

SERVICE DESCRIPTION
Children’s Home and Community-Based Services Waiver (CWP)

This service must be provided consistent with requirements outlined in the MDHHS Medicaid Provider Manual as updated. The manual is available at:

<http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf>

1. **Definition or Description of Service** The Children’s Home and Community-Based Services Waiver Program (CWP) provides services that are enhancements or additions to regular Medicaid coverage to children up to age 18 who are enrolled in the CWP.
 - a. This service must be provided consistent with requirements outlined in the MDHHS Medicaid Provider Manual.
 - b. The Children’s Waiver is a fee-for-service program administered by the CMHSP. The CMHSP will be held financially responsible for any costs incurred on behalf of the CWP beneficiary that were authorized by the CMHSP and exceed the Medicaid fee screens or amount, duration and scope parameters.
 - c. Services, equipment and Environmental Accessibility Adaptions (EAAs) that require prior authorization from MDHHS must be submitted to the CWP Clinical Review Team at MDHHS. The team is comprised of a physician, registered nurse, psychologist, and licensed master’s social work with consultation by a building specialist and an occupational therapist.

2. **Practice Principles**
 - a. The CWP enables Medicaid to fund necessary home- and community-based services for children with developmental disabilities who reside with their birth or legally adoptive parent(s) or with a relative who has been named legal guardian under the laws of the State of Michigan, regardless of their parent’s income.
 - b. The CMHSP or its designee is responsible for assessment of potential waiver candidates. The CMHSP is responsible for referring potential waiver candidates by completing the CWP “pre-screen” form and sending it to MDHHS to determine priority rating.
 - c. Application for the CWP is made through the CMHSP. The CMHSP is responsible for the coordination of the child’s waiver services. The case manager/supports coordinator, the child and their family, friends, and other professional members of the planning team work cooperatively to identify the child’s needs and to secure the necessary services. All services and supports must be included in the Individual Plan of Services (IPOS). The IPOS must be reviewed, approved and signed by the physician.
 - d. A CWP beneficiary must receive at least one children’s waiver service per month in order to retain eligibility.
 - e. Covered Waiver Services include:
 - i. Covered Medicaid services that continue to be available to CWP beneficiaries are listed in the Covered Services Section of this chapter. Refer to the Children's Waiver Community Living Support Services Appendix of this chapter for criteria for determining number of hours. Services covered under CWP include:
 - (1) Community Living Supports
 - (a) Community Living Supports (CLS) provides assistance to a family in the care of their child while facilitating the child’s independence and integration into the community. This service provides skill development related to activities of daily living, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; skill development to achieve or maintain mobility, sensory-motor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These

supports must be provided directly to, or on behalf of, the child. The supports, as identified in the individual plan of services, are provided in the child's home and may be provided in community settings when integration into the community is an identified goal. These supports may serve to reinforce skills or lessons taught in school, therapy or other settings, but are not intended to supplant services provided in school or other settings.

- (b) Individuals who are identified in the individual plan of services to provide CLS to the child and family must meet provider qualifications.
 - (c) The CMHSP must maintain the following documentation:
 - (i) A log of the CLS must be maintained in the child's record, documenting the provision of activities outlined in the plan.
 - (ii) Provider qualifications and standards must be maintained for all staff providing services and supports to the child and family.
 - (d) All service costs must be maintained in the child's file for audit purposes.
- (2) Enhanced Transportation
- (a) Transportation costs may be reimbursed when separately specified in the individual plan of service and provided by people other than staff performing CLS, in order to enable a child served by the CWP to gain access to waiver and other community services, activities and resources. Transportation is limited to local distances, where local is defined as within the child's county or a bordering county. This service is an enhancement of transportation services covered under Medicaid. Family, neighbors, friends, or community agencies that can provide this service without charge must be utilized before seeking funding through the CWP. The availability and use of natural supports should be documented in the record.
 - (b) Parents of children served by the waiver are not entitled to enhanced transportation reimbursement.
- (3) Environmental Accessibility Adaptations (EAAs)
- (a) Environmental Accessibility Adaptations (EAAs) include those physical adaptations to the home, specified in the individual plan of service, which are necessary to ensure the health, welfare and safety of the child, or enable him to function with greater independence in the home and without which the child would require institutionalization. Home adaptations may include the installation of ramps, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are essential to support the child's medical equipment.
 - (b) Requests for EAAs must be prior authorized by the CWP Clinical Review Team following denial by all applicable insurance sources, e.g., private insurance, Children's Special Health Care Services (CSHCS), Medicaid. All services shall be provided in accordance with applicable state or local building codes. A prescription is required and is valid for one year from the date of signature.
 - (c) Standards of value purchasing must be followed. The EAA must be the most reasonable alternative, based on the results of a review of all options, including a change in the use of rooms within the home or alternative housing.
 - (d) The existing structure must have the capability to accept and support the proposed changes. The infrastructure of the home involved in the funded EAA (e.g., electrical system, plumbing, well/septic, foundation, heating/cooling, smoke detector systems, roof) must be in compliance with any applicable local codes.

