Valley Area Agency On Aging

MINIMUM OPERATING STANDARDS FOR DIRECT SERVICE PROVIDERS

HOME AND COMMUNITY-BASED SERVICES

October 1, 2024

TABLE OF CONTENTS

VALLEY AREA AGENCY ON AGING
Minimum Operating Standards for Direct Providers of Services

GENERAL OPERATING STANDARDS FOR DIRECT SERVICE PROVIDERS AND CONTRACTED DIRECT SERVICE PROVIDERS

Administering agencies of Valley Area Agency on Aging (VAAA) Services must comply with all general program requirements established by VAAA.

Required Program Components:

A. CONTRACTUAL AGREEMENT

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

B. COMPLIANCE WITH SERVICE AUTHORIZATIONS

Direct Service Providers funds paid by VAAA may only pay for those services that VAAA has authorized. Direct Service Providers must adhere to the service authorization to receive reimbursement of allowable expenses.

C. PERSON-CENTERED PLANNING PROCESS

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 providing services as VAAA has authorized as determined by a thorough assessment by a support coordinator of the needs and desires of the participants. Any changes to service delivery shall be based on the participant's request or newly observed needs by the aides in the home. VAAA must authorize all permanent changes to services.

D. CONTRIBUTIONS

1. A Direct Service Provider under contract with VAAA may not require monetary donations from participants for their services as a condition of participation.
2. The direct service provider must accept VAAA payments for services as payment in full for such services. Consistent with the Code of Federal Regulations, Chapter 42, Section 438.60, and other federal, state, or local regulations.
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

Direct Service Providers must have procedures to protect the confidentiality of information about participants. 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 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 conforms with the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act of 1996. 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

i. Direct Service Providers must have sufficient insurance to indemnify the loss of federal, state, and local resources due to casualty or fraud. Insurance coverage sufficient to reimburse program funders or VAAA 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 program funders. The following insurances are required for each direct service provider:

1. Worker's compensation
2. Unemployment
3. Property and theft coverage
4. Fidelity bonding (for persons handling cash)
5. No-fault vehicle insurance (for agency-owned vehicles)
6. General liability and hazard insurance (including facilities coverage)

ii. VAAA recommends the following insurances for additional agency protection:

1. Insurance to protect the direct service provider from claims against VAAA or direct service provider drivers and/or passengers
2. Professional liability (both individual and corporate)
3. Umbrella liability
4. Errors and Omission Insurance for Board members and officers
5. Special multi-peril
6. Reinsurance/Stop-loss insurance

G. VOLUNTEERS

Direct Service Providers utilizing volunteers must have written procedures governing the recruiting, training, and supervising of volunteers. Volunteers must receive a written position description, orientation, training, and yearly performance evaluations, if appropriate.

H. FAMILY MEMBERS AS SERVICE PROVIDERS

Waiver agencies may pay relatives of MI Choice participants to furnish services. This authorization excludes legally responsible individuals and legal guardians. The MI Choice participant must specify his/her preference for a relative to render services. The relative must meet the same provider standards as established for non-related caregivers. All waiver services furnished shall be included in the person-centered service plan and authorized by thesupport's coordinator. The supports coordinator must periodically evaluate the effectiveness of the relative in rendering the needed service. If the supports coordinator finds that the relative fails to meet established goals and outcomes or fails to render services as specified in the person-centered service plan, the supports coordinator must rescind the authorization of that relative to provide waiver services to the participant. When the supports coordinator finds the relative has failed to render services, payments must not be authorized.

I. CRIMINAL HISTORY REVIEW

Each direct provider of home-based services must conduct a criminal history review **annually** through the Michigan State Police for each paid staff or volunteer who will be entering a participant's residence. The waiver agency and direct provider shall have completed reference and criminal history checks before authorizing an employee or volunteer to furnish services in a participant's residence. The scope of the investigation is statewide.

Both waiver agencies and MDHHS conduct administrative monitoring reviews of providers annually to verify that mandatory criminal history checks have been conducted in compliance with operating standards. Waiver agencies must comply with additional criminal history reviews mandated by the State for home and community-based services providers.

Waiver agencies and providers must also check the MDHHS Sanctioned Providers List and Office of Inspector General (OIG) federal exclusion list **monthly** and must not contract with any providers or employ any individual to provide Home and Community Based services on this list for the duration of the sanction period until approved by MDHHS to resume providing services. The MDHHS Sanctioned Provider List is located on the MDHHS website and OIG can be found at https://oig.hhs.gov/exclusions/exclusions_list.asp.

J. STAFFING

Direct Service Providers 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. Direct Service Providers must demonstrate an organizational structure, including established lines of authority. Each direct service provider must identify a contact person with whom VAAA can discuss work orders and service delivery schedules or problems.

K. STAFF IDENTIFICATION

All 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.

L. ORIENTATION AND TRAINING PARTICIPATION

Direct Service Provider staff must receive an orientation training that includes, at a minimum:

i. Maintenance of records and files (as appropriate);
ii. Emergency procedures
iii. Assessment and observation skills; and
iv. Ethics, specifically;
    1. Acceptable work ethics
    2. Honoring the participant's dignity
    3. Respect of participant and their property
    4. Prevention of theft of the participant's belongings
    5. Fraud, Waste, and Abuse

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

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. Direct Service Provider staff must participate in relevant in-service training as appropriate and feasible. Some services have specific requirements for in-service training required by the program funder. When applicable, the funder's service standard stipulates the required in-service training topics. A copy of all

MDHHS or AASA services standards will be provided as applicable at the time the service is contracted.

M. CIVIL RIGHTS COMPLIANCE

Direct Service Providers must not discriminate against any VAAA 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.

N. NONDISCRIMINATION (SECTION 1557 OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT)

Section 1557 of the Patient Protection and Affordable Care Act (ACA) 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 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.

O. EQUAL EMPLOYMENT

Direct Service Providers must comply with equal employment opportunity principles in keeping with Executive Order 1979-4 and Civil Rights Compliance in state and federal contracts.

