4.1.A. 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. All Adult Day Health providers must comply with the federal Home and Community Based Settings Final Rule. Requirements are described in the Home and Community Based Services chapter of this Manual.

Requirements	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. Each program must maintain comprehensive and complete files that include, at a minimum:
	
	▪ Details of the participant's referral to the adult day health program,
	▪ Intake records,
	▪ A copy of the MI Choice assessment (and reassessments),
	▪ A copy of the MI Choice PCSP,
	▪ Listing of participant contacts and attendance,
	▪ Progress notes in response to observations (at least monthly),
	▪ Notation of all medications taken on premises, including:
	  ➢ The medication;
	  ➢ The dosage;
	  ➢ The date and time of administration;
	  ➢ The initials of the staff person assisting with administration; and
	  ➢ Comments
	▪ Notation of basic and optional services provided to the participant,
	▪ Notation of all releases of information about the participant, and
	▪ A signed release of information form.
	
	Each program must provide directly, or arrange for, the provision of the following services. If the program arranges for provision of any service at a place other than program-operated facilities, a written agreement specifying supervision requirements and responsibilities must be in place. For MI Choice participants, the waiver agency must provide supports coordination.
	
	▪ Transportation.
	▪ Personal Care.
	▪ 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 8-14 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. ▪ 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. 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. ▪ Rehabilitative: Physical, occupational, speech, and hearing therapies provided by licensed professionals under order from a physician. ▪ Medical Support: Laboratory, x-ray, or pharmaceutical services provided by licensed professionals under order from a physician. ▪ Services within the scope of the Nursing Practice Act (PA 368 of 1978). ▪ Dental: Under the direction of a dentist. ▪ Podiatric: Provided or arranged for under the direction of a physician. ▪ Ophthalmologic: Provided or arranged for under the direction of an ophthalmologist. ▪ Health counseling. ▪ Shopping assistance/escort. 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. 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: ▪ 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. ▪ All paid drivers must be trained to cope with medical emergencies unless expressly prohibited by a labor contract. ▪ Each program must operate in compliance with PA 1 of 1985 regarding seat belt usage. A referral from a waiver agency for a MI Choice participant must replace any screening or assessment activities performed for other program participants. The adult day health service provider must accept copies of the MI Choice assessment and PCSP to eliminate duplicate assessment and service planning activities. 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: ▪ Written consent from the participant or participant's representative to assist in taking medications. ▪ Verification of the participant's medication regimen, including the prescriptions and dosages. ▪ 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. ▪ Procedures for medication set-up. ▪ Secure storage of medications belonging to, and brought in by, participants. ▪ Disposal of unused medications for participants that no longer participate in the program. ▪ Instructions for entering medication information in participant files, including times and frequency of assistance. 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 10 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 the other individual or organization. Staff must have basic first-aid training as well as other training as described in the Providers Section of this chapter. 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 Cardiopulmonary Resuscitation (CPR), present at all times when participants are at the program site. 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. The provider must maintain all equipment and furnishings used during program activities or by program participants in safe and functional condition. Each day care center must have the following furnishings: ▪ At least one straight back or sturdy folding chair for each participant and staff person. ▪ Lounge chairs or day beds as needed for naps and rest periods. ▪ Storage space for participants' personal belongings. ▪ Tables for both ambulatory and non-ambulatory participants. ▪ A telephone accessible to all participants. ▪ Special equipment as needed to assist persons with disabilities.

	Each day care center must document that it is in compliance with: ▪ Barrier-free design specifications of Michigan and local building codes. ▪ Fire safety standards. ▪ Applicable Michigan and local public health codes.
Limitations	Participants cannot receive Community Living Supports (CLS) while at the Adult Day Health center. Payment for Adult Day Health services includes all services provided while at the center. CLS may be used in conjunction with Adult Day Health services but cannot be provided at the exact same time. 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. HCPCS codes S5101 and S5102 are limited to one unit per day.

4.1.B. 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.
Requirements	Waiver funds used to pay for chore services may include materials and disposable supplies used to complete the chore tasks. The waiver agency may also use waiver funds to purchase or rent the equipment or tools used to perform chore tasks for waiver participants. Only properly licensed suppliers may provide pest control services.

4.1.C. 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.
Requirements	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. The CHW visits the participant at home within three 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. 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. 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. 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. 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. Providers for the CHW service may be unlicensed but must be trained in the duties of the job.