- (e) EAAs shall exclude costs for improvements exclusively required to meet local building codes. The EAA 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.
 - (f) The EAA must demonstrate cost-effectiveness. The family must apply, with the assistance of the case manager if needed, to all applicable funding sources, such as housing commission grants, MSHDA, and community development block grants, for assistance. Acceptances or denials by these funding sources must be documented in the child's records. The CWP is a funding source of last resort.
 - (g) Excluded are those adaptations or improvements to the home that are of general utility, are considered to be standard housing obligations of parents, and are not of direct medical or remedial benefit to the child. EAAs that are 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 child's home.
 - (h) All work must be completed while the child is enrolled in the CWP.
 - (i) Adaptations may be made to rental properties when the landowner agrees to the adaptation in writing. A written agreement between the landowner and the child's family must specify any requirements for restoration of the property to its original condition if the occupants move and must indicate that the CWP and MDHHS are not obligated for any restoration costs.
 - (j) If a family purchases a home or builds a home or addition while the child is receiving waiver services, it is the family's responsibility to assure that the home will meet the child's basic needs, such as having a ground floor bath/bedroom if the child has mobility limitations. The CWP does not cover construction costs in a new home or addition, or a home purchased after the beneficiary is enrolled in the waiver. The CWP funds may be authorized to assist with the adaptation notes above (e.g., ramps, grab bars, widening doorways) for a home recently purchased.
 - (k) Additional square footage may be prior authorized following a MDHHS specialized housing consultation if it is determined that adding square footage is the only alternative available to make the home accessible and the most cost-effective alternative for housing. Additional square footage is limited to the space necessary to make the home wheelchair-accessible for a child with mobility impairments to prevent institutionalization; the amount will be determined by the direct medical or remedial need of the beneficiary. The family must exhaust all applicable funding options, such as the family's ability to pay, housing commission grants, MSHDA and community development block grants. Acceptances or denials by these funding sources must be documented in the child's records.
- (4) Family Training
- (a) This provides for training and counseling services for the families of children served on the CWP. For purposes of this service, "family" is defined as the people who live with or provide care to a child served on the CWP, and may include a parent or siblings. Family does not include individuals who are employed to care for the child. Training includes instruction about treatment