P. STANDARD PRECAUTIONS

Direct Service Providers must evaluate the occupational exposure of employees to blood or other potentially infectious materials that may result from the employee's performance of duties. Direct Service Providers must establish appropriate standard precautions based upon the potential exposure to blood or infectious materials. Direct Service Providers 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.

Q. DRUG-FREE WORKPLACE

VAAA prohibits the unlawful manufacture, distribution, dispensing, possession, or use of controlled substances in all direct service provider workplaces.

Direct Service Providers must operate in compliance with the Drug-Free Workplace Act of 1988.

R. AMERICANS WITH DISABILITIES ACT

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

S. RECORD RETENTION

Direct Service Providers must keep all records related to or generated from the provision of services to VAAA participants for not less than ten years unless otherwise specified.

T. COMPLIANCE WITH HOME AND COMMUNITY BASED SERVICES SETTINGS REQUIREMENTS

Direct Service Providers 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.

VAAA will use the following process to ensure compliance with this requirement:

1) VAAA will assess all applicable providers using the Home and Community Based Residential or Non-Residential Survey. The results of the surveys will be submitted electronically to funders as applicable for a determination of compliance with the requirements.
2) Funders will notify both VAAA and the Direct Service Provider regarding the provider's compliance based upon the completed survey tool that was submitted.
3) For providers who are non-compliant, the provider will have 90 days to correct all issues that cause the non-compliance.
4) Once the issues are corrected, the provider will notify VAAA and schedule another on-site survey.
5) VAAA will have 90 days to complete another on-site survey and submit the survey to the applicable funder for review.
6) If a provider does not contact VAAA within 90 days, VAAA 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, VAAA will suspend the provider from receiving new **MI Choice** participants until 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.

U. VENDOR VIEW COMMUNICATION

Vendor View is VAAA's primary communication portal. Direct Service Providers must send all notices and correspondences through Vendor View. Service authorizations, SC communications, and provider updates will be posted through the vendor view system. The Vendor View system provides a record of each communication, including date, time, and sender information. VAAA will use the Vendor View System for quality assurance for participant notification and service authorizations.

Each Direct Service Providers is required to utilize the Vendor View system as the primary source of communication. VAAA expects that the Vendor View system be checked at minimum twice daily to ensure all communication is received in a timely manner. In addition, VAAA must be notified in writing immediately of any staff who no longer needs access to the system, including those who have quit, were terminated, or no longer works in that capacity. Failure to notify VAAA immediately is considered a HIPAA violation and will be documented in the Direct providers of service file. Continued violations of HIPAA may result in probation and/or termination of contract. Services provided that are not authorized will not be paid.

V. DIRECT PURCHASE OF SERVICE MANDATORY NOTIFICATION REQUIREMENTS

Direct Service Providers shall adhere to the following mandatory notification requirements:

Participant health and safety issue: Must be reported within 24 hours of the provider's knowledge of the issue.

1) Participant Hospitalization
2) Participant Injury
3) Family member or other participant acquaintances conflicts that result in a health and safety issue for the participant
4) Deteriorating medical or functional status of the participant

Federally mandatory reporting issues: Immediate report to VAAA upon knowledge, signs or concerns. The provider will have additional reporting to Adult Protective Services.

1) Physical and Sexual Abuse
2) Neglect
3) Exploitation

Critical Incidents: Must be reported within 24 hours of the provider's knowledge of the issue.

1) Illegal activity in the home with potential to cause serious or major negative event
2) Theft
3) Verbal Abuse
4) Worker consuming drugs and or alcohol on the job
5) A suspicious or unexpected death that VAAA, or other entity, reports to law enforcement and that is related to providing services, supports, or caregiving.

Service provisions: Must be reported within 24 hours of provider's knowledge of the issue.

1) Non-service delivery with reason
2) Participant Hospitalized
3) Participant Institutionalized
4) Participant requested a change in day of service: prior vendor view authorization required for payment
5) Participant requested a permanent time change for the service

Providers who accept participants whose service plan identifies that a participant needs services on Holidays are expected to provide the service on the holiday as ordered.

W. APPROVAL OF PUBLICATION 42 CFR 438.104

All providers must submit to Valley Area Agency on Aging (VAAA) for approval any publications, documents, web pages, or other published materials that mention any VAAA programs prior to distribution. This is based on Regulation 42 CFR 438.104, which states:

438.104 Marketing activities.
(a) Definitions. As used in this section, the following terms have the indicated meanings:
Cold-call marketing means any unsolicited personal contact by the MCO, PIHP, PAHP, PCCM or
PCCM entity with a potential enrollee for the purpose of marketing as defined in this paragraph (a).
No cold calling to VAAA participants is allowed.

Marketing means any communication, from an MCO, PIHP, PAHP, PCCM or PCCM entity to

a Medicaid beneficiary who is not enrolled in that entity that can reasonably be interpreted as intended to influence the beneficiary to enroll in that particular MCO's, PIHP's, PAHP's, PCCM's or PCCM entity's Medicaid product, or either to not enroll in or to disenroll from another MCO's, PIHP's, PAHP's, PCCM's, or PCCM entity's Medicaid product. Marketing does not include communication to a Medicaid beneficiary from the issuer of a qualified health plan, as defined in 45 CFR 155.20, about the qualified health plan.

Marketing materials means materials that—

(i) Are produced in any medium, by or on behalf of an MCO, PIHP, PAHP, PCCM, or PCCM entity; and

(ii) Can reasonably be interpreted as intended to market the MCO, PIHP, PAHP, PCCM, or PCCM entity to potential enrollees.

MCO, PIHP, PAHP, PCCM or PCCM entity include any of the entity's employees, network providers, agents, or contractors.

Private insurance does not include a qualified health plan, as defined in 45 CFR 155.20.

(b) Contract requirements. Each contract with an MCO, PIHP, PAHP, PCCM, or PCCM entity must comply with the following requirements:

(1) Provide that the entity—

(i) Does not distribute any marketing materials without first obtaining State approval.

(ii) Distributes the materials to its entire service area, as indicated in the contract.