4.1.D. COMMUNITY LIVING SUPPORTS

Definition	Community Living Supports (CLS) facilitate an individual's independence and promote participation in the community. CLS can be provided in the participant's residence or in community settings. CLS includes assistance to enable 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 ongoing 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.

Requirements	CLS includes: ▪ Assisting, reminding, cueing, observing, guiding and/or training in: ➢ Activities of Daily Living (ADL) such as bathing, eating, dressing, personal hygiene, toileting, transferring, etc. ***** ➢ Laundry and other household activities ➢ Non-medical care (not requiring nurse or physician intervention) * ➢ Meal preparation (does not include the cost of the meals themselves); ➢ Money management; ➢ Shopping for food and other necessities of daily living; ➢ Social participation, relationship maintenance, and building community connections to reduce personal isolation; ➢ Training and assistance on activities that promote community participation such as using public transportation, using libraries, or volunteer work; * ➢ 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 ➢ Routine, seasonal, and heavy household care and maintenance ➢ Attendance at medical appointments ➢ Participation in regular community activities incidental to meeting the individual's community living preferences. ▪ Reminding, cueing, observing or monitoring of medication administration.***** ▪ Dementia care including, but not limited to, redirection, reminding, modeling, socialization activities, and activities that assist the participant as identified in the individual's PCSP.***** ▪ Staff assistance with preserving the health and safety of the participant in order that he/she may reside and be supported in the most integrated independent community setting.***** ▪ Observing and reporting any change in the participant's condition and the home environment to the supports coordinator.***** 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. When the CLS services provided to the participant include tasks identified with an asterisk (*****) above, the direct service providers furnishing CLS must also: ▪ Be supervised by a RN licensed to practice nursing in Michigan. 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.

	▪ 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. ▪ 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. ▪ MDHHS strongly recommends each worker delivering CLS services complete a certified nursing assistant (CNA) training course, first aid, and CPR training. When the CLS services provided to the participant include transportation, the following standards apply: ▪ Waiver agencies may not use waiver funds to purchase or lease vehicles for providing transportation services to waiver participants. ▪ 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. ▪ 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. ▪ Each provider must operate in compliance with PA 1 of 1985 regarding seat belt usage. ▪ When transportation incidental to the provision of CLS is included, it shall not also be authorized as a separate waiver service for the participant. Individuals providing CLS must be at least 18 years old, and able to communicate effectively both orally and in writing and follow instructions. Members of a participant's family may provide CLS to the participant. However, waiver agencies must not directly authorize MI Choice funds to pay for services furnished to a participant by that person's spouse. Family members who provide CLS must meet the same standards as providers who are not related to the participant. The waiver agency or provider agency must train each worker to perform properly each task required for each participant the worker serves before delivering the service to that participant. The supervisor must ensure that each worker competently and confidently performs every task assigned for each participant served.

	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: ▪ 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. ▪ Verification of prescription medications and their dosages. The participant must maintain all medications in their original, labeled containers. ▪ Instructions for entering medication information in participant files. ▪ 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. CLS providers may only administer medications in compliance with Michigan Administrative Rule 330.7158: ▪ 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. ▪ A provider must ensure that medication use conforms to federal standards and the standards of the medical community. ▪ A provider must not use medication as punishment, for the convenience of the staff, or as a substitute for other appropriate treatment. ▪ A provider must review the administration of a psychotropic medication periodically as set forth in the participant's PCSP and based upon the participant's clinical status. ▪ If an 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. ▪ A provider must record the administration of all medication in participant's clinical record. ▪ 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. 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. CLS does not include the costs associated with room and board. Documentation in the participant's record must clearly identify the participant's need for additional supports and services not covered by licensure. The PCSP must clearly identify the portion of the participant's supports and services covered by CLS. Homemaking tasks incidental to the provision of assistance with ADL may also be included in CLS but must not replace usual and customary homemaking tasks required by licensure. When CLS services are provided to the participant under a self-determination arrangement, 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. These service needs differ in scope, nature, supervision arrangements, or provider type (including provider training and qualifications) from services available in the State Plan. The differences between the waiver coverage and the State Plan are that the provider qualifications and training requirements are more stringent for CLS tasks as provided under the waiver than the requirements for these types of services under the State Plan.
Limitations	CLS does not include the costs associated with room and board. When transportation incidental to the provision of CLS is included, the waiver agency must not also authorize transportation as a separate waiver service for the participant. CLS excludes nursing and skilled therapy services. 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: ▪ All informal supports must agree to provide the uncompensated (informal) services and supports to the participant as specified in the PCSP. Specifically, the record must show the following: ➢ All persons providing informal services and supports included on the PCSP 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. ➢ 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. ➢ 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. 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.