- regimens and use of equipment specified in the plan of services, and must include updates as necessary to safely maintain the child at home.
- (b) Family Training is also a counseling service directed to the family and designed to improve and develop the family's skills in dealing with the life circumstances of parenting a child with special needs. All family training must be included in the child's individual plan of services and must be provided on a face-to-face basis.
- (5) Non-Family Training
- (a) This service provides coaching, supervision and monitoring of CLS staff by professional staff (LLP, MSW, or QIDP). The professional staff will work with parents and CLS staff to implement the plan that addresses services designed to improve the child's social interactions and self-control by instilling positive behaviors in the place of behaviors that are socially disruptive, injurious to the child or others, or that cause property damage.
- (6) Fencing
- (a) Fencing may be approved with documentation that is essential to achieve the outcomes specified in the child's individual plan of service and necessary to meet a child's health and safety needs. Authorization for fencing is for a maximum of 200 feet of standard chain link fence and one gate. If it is determined that chain link fencing will not meet the child's health and safety needs, a standard stockade fence may be considered.
- (7) Financial Management Services/ Fiscal Intermediary Services
- (a) A fiscal intermediary is an independent legal entity – organization or individual – that acts as the fiscal agent of the CMHSP for the purpose of assuring fiduciary accountability for the funds authorized to purchase specific services identified in the consumer's individual plan of service (IPOS). The fiscal intermediary receives funds from the CMHSP and makes payments authorized by the consumer's parent or guardian, as the consumer's representative. The fiscal intermediary acts as an employer agent when the consumer's representative directly employs staff or other service providers.
 - (b) The fiscal intermediary can be an agency or organization (e.g., financial management services agency, accounting firm, local ARC or other advocacy organization) or individual (e.g., accountant, financial advisor/manager, attorney). The fiscal intermediary must meet requirements as identified in the MDHHS/CMHSP Managed Mental Health Supports and Services Contract – Attachment C3.3.4 and Medicaid Managed Specialty Supports and Services Concurrent 1915(b)(c) Waiver Program FY19 (and subsequent years) – part of Attachment P4.7.1.
 - (c) Healthcare Common Procedure Coding System (HCPCS) code "T2025" should be used to bill for this service. This is a "per month" service with a maximum unit of one per month.
 - (d) Financial Management Services/Fiscal Intermediary Services include, but are not limited to:
 - (i) Facilitation of the employment of service workers by the child's parent or guardian acting as the consumer's representative, including federal, state and local tax withholding/payments, unemployment compensation fees, wage settlements, and fiscal accounting;
 - (ii) Assuring adherence to federal and state laws and regulations; and
 - (iii) Ensuring compliance with documentation requirements related to management of public funds.

- (iv) The fiscal intermediary may also perform other supportive functions that enable the consumer – through his/her parent or guardian - to self-direct needed services. These functions may include helping the consumer’s representative recruit staff (e.g., developing job descriptions, placing ads, assisting with interviewing); contracting with or employing providers of services; verification of provider qualifications (including reference and background checks); and assisting the consumer and his/her representative to understand billing and documentation requirements.
 - (e) This is a service that handles the financial flow-through of Medicaid dollars for children enrolled in the CWP who are using Choice Voucher arrangements. This CWP waiver service is available only to CWP consumers whose parent or guardian, serving as the consumer’s representative, chooses to self-direct selected services through Choice Voucher arrangements. A CMHSP may terminate self-direction of services (and therefore Financial Management Services) when the health and welfare of the consumer is in jeopardy due to the failure of the consumer’s representative to direct services and supports or when the consumer’s representative consistently fails to comply with contractual requirements.
- (8) Respite Care
 - (a) Respite care services are provided to the child on an intermittent or short-term basis because of the absence or need for relief of the parent. Respite is intended to support the parent who is the primary caregiver. This service can be provided by a qualified provider under contract with the CMHSP in the child’s home, foster home, group home, licensed respite care facility, licensed camp, or the home of a friend or relative. A parent or guardian may not be considered a provider, nor be reimbursed for this service. All respite services are billed under HCPCS code T1005 – Respite Care Service 15 Min. – with modifiers as appropriate. The maximum respite allocation is 4,608 units (1,152 hours) per fiscal year.
 - (i) The cost of room and board cannot be included as part of respite care, unless provided as part of the respite care in a facility that is not a private residence. Respite provided in an institution (i.e., ICF/IID, nursing facility, or hospital) is not covered by the CWP. When a child requires skilled nursing interventions for twenty-four (24) hours, the maximum daily amount that one nurse can provide is sixteen (16) hours. When the family is not available to provide the additional eight (8) hours of care, a second nurse will be required to provide services for the remainder of the 24-hour period. If a nurse provides respite to more than one child at the same time, the nurse can only provide skilled nursing interventions to one child at a time. Therefore, service for that child would be covered as RN or LPN respite, and services to the other child(ren) would be covered as aide level respite.
- (9) Specialized Medical Equipment and Supplies
 - (a) Specialized medical equipment and supplies includes durable medical equipment, environmental safety and control devices, adaptive toys, activities of daily living (ADL) aids, and allergy control supplies that are specified in the child’s individual plan of services. This service is intended to enable the child to increase his abilities to perform ADLs or to perceive, control, or communicate with the environment in which the child lives. Generators may be covered for a beneficiary who is ventilator-dependent or requires daily use of oxygen via a concentrator. The size of a generator will be limited to the