(iii) Complies with the information requirements of §438.10 to ensure that, before enrolling, the beneficiary receives from the entity or the State, the accurate oral and written information he or she needs to make an informed decision on whether to enroll.

(iv) Does not seek to influence enrollment in conjunction with the sale or offering of any private insurance.

(v) Does not, directly or indirectly, engage in door-to-door, telephone, email, texting, or other cold-call marketing activities.

(2) Specify the methods by which the entity ensures the State agency that marketing, including plans and materials, is accurate and does not mislead, confuse, or defraud the beneficiaries or the State agency. Statements that will be considered inaccurate, false, or misleading includes, but are not limited to, any assertion or statement (whether written or oral) that—

(i) The beneficiary must enroll in the MCO, PIHP, PAHP, PCCM or PCCM entity to obtain benefits or to not lose benefits; or

(ii) The MCO, PIHP, PAHP, PCCM or PCCM entity is endorsed by CMS, the Federal or State government, or similar entity.

(c) State agency review. In reviewing the marketing materials submitted by the entity, the State must consult with the Medical Care Advisory Committee established under §431.12 of

this chapter or an advisory committee with similar membership.

X. PROVIDER EXCLUSIONS

Each Direct Service Provider will be screened monthly through Provider Trust to verify the provider agency entity. VAAA will not contract with, or otherwise pay for any items or services furnished, directed, or prescribed by a provider agency that has been excluded from participation in federal health care programs. VAAA shall not authorize any provider who has been terminated or suspended from participation in the Michigan Medicaid program, Medicare, or from another state's Medicaid program, to service participants and shall deny payments to such providers for services provided. VAAA shall notify CMS and MDHHS when it terminates, suspends or declines a vendor from its network because of fraud, integrity, or quality. CMS and MDHHS shall be notified on a quarterly basis when a provider agency fail credentialing or re-credentialing because of a program integrity or Adverse Action reason and shall provide related and relevant information to CMS and MDHHS as required by CMS, MDHHS, or State or federal laws, rules, or regulations.

Y. PROBATION POLICY

Step 1 – All issues should first be attempted to be resolved between the supports coordinator/provider/participant (and any additional applicable staff person, i.e., billing)

Step 2 – If the problem is not resolved via Step 1, an Incident Report should be completed and given to the contract manager (or designee) and the appropriate supervisor if applicable.

Step 3 – Should five (5) or more Incident Reports be written regarding the same issue and agency within a 6-month period, a monitoring visit (Provider Audit) will be scheduled, and a Corrective Action Plan (also called a "work plan") will be requested. The Corrective Action Plan should: state the issue(s), request resolution(s), provide technical assistance (if applicable), and have a due date. A provider may be deemed an "at-risk" provider (See below for a description of an "at-risk" agency.)

Step 4 – The Corrective Action Plan will be reviewed and monitored for compliance by the Contracts Manager (or designee). The Contracts Manager may request information from the Supports Coordinators or other staff in order to gauge compliance. If the issue is not resolved within 30 days (or otherwise specified) the following actions will be taken:

a. Written notification will be sent to the provider stating compliance issues have not been resolved, and a second date of resolution will be given. No new clients will be given to the Provider.
b. If there is no resolution by the date listed in "A," the provider will be placed on a Probationary Status for a period of at least 90 days. Providers will be notified in writing of the length of the probationary period, the adverse actions, and any other requirements. During said probationary status:
    - New clients will not be given to the provider;
    - Monthly reporting may be required;
    - Current clients may be moved to another provider; and
    - Funding may be reduced to Subcontractor

c. If there is no resolution by the date listed in "B," the following actions may be taken:
   - Extension of the probationary period (extended if progress is being made and more time is needed, as determined by the Contract Manager and/or his/her supervisor).
   - Recommendation of termination of the provider's contract – must be approved by the President/ CEO prior to contract termination. All clients must have services placed with another provider prior to contract termination. The provider has the right to dispute the contract termination in writing within five (5) business days of receiving notification of contract termination. In the event of a dispute, the President/CEO has the final decision regarding the dissolution of contracts.

The OIG has the authority to exclude individuals and agencies from receiving Medicaid or Medicare funding. If a provider is excluded from receiving Medicaid or Medicare funded payments by the OIG, VAAA is prohibited from paying with funds for goods and services furnished by an excluded person or agency during the exclusion period.
To apply for reinstatement, an excluded individual or agency must send a written request or fax to the OIG at:

HHS, OIG, OI
Attn: Exclusions
P.O. Box 23871
Washington, DC 20026
Or
Fax: (202) 691-2298

Upon receipt of a request for reinstatement, if the individual is eligible to apply for reinstatement, OIG will mail Statement and Authorization forms that must be completed, notarized, and returned to the OIG via mail. This process generally requires up to 120 days to complete but can take longer. If reinstatement is denied, the excluded individual or agency is eligible to reapply after one (1) year.
A former OIG excluded provider may reapply to contract with VAAA after reinstatement from the OIG. VAAA's President/CEO will make the final decision to extend a provider contract to a reinstated provider. VAAA reserves the right to immediately deem a provider At-Risk and institute immediate probationary status or contract termination before initiating the steps included in this policy. At-Risk status may be immediately imposed for reasons including but not limited to:

- Substantiated concerns for participant's health, safety, and welfare;
- Failure to comply with mandatory reporting requirements;
- Failure to adhere to provider contract requirements;
- Fraud, Waste or Abuse;
- Office of Inspector General disciplinary actions;
- Licensing and Regulatory Affairs disciplinary actions
- Recurrent (related to timeliness/accuracy/consistency of billing) or serious financial issues;
- Issues of non-compliance with Federal, State or VAAA standards; and

Z. FALSE CLAIMS ACT

Under the Deficit Reduction Act, VAAA is required to provide employees, volunteers, contractors and members 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 VAAA programs for detecting and preventing fraud, waste, and abuse in Medicaid programs.
Requirements:
The policy is intended to cover the following Acts:

Federal False Claims Act
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
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;
- 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

The Federal False Claims Act includes a “qui tam,” or whistleblower provision to report misconduct involving false claims. The qui tam provision allows any private person (Qui Tam Relater) with actual knowledge of allegedly false claims to file a lawsuit on behalf of the United States government.