4.1.E. 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 service 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.
Requirements	Waiver agencies will ensure MI Choice participants have access to community transportation as needed to obtain medical services. Utilization of family, friends, or community agencies who provide transportation services without charge must be explored before MI Choice will authorize community transportation. Community transportation services include, but are not limited to, transportation to obtain the following medical services: ▪ Chronic and ongoing treatment; ▪ Prescriptions; ▪ Medical supplies and devices; ▪ One-time, occasional and ongoing visits for medical care; and ▪ Services received at a Veterans' Affairs hospital. Travel expenses related to the provision of community transportation include: ▪ 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; ▪ Mileage reimbursement for individuals or volunteers with a valid driver's license utilizing personal vehicles to transport the MI Choice participant; ▪ The cost of meals and lodging en route to and from medical care, and while receiving medical care; ▪ The cost of an attendant to accompany the MI Choice participant, if necessary; ▪ The cost of the attendant's transportation, meals, and lodging when transporting to or from medical care; and ▪ 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. Delivery services for medical items, such as medical supplies or prescriptions, should be utilized before authorizing community transportation services through the MI Choice program. When authorizing CT, waiver agencies are to authorize the least expensive available means suitable to the participant's needs. Waiver agencies may only authorize CT to provide transportation assistance to the participant. The participant must travel away from home to other locations within the community. CT does not include reimbursement for caregivers of the participant to run errands or otherwise travel on behalf of the participant. Each provider must operate in compliance with PA 1 of 1985 regarding seat belt usage unless the provider is a volunteer driver only seeking mileage reimbursement. Additionally, delivery services for medical items, such as medical supplies or prescriptions, should be utilized before authorizing CT through the MI Choice program.

	Waiver agencies must use the SC modifier when billing for ancillary items that are only available for specific medically-related travel. This includes meals (A0190, A0210), lodging (A0180, A0200), and waiting time for air ambulances and non-emergency vehicles (T2007). Waiver agencies may utilize a process to prior authorize requests for the following: ▪ All outstate travel that is non-borderland for medical treatment. ▪ Overnight stays if within 50 miles one-way from the participant's home for medical treatment. ▪ Overnight stays beyond five nights, including meals and lodging, when traveling for medical treatment. ▪ An attendant in addition to the driver of a wheelchair lift/medivan vehicle. ▪ Mileage and meal expenses for daily long-distance trips for medical treatment.
Limitations	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. Waiver agencies must not authorize MI Choice CT services to reimburse caregivers (paid or informal) to run errands for participants when the participant does not accompany the driver in the vehicle. The purpose of the CT service is to enable MI Choice participants to gain access to medical services and community activities/outings. Reimbursement for CT **DOES NOT** include the following: ▪ Waiting time, unless for an air ambulance or non-emergency vehicle. ➢ 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.). ▪ Transportation for medical services that have already been provided. ▪ 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. ▪ 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. 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. 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.

4.1.F. Counseling

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.
Requirements	Counseling services must be directed to participants who are experiencing emotional distress or a diminished ability to function. 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. 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. Counseling services are not intended to address long-term behavioral or mental health needs. Providers receiving waiver funds for counseling services must provide the following service components, at a minimum: ▪ Psychosocial evaluation to determine appropriateness of counseling options. ▪ Treatment plan that states goals and objectives, and projects the frequency and duration of service. ▪ Individual, family, and/or group counseling sessions. ▪ Home visits and on-site counseling. ▪ Case conferencing with a waiver supports coordinator at least once every six weeks with participant's release. Persons providing counseling services must: ▪ Have a master's degree or higher in social work, psychology, psychiatric nursing, or counseling, or ▪ 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 ▪ Be licensed in the State of Michigan.

