)	NEMCSA Main Office 2375 Gordon Road Alpena, MI 49707 989/356-3474 989/354-5909 Fax
Annex Office Address	NEMCSA Alpena Annex 2569 U.S. 23 South Alpena, MI 49707 989/356-3474, ext. 231 989/354-6913 Fax

STAFF NAME	EXTENSION	POSITION
Laurie Sauer	989.358.4663	Region 9 AAA Director
Gina Bey	989.358.4682	Region 9 AAA Associate Director
Patty Rings	989.358.4611	Director Business/Financial Resources–Aging
Yvette Smigelski	989.358.4613	Business/Financial Resources Manager-Aging
Cheryl Riopelle	989.358.4604	Program Specialist
Christine Elowski	989.358.4646	Program Specialist
Jennifer Ordway	989.358.4685	Community Based Care Supervisor
Caitlin Wade	989.358.4601	Registered Nurse
Brian Zwolinski	989.358.4610	Registered Nurse
Carey Steinke	989.358.4607	Registered Nurse
Julie Mitchell	989.358.4624	Registered Nurse
Meghan Winterstein	989.358.4608	Social Worker
Carolyn Riske Miller	989.358.4606	Social Worker
Jessica Dziesinski	989.358.4684	Social Worker
Shirley Diemond	989.358.4609	Social Worker
Ann Weir	989.358.4657	Eligibility and Hearings Coordinator
Open Position	989.358.4631	Intake Specialist

NORTHEAST MICHIGAN COMMUNITY SERVICE AGENCY, INC.
Region 9 Area Agency on Aging
Care Management / MI Choice Waiver Program
Satellite Office Locations and Staff
Fiscal Year 2021

West Branch Office Address		630 Progress Street, Suite 100 West Branch, MI 48661 989/345-1975 989/345-3684 Fax
STAFF NAME	**EXTENSION**	**POSITION**
Rebecca Tousigna	989.272.2259	Community Based Care Supervisor
Whitney Linsenman	989.272.2268	Intake Specialist
Tina Vliet	989.272.2291	Registered Nurse
Kammy Maroney	989.272.2251	Registered Nurse
Tina Pate	989.272.2279	Registered Nurse
Lisa Flinn	989.272.2282	Registered Nurse
Chelsea Hunke	989.266.5632	Registered Nurse
Sarah Jansen	989.282.4343	Social Worker
Carol Jansen	989.272.2264	Social Worker
Kathy Miner	989.272.2301	Social Worker
Sarah Parrott	989.272.2298	Social Worker
Laura Clark	989.272.2261	Social Worker
Cheboygan Office Address		AHM Building 520 N. Main Street, Suite 303 Cheboygan, MI 49721 989/356-3474 231/627-7093 Fax
STAFF NAME	**EXTENSION**	**POSITION**
Jenna Lindholm	989.358.4731	Clinical Quality Supervisor
Miranda Doyle	989.358.4730	Intake Specialist
Beth Connors	989.358.4734	Registered Nurse
Erica Sias	989.358.4732	Social Worker
Gaylord Office Address		Alpine Executive Center 400 W. Main Street, Suite 201 Gaylord, MI 49735 989/356-3474 989/448-8204 Fax
STAFF NAME	**EXTENSION**	**POSITION**
Jenna Lindholm	989.358.4731	Clinical Quality Supervisor
Amy Travis	989.358.4738	Registered Nurse
Carol Elm	989.358.4737	Social Worker

THIS LIST IS FOR INTERNAL PROVIDER USE ONLY AND IS NOT BE DISTRIBUTED.

PROVIDER INCIDENT REPORT

MI CHOICE WAIVER & CARE MANAGEMENT PROGRAMS

REGION 9 AREA AGENCY ON AGING
A DIVISION OF NEMCSA

This form is to be used whenever a problem is identified with a provider

Complete the appropriate sections and forward to your supervisor for review.

Participant Name: _____ Last 4 Digits of Soc. Security #: _____

Program: ☐ MI Choice Waiver ☐ Care Mgmt. ☐ Caregiver Respite ☐ Other: _____

Provider Agency: _____ Worker Name:_____

Supports Coordinator: _____ Date of Incident:_____

Type of Incident (Select all the apply)

☐ No Notification of Participant Death
☐ Significant delay in initiating service(s)
☐ Inadequate/Incomplete Service(s) :_____
☐ Worker Consistently Late. _____ Number of times with _____
☐ Violation of Code of Ethics:_____
☐ Other:

Action/Resolution (Select all the apply)

☐ Duties clarified with provider and worker
☐ Request to change worker
☐ Changed Provider Agency
☐ SC Staff followed up with participant or their designee
☐ SC staff notified Supervisor
☐ Follow-up Action by Supervisor
☐ SC Staff notified provider. Person Contacted:_____