The federal government has the opportunity to intervene in the lawsuit and assume primary responsibility for prosecuting, dismissing, or settling the action. If the federal government decides to intervene, the private person (Qui Tam Relater) who initiated the action may be eligible for a portion of the proceeds of the action or settlement of the claim. If the federal government does not proceed with the action, the Qui Tam Relater 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 Qui Tam Relater 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.

Michigan Medicaid False Claims Act
Any person (Qui Tam Relater) may bring a civil action on behalf of the State of Michigan to recover losses that the State suffered from a person violating the Michigan Medicaid False Claims Act, and the Michigan Attorney General is to be notified and has an opportunity to appear and intervene in the

action brought on behalf of the State of Michigan. If the Michigan Attorney General intervenes, in addition to the person (Qui Tam Relater) receiving his or her expenses, costs, and reasonable attorney fees, the person may also receive a portion of the monetary proceeds resulting from the action or any settlement. If the Michigan Attorney General does not intervene, the Qui Tam Relater will receive a portion of the monetary proceeds.

Whistleblower Protection Laws

In addition to VAAA's Whistleblowing policy, both the federal and state laws protect individuals who investigate or report possible False Claims made by their employer against discharge or discrimination in employment because of such investigation. Employees who are discriminated against based on whistleblower activities 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

VAAA 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 employee education on fraud and abuse prevention, recognition and reporting
- Encourage and promote the reporting of fraud or abuse by employees and contractors

Types Of Fraud Prosecuted Under The 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

NOTICE/INFORMATION

VAAA prohibits the actions listed above, and any other action (or inaction) that results in fraud, waste, or abuse of public resources.

Please visit the following websites to review 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 VAAA 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
The Board of Directors, Chief Executive Officer, management, and supervisors are responsible for enforcing this policy. All employees, volunteers, contractors, and members will be given a copy of this policy and requested to sign an attestation of compliance. VAAA reserves the right to modify or amend this policy at any time as it may deem necessary.

AA. FRAUD, WASTE, AND ABUSE

Fraud - an intentional act of deception, misrepresentation, or concealment in order to gain something of value. The intent to deceive is high despite knowing an act is illegal.

- Forging a signature on a timesheet; or
- Billing for services that were not provided.

Waste - overutilization of services (not caused by criminally negligent actions) and the misuse of resources. The intent to deceive is low.

- Not providing services as requested by care plan;
- Withholding information may affect service authorization or continuation.

Abuse - excessive or improper use of services or actions that are inconsistent with acceptable business or medical practice. Abuse refers to incidents that, although not fraudulent, may directly or indirectly cause financial loss. The intent to deceive is in the middle.

- Unacceptable billing practices;
- Changing service authorizations to benefit a provider.

Help fight fraud, waste, and abuse by:

- Reporting suspicions of fraud, waste, and abuse to VAAA;
- Reviewing staff timesheets to verify there are no duplication of service times and that all hours being claimed were worked;
- Only billing VAAA for services that were provided by you or your staff **NOT** just billing what is authorized;
- Notifying VAAA within 24 hours of hospitalizations;

- Immediately notifying VAAA when you or your staff become aware of participant changes that could result in service decrease or termination, i.e., excess meals on wheels in home, additional family in the home, or medication dispenser equipment not being used.

Contact VAAA's Compliance Officer to report suspicions:
810-249-6549
fwa@valleyaaa.org

BB. USE OF RESTRAINTS, SECLUSION OR RESTRICTIVE INTERVENTIONS

Providers are prohibited from using seclusion or restrictive interventions in addition to using restraints. Qualified reviewers conduct Clinical Quality Assurance Reviews and home visits which include a discovery process to examine the use of restraints, seclusion or restrictive interventions by family or caregivers. Supports coordinators have the primary responsibility for identifying and addressing the use of restraints, seclusion or restrictive interventions.
An exception to restraints or restrictive intervention is bed rails or bed canes. If bed rails or bed canes are used, this must be based upon assessed need for the participant and documented in the person- centered service plan. If the participant resides in a provider-controlled setting, there must be an order from a licensed medical professional, and this must be kept on file in the participant's case record at the waiver agency. As per requirements in federal law and the Home and Community-Based Services Chapter in this Manual, the use of bed rails or bed canes must be reviewed on an annual basis to ensure they are still required. If no longer required, the bed rail or bed cane must be removed.

CC. HOME-BASED SERVICE PROVIDERS

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

Charging for Services

Direct Service Providers must not charge participants a fee to receive services.

Participant Assessments

Direct providers of home-based services must avoid duplicating assessments of individual participants to the maximum extent possible. Home-based Direct Service providers must accept assessments conducted by VAAA and initiate home-based services without having to conduct a separate assessment unless there is a legitimate reason to conduct the separate assessment. VAAA will 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.

Service Need Level

VAAA will classify each participant into a service need level based upon the participant's immediacy of need for the provision of services and the availability of informal support. Direct Service Providers 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. VAAA will 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.

1. Immediacy of need for the provision of services
    a. Immediate – the participant cannot be left alone

b. Urgent – the participant can be left alone for a short time (less than 12 hours)
c. Routine – the participant can be left alone for a day or two

2. Availability of Informal Supports
   1. No informal supports are available for the participant
   2. Informal supports are available for the participant
   3. The participant resides in a supervised residential setting

3. Grid of Service Need Levels (see below)

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.

Supervision of Direct-Care Workers

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

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 10 years.

In-Service Training

Staff of Direct Service Providers must receive in-service training at least twice each fiscal year. Direct Service 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. Direct Service Providers 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.