4.1.G. Environmental Accessibility Adaptations

Definition	Environmental Accessibility Adaptations (EAA) include physical adaptations to the home required by the participant's person-centered service plan 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.
Requirements	Adaptations may include: ▪ Installation of ramps and grab bars; ▪ Widening of doorways; ▪ Modification of bathroom facilities; ▪ Modification of kitchen facilities;

	▪ Installation of specialized electrical and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the participant; and ▪ Environmental control devices that replace the need for paid staff and increase the participant's ability to live independently, such as automatic door openers. 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. 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. 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. The waiver agency must ensure there is a signed contract or bid proposal with the licensed builder or contractor prior to the start of an environmental adaptation. It is the responsibility of the waiver agency to work with the participant and the licensed builder or contractor to ensure the work is completed as outlined in the contract or bid proposal. The waiver agency must document approval of all EAA in the participant's record. This documentation must minimally include dates, tasks performed, materials used, and cost. All services must be provided in accordance with applicable state or local building codes. The existing structure must have the capability to accept and support the proposed changes. 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. Under the EAA service, waiver agencies may use MI Choice funds to purchase materials and labor used to complete the modifications to prevent or remedy a sub-standard condition or safety hazard. The direct service provider must provide equipment or tools needed to perform modifications or adaptations unless another source can provide the tools or equipment at a lower cost or free of charge and the provider agrees to use such equipment or tools. The waiver agency may purchase supplies for the modification or adaptation, such as grab bars, lumber, or plumbing supplies, and provide them to the direct service provider at their discretion. The participant, with the direct assistance of the waiver agency's 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. 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. The participant's case record must include

	evidence of efforts to apply for alternative funding sources and the acceptances or denials of these funding sources. Adaptations may be made to rental properties when the lease or rental agreement does not indicate that 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 waiver agency must specify any requirements for restoration of the property to its original condition if the occupant moves. Providers of EAA must be licensed in the State of Michigan.
Limitations	Excluded are those adaptations or improvements to the home that: ▪ Are of general utility. ▪ Are considered to be standard housing obligations of the participant or homeowner. ▪ Are not of direct medical or remedial benefit. Examples of exclusions include, but are not limited to: ▪ Carpeting ▪ Roof repair ▪ Sidewalks and driveways ▪ Heating ▪ Central air conditioning (except under exceptions noted in the service definition) ▪ Garages and raised garage doors ▪ Storage and organizers ▪ Hot tubs, whirlpool tubs, and swimming pools ▪ Landscaping ▪ General home repairs MI Choice 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 ensure the home will meet basic needs, such as having a ground floor bath or bedroom if the participant has mobility limitations. MI Choice funds may be authorized to assist with the adaptations noted above (e.g., ramps, grab bars, widening doorways, bathroom modifications, etc.) for a home recently purchased. If modifications are needed to a home under construction that require special adaptation to the plan (e.g., roll-in shower), the MI Choice program may be used to fund the difference between the standard fixture and the modification required to accommodate the participant's need. 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. Environmental adaptations shall exclude costs for improvements exclusively required to meet applicable state or local building codes. The existing structure must have the capability to accept and support the proposed changes.

4.1.H. Fiscal Intermediary

Definition	Fiscal Intermediary (FI) services assist participants who choose the self-determination option in acquiring and maintaining services defined in the participant's person-centered service plan, controlling a participant's budget, and choosing staff authorized by the waiver agency. The Fiscal Intermediary helps a participant manage and distribute funds contained in an individual budget. Funds are used to purchase waiver goods and services authorized in the participant's person-centered service plan. 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 ensuring 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 reviews, and assisting the participant to understand billing and documentation requirements.
Requirements	Each FI must be bonded and insured. The insured amount must exceed the total budgetary amount the FI is responsible for administering. 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. Each FI must demonstrate competence in managing budgets and performing other functions and responsibilities of a fiscal intermediary. Each FI will provide four basic areas of performance: ▪ Function as the employer agency for participants directly employing workers to ensure compliance with payroll tax and insurance requirements; ▪ 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; ▪ 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 ▪ Offer supportive services to enable participants to self-determine and direct the services and supports they need. The waiver agency and FI must abide by the principles set forth in the Self-Determination Technical Advisory "Choice Voucher System" available in the Directory Appendix. 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	FI services are only available to those participants choosing the self-determination option for service delivery. Providers of other covered services to the participant, family, or guardians of the participant may not provide FI services to the participant.

4.1.I. Goods and Services

Definition	Goods and Services are services, equipment or supplies not otherwise provided through either the MI Choice Waiver or the State Plan that address an identified need in the person-centered service plan (including improving and maintaining the participant's opportunities for full membership in the community) and meet the following requirements.
Requirements	Each item or service specified in the PCSP must meet the following requirements: ▪ Decrease the need for other Medicaid services. ▪ Promote inclusion in the community. ▪ Increase the participant's safety in the home environment. ▪ The participant does not have the funds to purchase them or they are not available through another source. Goods and Services are only approved by CMS for participants choosing the self-determination option. Self-directed Goods and Services are purchased from the participant-directed budget. Experimental or prohibited treatments are excluded. Goods and Services must be documented in the person-centered service plan.
Limitations	This service is only available to those participants choosing self-determination. This service excludes experimental or prohibited treatments.