Comments:

SC Signature: _____ Date: _____

Follow-up done? ☐ Yes ☐ No: _____
Issue resolved? ☐ Yes ☐ No: _____
Describe Resolution:

Supervisor Signature: _____ Date:_____

Director Signature: _____ Date:_____

NORTHEAST MICHIGAN COMMUNITY SERVICE AGENCY
REGION 9 AREA AGENCY ON AGING
VENDOR VIEW/VENDOR BILLING ENROLLMENT

PLEASE PRINT

VENDOR NAME:
VENDOR ADDRESS:
CITY/STATE/ZIP:
CONTACT PERSON NAME:
CONTACT PERSON PHONE NUMBER:
CONTACT PERSON E-MAIL:

NEW VENDOR VIEW/ VENDOR BILLING USERS:

NAME:
E-MAIL ADDRESS:
PASSWORD:
O Vendor View Only O Vendor View and Vendor Billing

- **Passwords cannot be full first/last names, "password", start with a number or contain a special character.**

NAME:
E-MAIL ADDRESS:
PASSWORD:
O Vendor View Only O Vendor View and Vendor Billing

NAME:
E-MAIL ADDRESS:
PASSWORD:
O Vendor View Only O Vendor View and Vendor Billing

Use Additional Pages, if needed.

FOR VENDOR BILLING, THE FOLLOWING CERTIFICATION MUST BE COMPLETED AND SIGNED BY EACH PERSON SUBMITTING INVOICES.

NORTHEAST MICHIGAN COMMUNITY SERVICE AGENCY
REGION 9 AREA AGENCY ON AGING

PROVIDER CERTIFICATION

Provider Name: _____

Provider NPI or Tax ID Number: _____

By signing this statement, I, the provider representative, certify that I am responsible for the accuracy and completeness of all claims transmitted to MDHHS by NORTHEAST MICHIGAN COMMUNITY SERVICE AGENCY – REGION 9 AREA AGENCY ON AGING and their billing agent.

I acknowledge that my signature on this document to support submission of claims will indicate my organization's agreement to abide by the rules and regulations for all purposes related to Title XIX (Medicaid) reimbursement by the MDHHS, including any administrative, civil and/or criminal action(s) relating to my participation in the Medicaid program. A lack of my Waiver Agent's or billing agent representative's signature on claims made on my behalf shall not be used to avoid criminal and/or civil responsibility.

This document will be kept on file to certify expenditures submitted to NORTHEAST MICHIGAN COMMUNITY SERVICE AGENCY – REGION 9 AREA AGENCY ON AGING for reimbursement and for reference when bills are submitted.

NAME: _____ TITLE: _____
(PLEASE PRINT)

SIGNATURE: _____ DATE: _____

ADDENDUM B

HOME & COMMUNITY BASED SERVICES WAIVER FOR THE ELDERLY & DISABLED	NEMCSA USE ONLY
MINIMUM STANDARDS ASSURANCE	Begin Date: 10/01/2020 End Date: 09/30/2022

Any service purchased by NEMCSA must be in compliance with the Department of Health and Human Services and NEMCSA service definitions, unit definition, and minimum standards of operation.

As a Provider Agency for NEMCSA, _____

HEREBY ASSURES the persons involved in implementing the Subcontractor Agreement have read the minimum standards for each of the services for which service may be purchased by NEMCSA from the Provider Agency.

FURTHERMORE, the Provider Agency assures that it is completely in compliance with all standards for the following services and will maintain compliance with these standards throughout the term of this Agreement. (List all services for which the Provider Agency is proposing to make available for purchase by NEMCSA).

1. 6.
2. 7.
3. 8.
4. 9.
5. 10.

FURTHERMORE, the Provider Agency assures that it possesses insurance coverage as required by the Department of Health and Human Services in the Service Standards/Definitions, that **NEMCSA is listed as an additional insured under such insurance coverage, and that a Certificate indicating that NEMCSA is an additional insured under such insurance coverage is included as an appendix to this agreement. The Provider Agency understands that service purchasing cannot begin until such time as NEMCSA has in its possession such a Certificate of Insurance.**

This assurance is given in consideration of and for the purpose of obtaining Federal or State funds though a purchase of service arrangement with NEMCSA. The Provider agency recognizes and agrees that any approved financial assistance will be extended based on agreements made in this assurance and that NEMCSA shall have the right to seek enforcement of this assurance.

This assurance is binding on the Provider Agency, its successors, transferees, and assignees.

SIGNATURES

Signature of NEMCSA Representative	Signature of Provider Agency Representative
NEMCSA-AAA Director Title	Title
Date	Date