Reference and Criminal History Screening Checks

Direct Service Providers must require and thoroughly check references of paid staff that will enter participant homes. In addition, direct providers 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 Direct Service Provider must conduct the reference and criminal history screening checks before authorizing the employee to furnish services in a participant's home. Direct Service Providers must also check the Michigan Medicaid sanctioned provider list **monthly** to determine if anyone from their staff is on the list; these staff must be excluded from providing any services paid by Medicaid until the provider is approved to resume providing Medicaid services.

Additional Conditions and Qualifications

Direct Service Providers will assure employees or volunteers who enter and work within participant homes abide by the following additional conditions and qualifications:

- Direct Service providers must have procedures in place for obtaining participant signatures on the timesheets (or similar document) of direct care workers to verify the direct service worker provided the work ordered by the VAAA. Electronic Visit Verification systems may take the place of this requirement as long as the verification is available to VAAA. If providers are utilizing electronic visit verification systems, paper timesheets are not needed.
- Direct service workers are prohibited from smoking in participant's homes.
- Direct service workers must demonstrate the ability to communicate adequately and appropriately, both orally and in writing, with their employers and the participant 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.)
- 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. Direct service workers should engage with the participants while furnishing the services specified on the person-centered service plan.
- Direct service workers must not threaten or coerce participants in any way. Failure to meet this standard is grounds for immediate discharge.
- Direct Service Providers will inform direct service workers promptly of new service standards or any changes to current services standards.

DD. COMMUNITY-BASED SERVICE PROVIDERS

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

Adherence to Standards

Direct providers of community-based services must adhere to standards 1-3 of the home-based service provider standards.

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

Reference and Criminal History Checks

Direct Service Providers must require and thoroughly check references of paid staff that will enter participant homes. In addition, direct providers 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. VAAA and direct provider must conduct the reference and criminal history screening checks before authorizing the employee to furnish services in a participant's home. Direct Service Providers must also check the Michigan Medicaid sanctioned provider list **monthly** to determine if anyone from their staff is on the list; these providers must be excluded from providing any services paid by Medicaid until the provider is approved to resume providing Medicaid services.

EE. SELF-DETERMINED PROVIDERS

Participants choosing the self-determination option may directly manage service providers for the following home and community-based 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.

Supervision of Direct-Care Workers

The 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.

Use of a Fiscal Intermediary

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 service.

Reference and Criminal History Screening Checks

Each 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 and annually thereafter. Direct Service Providers must also check the Michigan Medicaid sanctioned provider list **monthly** to determine if anyone from their staff is on the list; these providers must be excluded from providing any services paid by Medicaid until the provider is approved to resume providing Medicaid services.

Provider Qualifications

Providers of self-determined services must minimally:

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

SPECIFIC OPERATING STANDARDS FOR MI CHOICE WAIVER SERVICE PROVIDERS

The following pages describe specific operating standards for MDHHS services. 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 services.

ADULT DAY HEALTH

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 shall not constitute a "full nutritional regimen," (i.e., three meals per day). Physical, occupational and speech therapies may be furnished as component parts of this service.
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 Direct Service Providers and Contracted Direct Service Providers”.

2. A referral from VAAA for a participant must replace any screening or assessment activities performed for other program participants. The adult day health service provider must accept copies of VAAA’s assessment and PCSP to eliminate duplicate assessment and service planning activities.
3. 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.

4. 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.

   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.

5. 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.

6. 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, then MI Choice would pay for the transportation to and from the Adult Day Health center separately.

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 Direct Service Providers 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. Participants must require regular supervision to live in their own homes or the homes of a relative. Participants with caregivers must require a substitute caregiver while their regular caregiver is at work, in need of respite, or otherwise unavailable. Participants must have difficulty performing activities of daily living (ADL) without assistance. Participants must be capable of leaving their residence with assistance to receive service. 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. HCPCS codes S5101 and S5102 are limited to one unit per day.

VALLEY AREA AGENCY ON AGING
Minimum Operating Standards for Direct Providers of Services

CHORE 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 landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.
HCPCS CODES	**S5120**, Chore services; per 15 minutes **S5121**, Chore services; per diem
UNITS	S5120 = 15 minutes S5121 = Per diem
SERVICE DELIVERY OPTIONS	❒ Traditional/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 Direct Service Providers and Contracted Direct Service Providers".
2. VAAA funds used to pay for chore services may include materials and disposable supplies used to complete the chore tasks.
3. Only properly licensed suppliers may provide pest control services.

Minimum Standards for Self-Determined Service Delivery

1. Each chosen provider must minimally comply with the General Operating Standards.

2. Providers must have previous relevant experience and/or training for the tasks specified and authorized in the PCSP.
3. VAAA must deem the chosen provider capable of performing the required tasks.

COMMUNITY HEALTH WORKER

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 participants with obtaining access to community resources. The CHW may also perform the duties of a supports broker, providing assistance throughout the planning and implementation of the PCSP, assist the participant in making informed decisions about what works best for the participant, and assists with access to housing and employment. The CHW may offer practical skills training to enable participants to remain independent, including information for recruiting, hiring and managing workers as well as effective communication and problem solving. The CHW may also coach participants in managing health conditions, assist with scheduling appointments, facilitate coordination between various providers, and assist participants with completion of applications for programs for which they may be eligible. 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.
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. Providers for the CHW service may be unlicensed but must be trained in the duties of the job.

COMMUNITY LIVING SUPPORTS

NAME	**Community Living Supports**
DEFINITION	Community Living Supports (CLS) 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.
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 Direct Service Providers."
2. Community Living Supports (CLS) include:
   a. Assisting, reminding, cueing, observing, guiding and training in:
      i. Activities of Daily Living (ADL) such as bathing, eating, dressing, personal hygiene, toileting, transferring, etc. *
      ii. Laundry and other household activities
      iii. Non-medical care (not requiring nurse or physician intervention) *
      iv. Meal preparation (does not include the cost of the meals themselves);
      v. Money management;
      vi. Shopping for food and other necessities of daily living
      vii. Social participation, relationship maintenance, and building community connections to reduce personal isolation;
      viii. Training and assistance on activities that promote community participation such as using public transportation, using libraries, or volunteer work; *
      ix. Transportation from the participant's residence to medical appointments, community activities,

among community activities, and from the community activities back to the participant's residence; and

x. Routine, seasonal, and heavy household care and maintenance
xi. Attendance at medical appointments

b. Participation in regular community activities incidental to meeting the individual's community living preferences.