4.1.J. 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 person-centered service plan. A HDM cannot constitute a full nutritional regimen.
Requirements	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: ▪ The participant must be unable to consistently obtain food or prepare complete meals. ▪ The participant does not have an adult living at the same residence or in the vicinity who is able and willing to prepare all meals. ▪ The participant does not have a paid caregiver who is able and willing to prepare meals for the participant.

	▪ The provider can appropriately meet the participant's special dietary needs, and the meals available will not jeopardize the participant's health. ▪ The participant must be able to feed himself/herself. ▪ The participant must agree to be home when meals are delivered, or contact the program when an absence is unavoidable. Federal regulations prohibit the MI Choice program from providing three meals per day to waiver participants. Providers must vary the level of meal service for an individual in response to varying availability of help from allies and formal caregivers, and changes in the participant's status or condition. When MI Choice provides home delivered meals less than seven days per week, the waiver agency must identify and document in the case record the usual source of all meals for the participant that are not provided by the program. HDM providers and waiver agencies must follow the home delivered meals guidelines provided in the Directory Appendix. 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. 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. Key recommendations from the United States Department of Agriculture (USDA) Dietary Guidelines for Americans (DGA) should be considered when planning meals 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. 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. 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. The provider may offer liquid meals to participants when ordered by a physician. The regional dietitian must approve all liquid meals products used by the provider. The provider or supports coordinator must provide instruction to the participant, the participant's caregiver, and participant's family in the proper care and handling of liquid meals. The waiver agency and provider must meet the following requirements when liquid meals are the sole source of nutrition: ▪ Diet orders must include participant weight and specify the required nutritional content of the liquid meals. ▪ The supports coordinator must ensure the participant's physician renews the diet orders every three months, and

	▪ The MI Choice RN supports coordinator and participant must develop the PCSP for participant receiving liquid meals in consultation with the participant's physician. The provider may supply liquid nutritional supplements ordered by a supports coordinator where feasible and appropriate. When liquid nutrition supplements a participant's diet, the supports coordinator must ensure the physician renews the order for liquid nutritional supplements every six months. However, liquid nutritional supplements are classified as a specialized medical supply for purposes of the MI Choice program and must be billed accordingly. 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. 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: ▪ 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; ▪ 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. ▪ MI Choice participants may receive two emergency meals. ▪ Back-up plan for food preparation if usual kitchen facility is unavailable; ▪ 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; ▪ Communications system to alert congregate and home-delivered meals participants of changes in meal site/delivery; ▪ The plan shall cover all the sites and participants for each provider, including sub-contractors of the provider. A record of the menu actually served each day shall be maintained for each fiscal year's operation. 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 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. Complaints from participants should be referred to the provider that hosts the site or manages the HDMs. Each provider shall have a written procedure for handling complaints. The provider and waiver agency must develop a plan for what type of complaints need to be referred to the waiver agency. 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: ▪ Definition of a verbal or physical threat; ▪ How a report should be made/who investigates the report; ▪ What actions should be taken by the assessor or driver if they are threatened; ▪ What warnings should be given to the participant; ▪ What actions should be taken for repeated behaviors; ▪ What information gets recorded in the chart; and ▪ Situations requiring multiple staff/volunteers.
Limitations	The meals authorized under this service must not constitute a full nutritional regimen. Providers must not solicit donations from waiver participants. Providers must not use waiver funds to purchase dietary supplements such as vitamins and minerals. When the participant has informal supports or paid caregivers available during meal times, the case record must clearly document the need for a home delivered meal.