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. Dementia care, 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. *
f. Observing and reporting to the supports coordinator any changes in the participant's condition and the home environment.

3. As applicable to the tasks being performed, the direct service provider 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 identified with an asterisk (*) 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 ensure 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 ensure each worker's confidence and competence in the performance of each task required.
   d. MDHHS strongly recommends each worker delivering CLS services complete a certified nursing assistant (CNA) training course, first aid, and CPR training.

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

   a. Direct Service Providers may not use VAAA funds to purchase or lease vehicles for providing transportation services to waiver participants.
   b. 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.
   c. 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.

d. Each provider must operate in compliance with P.A. 1 of 1985 regarding seat belt usage.
e. When transportation incidental to the provision of CLS is included, it shall not also be authorized as a separate waiver service for the participant.

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

7. Members of a participant's family may provide CLS to the participant. However, Direct Service Providers must not directly authorize MI Choice funds to pay for services furnished to a participant by that person's spouse.
8. Family members who provide CLS must meet the same standards as providers who are unrelated to the participant.
9. VAAA 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.
10. Each direct service provider who chooses to allow staff to assist participants with self-medication, 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.

11. 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 a participant 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 CLS Provided in Residential Settings:

1. CLS provided in a residential setting like assisted living, Adult Foster Care, or Homes for the Aged, 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. CLS does not include the costs associated with room and board.
3. Documentation in the participant's record must clearly identify the participant's need for additional supports and services not covered by licensure.
4. The PCSP must clearly identify the portion of the participant's supports and services covered by CLS.
5. 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.

Minimum Standards for Self-Determined Service Delivery:

1. When authorizing Community Living Supports for participants choosing the self-determination option, Direct Service Providers must comply with items 2, 5, 6, 7, 8, and 11 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.iv, 2.a.ii, 2.a.x, 2.a.i, 2.a.v, 2.a.vii, 2.a.xi,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.e (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, VAAA must not also authorize transportation as a separate waiver service for the participant.
5. CLS services cannot be provided in circumstances where there 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.

VALLEY AREA AGENCY ON AGING ADULT FOSTER CARE/ ASSISTED LIVING REQUIREMENTS

CLIENT RESPONSIBILITIES

- Basic Room & Board: Covers what the Adult Foster Care is responsible for under their licensure as a Michigan Licensed AFC. The following activities are presumed to be activities that fall under the AFC license:
    - Room rental
    - Supervision/cues/prompts/reminders/redirecting
    - Medication Management
    - Meals & Toiletries
    - Housekeeping
    - Laundry
    - Dressing/Undressing
    - Grooming
    - Personal Hygiene
    - Assist Resident with keeping appointments
    - Ensure the health, safety and well-being of residents

- The client is expected to pay privately for any additional or separate services that are not included.

STATE OF MICHIGAN RESPONSIBILITIES

- Personal Care supplemental payment for SSI Qualified AFC residents.

SSI Participants can keep $44/month for miscellaneous expenses (co-pays, snacks, haircuts, activities/hobbies, phone, clothes, gifts, bad habits, etc.).

VALLEY AREA AGENCY ON AGING RESPONSIBILITIES

- Assess the participant/resident to determine service needs.
- VAAA pays only for services that are over and above what an AFC is required to do under licensure and less any services paid for by the states personal care supplement.

- Services are calculated by minutes needed to complete activities. Once calculated VAAA will issue service authorization based on a per 15-minute unit bill rate.
- VAAA contracts with the AFC to provide the above and beyond services paid for by VAAA. It is expected that the AFC will employ additional staff as needed to provide the participant authorized services.
- VAAA must adjust the participants services based on improvement and declines this could affect the service authorization.

Services that VAAA may pay for include:

- Assistance with feeding
- Assistance with mobility
- Assistance with one-on-one bathing/toileting/grooming
- Assistance with transferring
- Assistance with re-positioning
- Assistance/Attendance at medical appointments outside of the home
- Assistance/Attendance at activities outside of the home
- Assistance/Intervention with repetitive Inappropriate/Disruptive Behaviors

Adult Foster Care Home Responsibilities

- The AFC must complete VAAA's provider contract meeting all the requirements prior to VAAA paying for any services. VAAA will determine the unit rate and number of units that they will pay toward the patients care.
- The AFC must keep a daily log documenting dates, times, duration and type of service provided for VAAA services as well as ADL's, what was done and not done, and why, behavior logs and medication logs be completed daily on our participants.
- All logs must be available for VAAA's Support Coordinators during reassessments. All logs should reflect what has been billed. VAAA will request logs on a random review to assure billing is accurate.
- The AFC cannot bill for services not provided. In the event the participant refuses or does not want assistance that VAAA authorized the AFC staff should notify VAAA's Supports Coordinators immediately to adjust the service authorization. (Examples: hospitalization, rehabilitation, visiting family/friends)
- Providers bill VAAA monthly for the approved service authorization. Billing for services not provided is Medicaid fraud. VAAA is required to report Medicaid fraud, waste and abuse.
- BCAL forms for AFC must be completed and updated yearly. These forms include BCAL-2318, BCAL-2319, BCAL-3265*, BCAL-3266*, BCAL-3267, BCAL-3483, BCAL-3485, BCAL-3947 (BCAL forms 3265 and 3266 must be updated yearly and a copy must be given to VAAA to file. BCAL-4607 for incident reports must be faxed to VAAA after each occurrence that requires reporting)
- The AFC must complete the monthly census form showing the AFC's open availability and fax to VAAA)
- The rent paid to the AFC is negotiated between the AFC home and participant. The agreed upon rental fee shall be written on the Resident Care Agreement and DOES NOT include the over and above services authorized by VAAA.

VALLEY AREA AGENCY ON AGING
Minimum Operating Standards for Direct Providers of Services

COMMUNITY TRANSPORTATION

NAME	Community Transportation
DEFINITION	Community Transportation (CT) service includes both non-emergency medical transportation and non-medical transportation. Community Transportation services are offered to enable waiver participants to access waiver services and other community services, activities, and resources as specified in the person-centered care plan. The Community Transportation service may also include expenses related to transportation and other 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. Direct Service Providers 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 Veterans' 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 who is not already a paid caregiver 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 Direct Service Providers."
5. Each provider must operate in compliance with P.A. 1 of 1985 regarding seat belt usage.

6. Additionally, delivery services for medical items, such as medical supplies or prescriptions, should be utilized before authorizing CT through the MI Choice program.
7. Direct Service Providers must use the SC modifier when billing for ancillary items that are only available for specific medically related travel. This includes meals, lodging, and waiting time for air ambulances and non-emergency vehicles.

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

8. 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 6 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. Direct Service Providers 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.

VALLEY AREA AGENCY ON AGING
Minimum Operating Standards for Direct Providers of Services

COUNSELING SERVICES

NAME	**Counseling Services**
DEFINITION	Counseling services seek to improve the participant's emotional and social well-being through the resolution of personal problems or through changes in a participant'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 Direct Service Providers and Contracted Direct Service Providers," and minimally, Section A of the "General Operating Standards for MI Choice Waiver Providers."
2. Direct Service Providers must only authorize counseling services for participants who are experiencing emotional distress or a diminished ability to function Individuals
   a. Family members, including children, spouses or other responsible relatives, may participate in the counseling session to address and resolve the problems experienced by the participant and to prevent future issues from arising.
3. Counseling services are typically provided on a short-term basis to address issues such as: adjusting to a disability, adjusting to community living, and maintaining or building family support for community living.
4. Counseling services are not intended to address long-term behavioral or mental health needs.

5. Providers receiving waiver funds for counseling services must provide the following service components, at a minimum, and maintain ongoing case files with each component:
   a. Psychosocial evaluation to determine appropriateness of counseling options.
   b. A treatment plan that states goals and objective, and projects the frequency and duration of service.
   c. Documentation of the needs assessed, and progress achieved at each session.
   d. Individual, family, and/or group counseling sessions.
   e. Home visits and on-site counseling.
   f. Case conferencing with a waiver supports coordinator at least once every six weeks with participant's release.

6. Persons providing counseling services must:
   a. Have a master's degree or higher in social work, psychology, psychiatric nursing, or counseling, or
   b. Have 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 or higher, AND
   c. Be licensed in the State of Michigan.
7. Each waiver agency will verify the licensure of each prospective counselor.

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.

ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS

NAME	**Environmental Accessibility Adaptations**
DEFINITION	Environmental Accessibility Adaptations (EAA) include 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.
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 Direct Service Providersand 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. 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.
5. The case record must contain documented evidence that the adaptation is the most cost-effective and reasonable **alternative** to meet the participant's need(s). 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. The participant must agree to the reasonable alternative prior to starting the modifications.
6. 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.
7. 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.

8. Under the EAA service, Direct Service Providers 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. VAAA 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.
9. VAAA 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.
10. 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.
11. VAAA 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.
12. VAAA must document approval of all EAA in the participant's record. This documentation must minimally include dates, tasks performed, materials used, and cost.

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

14. VAAA may not approve repairs, modifications, or adaptations to a condemned structure.

15. The PAHP must assure there is a signed contract or bid proposal with the builder or contractor prior to the start of an EAA.
16. 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.
17. All services must be provided in accordance with applicable state or local building codes.

18. 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
19. 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, Direct Service Providers 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, VAAA 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.

FISCAL INTERMEDIARY SERVICES

NAME	**Fiscal Intermediary Services**
DEFINITION	Fiscal Intermediary (FI) services assist participants participants who choose the self-determination option in acquiring and maintaining services defined in the participant's PCSP, controlling a participant's budget, and choosing staff authorized by VAAA. 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 VAAA, usually a monthly or bi-weekly fee.
SERVICE DELIVERY OPTIONS	☐ Traditional/Agency-Based ❒ Self-Determination

Minimum Standards for Self-Determined Service Delivery

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

2. 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.

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

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

    a. Function as the employer agency for participants directly employing workers to ensure 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.

5. VAAA and FI must abide by the principles set forth in the Self-Determination Technical Advisory "Choice Voucher System" available at:
https://www.michigan.gov/-/media/Project/Websites/mdhhs/Folder4/Folder7/Folder3/Folder107/Folder2/Folder207/Folder1/Folder307/MI_Health_Link_Self_Determination_Implementation_Technical_Advisory_v1_2015.pdf?rev=0dae4426c5c543fb84a7fc78dea4c2df

6. 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 four basic areas of performance outlined 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

GOODS AND SERVICES

NAME	**Goods and Services**
DEFINITION	Goods and Services are services, equipment, or supplies not otherwise provided 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. Direct Service Providers 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, VAAA must assure the item purchased meets the service standards. VAAA may choose to open a business account with a retail store for such purchases. VAAA must maintain the original receipts and maintain accurate systems of accounting to verify the specific participant who received the purchased item.

3. Each item or service specified in the PCSP 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 items or services, or they are not available through another source.

4. Goods and Services are only approved by CMS for participants choosing the self- determination option.
5. 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.
6. Self-directed Goods and Services are purchased from the participant-directed budget.

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.

HOME DELIVERED MEALS

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 recommended dietary allowance (RDA) for the age group as established by the Food and Nutritional Board of the National Research Council of the National Academy of Sciences. Allowances must be made in HDMs for specialized or therapeutic diets as indicated in the participant's PCSP. A HDM 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 Services is purchasing home delivered or congregate meals. Direct Service Providers 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 Direct Service Providers 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 an adult living in the same residence or in the vicinity who is able and willing to prepare all meals.
   c. The participant does not have a paid caregiver that is able and willing to prepare meals for the participant.

d. 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", and the meals will not jeopardize the participant's health.
e. The participant must be able to feed him or herself.
f. 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 integrate 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, VAAA 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 dietary reference intake (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. VAAA 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 support's 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 VAAA.