4.1.K. 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. These services are provided by a

	registered nurse (RN) or a licensed practical nurse (LPN) under the direct supervision of an RN. Nursing Services are for participants who require more periodic or intermittent nursing than available through the State Plan or third party 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.
Requirements	When the participant's condition is unstable, could easily deteriorate, or significantly changes, 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 professional to prevent additional decline, illness, or injury to the participant. The supports coordinator must communicate with both the nurse providing this service and the participant's health professional to ensure the nursing needs of the participant are being addressed. Participants must meet at least one of the following criteria to qualify for this service: ▪ Be at high risk of developing skin ulcers or have a history of resolved skin ulcers that could easily redevelop. ▪ Require professional monitoring of vital signs when changes may indicate the need for modifications to the medication regimen. ▪ Require professional monitoring or oversight of blood sugar levels, including participant-recorded blood sugar levels, to assist with effective pre-diabetes or diabetes management. ▪ 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. ▪ 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. ▪ Require professional evaluation of the participant's physical status to encourage optimal functioning and discourage adverse outcomes. ▪ 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 appropriate health professional. 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: ▪ Administering prescribed medications that cannot be self-administered (as defined under Michigan Compiled Law (MCL) 333.7103(1)). ▪ Setting up medications according to physician orders. ▪ Monitoring participant's adherence to their medication regimen. ▪ Applying dressings that require prescribed medications and aseptic techniques. ▪ Providing refresher training to the participant or informal caregivers to ensure 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 ADL, or safe ambulation within the home.

Limitations	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). Participants receiving Private Duty Nursing/Respiratory Care services are not eligible to receive MI Choice Nursing Services. All providers furnishing this service must be licensed as either a Registered Nurse or a Licensed Practical Nurse in the State of Michigan.

4.1.L. 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.
Requirements	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. The response center must maintain the monitoring capacity to respond to all incoming emergency signals 24 hours per day, 365 days per year. The response center will provide accommodations for persons with limited English proficiency. 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. The provider will furnish each responder with written instructions and provide training, as appropriate. The provider will verify the responder and contact names for each participant on a semi-annual basis to ensure current and continued participation. The provider will ensure at least monthly testing of each PERS unit to ensure continued functioning. 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. The provider will maintain individual client records that include the following: ▪ Service order, ▪ Record of service delivery, including documentation of delivery and installation of equipment, participant/caregiver orientation, and monthly testing, ▪ List of emergency responders for each participant, and ▪ A case log documenting participant and responder contacts. 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.

Limitations	PERS does not cover monthly telephone charges associated with phone service. 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. Waiver agencies may authorize PERS units for persons who do not live alone if both the participant and the person with whom they reside would require extensive routine supervision without a PERS unit in the home. The supports coordinator must clearly document in the case record the reason for provision of a PERS. Waiver agencies may provide a purchased unit like a PERS device. This type of unit does not require an installation or monthly fee but is a one-time cost. These units are covered under the Specialized Medical Equipment and Supplies service. Participants should not have both a purchased and a rented unit.

4.1.M. 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 person-centered service plan. RC may be provided by a licensed respiratory therapist to a participant who is ventilator dependent. To be eligible for PDN/RC services, the waiver agency must find the participant meets either Medical Criteria I or Medical Criteria II, and Medical Criteria III. Regardless of whether the participant meets Medical Criteria I or II, the participant must also meet Medical Criteria III. The participant's PCSP must provide reasonable assurance of participant safety. This includes a strategy for effective backup in the event of an absence of providers. The backup strategy must include informal supports or the participant's capacity to manage his/her care and summon assistance. PDN/RC for a participant between the ages of 18-21 is covered under the State Plan.
Requirements	Through a person-centered planning process, the waiver agency must determine the length and duration of services provided. 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. 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. This service may include medication administration as defined under Michigan law. The waiver agency 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, the waiver agency is responsible for assuring the PDN/RC provider has a copy of these orders and delivers PDN/RC services according to the orders. The waiver agency must maintain a copy of the physician orders in the case record.

Medical Criteria	To be eligible for PDN/RC services, the waiver agency must find the participant meets either Medical Criteria I or Medical Criteria II, and Medical Criteria III. Regardless of whether the participant meets Medical Criteria I or II, the participant must also meet Medical Criteria III. **Medical Criteria I** – The participant is dependent daily on technology-based medical equipment to sustain life. "Dependent daily on technology-based medical equipment" means: ▪ 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 [Bi-PAP]); or ▪ Deep oral (past the tonsils) or tracheostomy suctioning eight or more times in a 24-hour period; or ▪ Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility; or ▪ Total parenteral nutrition delivered via a central line, associated with complex medical problems or medical fragility; or ▪ Continuous oxygen administration (eight or more hours per day), in combination with a pulse oximeter and a documented need for skilled assessment, judgment, and intervention in the rate of oxygen administration. This would not be met if oxygen adjustment is done only according to a written protocol with no skilled assessment, judgment or intervention required. Continuous use of oxygen therapy is a covered Medicaid benefit for 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 P02 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: ▪ "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. ▪ "Medical instability" means emergency medical treatment in a hospital emergency room or inpatient hospitalization related to the underlying progressively debilitating physical disorder. ▪ "Emergency medical treatment" means covered inpatient and outpatient services that are furnished by a provider who is qualified to furnish such services and that are needed to evaluate or stabilize an emergency medical condition. ▪ "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 that 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.