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. 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.

4. Each meal served by the provider must meet the current U.S. Department of Agriculture Dietary Guidelines for Americans (DGA) 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.

5. 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.

6. 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.

7. 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.
8. 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

9. 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.

10. 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.

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

12. 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 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 mealtimes, the case record must clearly document the need for a home delivered meal.

NAME	**Nursing Services**
DEFINITION	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

NURSING SERVICES

Minimum Standards for Traditional Service Delivery

1. Each direct service provider must have written policies and procedures compatible with the "General Operating Standards for Direct Service Providers 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 ensure 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 ensure 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, Direct Service Providersmust 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.

PERSONAL EMERGENCY RESPONSE SYSTEM

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. Installation,upkeep and maintenance of devices and systems are also provided.
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 Direct Service Providersand 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 24 hours per day, 365 days per year.
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 ensure current and continued participation.
9. The provider will ensure 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. Direct Service Providers 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, VAAA 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. Direct Service Providers 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.

PRIVATE DUTY NURSING/ RESPIRATORY CARE

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 skilled 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. RC may be provided by a licensed respiratory therapist to a participant who is ventilator dependent. To be eligible for PDN/RC services, VAAA 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 backup in the event of an absence of providers. The backup 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-level positive airway pressure 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;

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 assessments, judgments, or interventions (as described in III below) as a result of a substantiated medical condition directly related to the physical disorder.

Definitions of Medical Criteria II:
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 progress notes.

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

Definitions of Medical Criteria III:
1. "Continuous" means at least once every three 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.

2. Equipment needs alone do not create the need for skilled nursing services.

3. "Skilled" means assessments, judgments, interventions, and evaluations of interventions requiring the education, training, and experience of a licensed nurse or respiratory therapist. Skilled 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 prn injections that are required at least once per month (insulin administration is not considered a skilled 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 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 Direct Service Providersand 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, VAAA 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. VAAA is responsible for assuring there is a physician order for the PDN services authorized. The physician may issue this order directly to the provider furnishing PDN/RC services. However, VAAA is responsible for assuring the PDN/RC provider has a copy of these orders and delivers PDN/RC services according to the orders.
9. VAAA 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, Direct Service Providersmust 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 VAAA and provider agency to ensure services are delivered according to that order. Orders should be updated on an annual basis unless the order states otherwise due to ongoing medical need that is unlikely to improve over time.

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

5. VAAA 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. Direct Service Providers 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 PCSP 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.

11. Providers of PDN/RC must be licensed by the State of Michigan.

VALLEY AREA AGENCY ON AGING
Minimum Operating Standards for Direct Providers of Services

RESPITE (PROVIDED IN THE PARTICIPANT'S HOME OR IN THE HOME OF ANOTHER)

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 Direct Service Providersand 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 VAAA 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, VAAA 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. There is a 30-days-per-calendar-year limit on respite services provided outside the home. Respite services cannot be scheduled on a daily basis, except for longer-term stays at an out-of-home respite facility. Respite should be used on an intermittent basis to provide scheduled relief of informal caregivers

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

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

12. VAAA must not authorize respite services to relieve a caregiver that receives waiver funds to provide another service to the waiver participant. For example, if VAAA 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, VAAA must not also authorize additional hours of respite to relieve that niece of her caregiver duties. Rather, VAAA 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, Direct Service Providersmust 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, Direct Service Providers 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. Direct Service Providers cannot authorize respite services on a continual daily basis. Direct Service Providersmay 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. VAAA must not authorize waiver funds to pay for respite services provided by the participant's usual caregiver.

RESPITE (PROVIDED OUTSIDE OF THE HOME)

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 Direct Service Providersand 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 VAAA 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, VAAA 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, Direct Service Providersshould 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, VAAA 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. Direct Service Providerscannot authorize respite services on a continual daily basis. Direct Service Providersmay 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. VAAA must not authorize waiver funds to pay for respite services provided by the participant's usual caregiver.

SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES

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 includes 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. All items must be specified in the PCSP. 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. Direct Service Providers 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, VAAA must ensure the item purchased meets the service standards. VAAA may choose to open a business account with a retail store for such purchases. VAAA 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 Direct Service Providersand Contracted Direct Service Providers," and minimally, Section B of the "General Operating Standards for MI Choice Waiver Providers."
4. VAAA and/or direct service provider must pursue payment by Medicare, Medicaid state plan, or other entities, as applicable before VAAA authorizes MI Choice payment.
5. VAAA must document the medical or remedial benefit the equipment or supply provides to the participant in the participant's case record.

6. Where feasible, VAAA or direct service provider must seek affirmation of the need for the item provided from the participant's physician.
7. VAAA 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, VAAA, 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. VAAA 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. VAAA must not authorize MI Choice payment for herbal remedies or other over-the- counter medications for uses not authorized by the FDA.

VALLEY AREA AGENCY ON AGING
Minimum Operating Standards for Direct Providers of Services

SUPPORTS COORDINATION

NAME	**Supports Coordination**
DEFINITION	Supports Coordination is provided to ensure the provision of supports and services required 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 welfare 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 Direct Service Providersand 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. Ensure the participant meets the LOCD 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 VAAA'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 VAAA 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 under the Transition Services benefit.

TRAINING

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 Direct Service Providers 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. VAAA must identify the training needs in the comprehensive assessment or in a professional evaluation and include them in the PCSP. VAAA must provide a description of these needs to the direct service provider.

4. VAAA 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.

VALLEY AREA AGENCY ON AGING
Minimum Operating Standards for Direct Providers of 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.
OIG	Office of Inspector General
PAHP	Pre-paid Ambulatory Health Plan, an agency that administers the Services for MDHHS.
Participant	A person receiving services from a Direct Service Provider .

Acronym or Term	Definition
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
RC	Respiratory Care
Waiver Agency	An entity, under contract with MDHHS to administer the MI Choice program in a specific PSA.