	▪ "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 three or more ADL. ▪ "Substantiated" means documented in the clinical or medical record, including the progress notes. **Medical Criteria III** – The participant requires continuous skilled 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: ▪ "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. ▪ Equipment needs alone do not create the need for skilled services. ▪ "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: ➢ 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. ➢ Managing mechanical rate-dependent ventilation or assisted rate-dependent respiration (e.g., some models of Bi-PAP) that is required by the participant four or more hours per day. ➢ Deep oral (past the tonsils) or tracheostomy suctioning. ➢ 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). ➢ Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility. ➢ Total parenteral nutrition delivered via a central line and care of the central line. ➢ 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 P02 level is 55 mm HG or below. ➢ 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.
Limitations	Participants receiving MI Choice Nursing Services are not eligible to receive PDN/RC services. All PDN/RC services authorized must be medically necessary as indicated through the MI Choice assessment and meet the medical criteria described above. The participant's physician, physician assistant, or nurse practitioner must order PDN/RC services and work in conjunction with the waiver agency 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. PDN is limited to persons age 21 or older. PDN is a State Plan benefit for persons under the age of 21 who qualify for the service. 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 on the person-centered service plan and approved by MDHHS. PDN/RC services provided 24/7 cannot be authorized for participants who cannot direct their own services and supports, make informed decisions for themselves, or engage their emergency backup plan without assistance. These participants must have informal caregivers actively involved in providing some level of direct services to them on a routine basis. Providers of PDN/RC must be licensed by the State of Michigan.

4.1.N. RESPITE

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 unpaid individuals normally providing services and supports for the participant. Respite services may be provided in the participant's home, in the home of another, or in a Medicaid-certified hospital, nursing facility, or a licensed Adult Foster Care (AFC) facility. Respite does not include the cost of room and board, except when provided as part of respite furnished in a facility approved by MDHHS that is not a private residence. Respite can only be provided in the home of another when the participant is using the self-determination option for service delivery. Each out-of-home respite service provider must be either a Medicaid-certified hospital or a licensed group home as defined in Michigan law, which includes AFC homes and Homes for the Aged. Properly licensed nursing facilities may be providers of out-of-home respite services.
Requirements	Each waiver agency must establish and follow written eligibility criteria for in-home respite that includes, at a minimum: ▪ 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.

	▪ Participants have difficulty performing or are unable to perform ADL without assistance. Respite services include: ▪ Attendant Care (participant is not bed-bound), such as companionship, supervision, and assistance with toileting, eating, and ambulation. ▪ Basic Care (participant may or may not be bed-bound), such as assistance with ADL, a routine exercise regimen, and self-medication. The direct service provider must obtain a copy of appropriate portions of the assessment conducted by the waiver agency before initiating service. The assessment information must include a recommendation made by the assessing RN describing the respite support services the participant needs. Each waiver agency or direct service provider must ensure the skills and training of the respite care worker assigned coincide with the condition and needs of the participant. With the assistance of the participant or participant's caregiver, the waiver agency or direct service provider must determine an emergency notification plan for each participant, pursuant to each visit. 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 RN and must include, at a minimum: ▪ 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. ▪ Verification of prescription medications and their dosages. The participant must maintain all medications in their original, labeled containers. ▪ Instructions for entering medication information in participant files. ▪ 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. Each direct service provider must employ a professionally qualified supervisor that is available to staff during their shift while providing respite care. 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. Members of a participant's family who are not the participant's regular caregiver may provide respite for the regular caregiver. However, waiver agencies must not authorize MI Choice funds to pay for services furnished to a participant by that person's spouse. Family members who provide respite services must meet the same standards as providers who are unrelated to the individual. The waiver agency must not authorize respite services to relieve a caregiver that receives waiver funds to provide another service to the waiver participant. This requirement may be waived if:

	▪ 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., the participant has a medical need for 50 hours per week of services); and ▪ The case record demonstrates the paid caregiver furnishes unpaid services and supports to the participant (i.e., the caregiver is paid for 30 hours per week, but actually delivers 50 hours per week of services); and ▪ 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 caregiver regularly furnishes).
Limitations	MDHHS does not intend to furnish respite services on a continual basis. Respite services should be utilized for the sole purpose of providing temporary relief to an unpaid caregiver. When a caregiver is unable to furnish unpaid medically necessary services on a regular basis, waiver agencies should work with the participant and caregiver to develop a PCSP that includes other MI Choice services, as appropriate. The costs of room and board are not included. Waiver agencies cannot authorize respite services on a continual daily basis. Waiver agencies may authorize respite services on a daily basis for a short period, such as when informal supports are on vacation. Respite should be used on an intermittent basis to provide scheduled relief of informal caregivers. The waiver agency must not authorize waiver funds to pay for respite services provided by the participant's usual caregiver.

4.1.O. Specialized Medical Equipment and Supplies

Definition	Specialized Medical Equipment and Supplies includes devices, controls, or appliances which enable participants to increase their abilities to perform ADL, 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.
Requirements	Waiver agencies may obtain some items directly from a retail store that offers the item to the public (i.e., Wal-Mart, Meijer, Costco, etc.). When utilizing retail stores, the waiver agency must ensure the item purchased meets the service standards. The waiver agency may choose to open a business account with a retail store for such

	purchases. The waiver agency must maintain the original receipts and maintain accurate systems of accounting to verify the specific participant who received the purchased item. The waiver agency must document the medical or remedial benefit the equipment or supply provides to the participant in the participant's case record. Where feasible, the waiver agency or direct service provider must seek affirmation of the need for the item provided from the participant's physician. The waiver agency may provide liquid nutritional supplements as a specialized medical supply. The participant's physician or other health care professional must first order liquid nutritional supplements as described in the HDM 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.
Limitations	The waiver agency may not authorize MI Choice payment for prescription medications not found on the Medicaid prescription drug formulary. If a participant requires a medication not found on the formulary, the waiver agency, participant, or pharmacy must seek prior authorization of payment through the State Plan. Regardless of approval or denial of State Plan prior authorization, MI Choice funds must not pay for the medication. The waiver agency must not authorize MI Choice payment for herbal remedies or other over-the-counter medications for uses not authorized by the Food and Drug Administration (FDA).

4.1.P. 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 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. Supports coordinators perform all functions described in the Supports Coordination Section of this Chapter.
Requirements	Each supports coordinator must have a valid Michigan license as a Registered Nurse (RN) or Social Worker (SW), and be trained and knowledgeable about the program requirements for MI Choice as well as other available community resources. Functions performed by a supports coordinator include: ▪ Ensure the participant meets the LOCD per MDHHS policy. ▪ Conduct the initial assessment and periodic reassessments. ▪ 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. ▪ Develop a PCSP, including revisions to the PCSP at the participant's initiation or as changes in the participant's circumstances may warrant.

	▪ Communication with the participant is a requirement and must be incorporated into the person-centered service plan. ▪ 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.
Limitations	Participant must need and agree to accept at least one additional MI Choice service every 30 days to qualify for the program. Supports coordinators must **not** also provide Transition Navigation under the Transition Services benefit.

4.1.Q. 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 person-centered service plan. Training is covered for areas such as ADL, 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 and supervision, or other areas related to self-direction.
Requirements	Direct service providers must possess credentials required by Michigan laws or federal regulations, including: ▪ MCL 333.17801…333.17831 (physical therapist), ▪ MCL 333.18301…333.18311 (occupational therapist), ▪ MCL 333.18501…333.18518 (social worker), and/or ▪ MCL 333.17201…333.17242 (nursing) The waiver agency must identify the training needs in the comprehensive assessment or in a professional evaluation and include them in the PCSP. The waiver agency must provide a description of these needs to the direct service provider. The waiver agency must maintain verification of training provided to self-determined workers in the participant's case record.

4.2 STATE PLAN SERVICES

MI Choice services are designed to address the unique needs and circumstances of program participants. Some waiver services appear to be the same as services offered in the State Plan; however, they differ in terms of key elements, such as scope of coverage or provider qualifications. Inasmuch as waiver services are designed to meet the specific demands of participants, it is expected that a waiver service will be more appropriate for a participant than a similar State Plan service. Under no circumstances shall the participant receive both services. As a Prepaid Ambulatory Health Plan (PAHP), waiver agencies have authority to authorize payment only for MI Choice services for which they receive a capitated payment.