wattage required to provide power to essential life-sustaining equipment. This service also includes vehicle modifications, van lifts and wheelchair tie-downs. Specialized medical equipment and supplies includes items necessary for life support, ancillary supplies and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment not covered by Medicaid or through other insurance. (Refer to the Medical Supplier Chapter for information regarding Medicaid-covered equipment and supplies).

- (b) Equipment and supplies must be of direct medical or remedial benefit to the child. "Direct medical or remedial benefit" is a prescribed specialized treatment and its associated equipment or environmental accessibility adaptation that is essential to the implementation of the child's individual plan of services. The plan must include documentation that, as a result of the treatment and its associated equipment or adaptation, institutionalization of the child will be prevented.
- (c) A prescription is required and is valid for one (1) year from the date of signature. All items must be determined to be essential to the health, safety, welfare, and independent functioning of the child as specified in the individual plan of services. There must be documented evidence that the item is the most cost-effective alternative to meet the child's need following value purchasing standards. All items must meet applicable standards of manufacture, design and installation. The CMHSP, or its contract agency, must maintain documentation to support that the best value in warranty coverage (e.g., the most coverage for the least cost, per industry standards) was obtained for the item at the time of purchase.
- (d) The following are examples of items not covered under this service:
 - (i) Items that are not of direct medical or remedial benefit or that are considered to be experimental. "Experimental" means that the validity of use of the item has not been supported in one or more studies in a preferred professional journal.
 - (ii) Furniture, appliances, bedding, storage cabinets, whirlpool tubs, and other non-custom items that may routinely be found in a home.
 - (iii) Items that would normally be available to any child and would ordinarily be provided by the family.
 - (iv) Items that are considered family recreational choices (outdoor play equipment, swimming pools, pool decks and hot tubs).
 - (v) The purchase or lease of vehicles and any repairs or routine maintenance to the vehicle.
 - (vi) Educational supplies and equipment expected to be provided by the school.

f. Local Authorization of Specialized Medical Equipment and Supplies

- i. As defined below under the various Healthcare Common Procedure Coding System (HCPCS) codes, the CMHSP may locally authorize selected medical equipment and supplies covered under this service category. Medicaid payment will not be made for items that exceed quantity/frequency limits or established Medicaid fee screens as published in the MDHHS CMHSP Children's Waiver Database in effect at the time the equipment or supply is authorized.

(1) Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified; identify product in "Remarks" **(HCPCS T1999)**.

- (a) This code is used to bill Medicaid for age-appropriate adaptive toys identified in the child's IPOS to address the adaptive or therapeutic need for

the item and the specific habilitative outcome. Items that are typically available in a home and ordinarily provided by families, schools, etc. (e.g., crayons, coloring books, regular board games, educational or non-adaptive toys/software, CD/DVD players, camera, film, computers) are not covered.

- (b) Personal care item, not otherwise specified, each; identify product in “Remarks” (**HCPCS S5199**). This code is used to bill Medicaid for ADL aids that enable the child to be as independent as possible in areas of self-care. The child’s individual plan of services must describe the purpose and use of the ADL aid and any training that the child requires for its use. ADL aids must not be similar in function to items previously billed to Medicaid.
- (c) Specialized supply, not otherwise specified, waiver; identify product in “Remarks” (**HCPCS T2028**). This code is used to bill Medicaid for allergy control supplies used for the on-going management of a diagnosed severe reaction to airborne irritants and must be specified in the child’s individual plan of services. Household items routinely found in the home are not covered (e.g., bed linens, mattress, pillow, vacuum cleaner).

g. State-level Prior Authorization of Specialized Medical Equipment and Supplies

- i. All other items and services covered under this category must be prior authorized by the MDHHS CWP Clinical Review Team following denial by all applicable insurance sources, e.g., private insurance, CSHCS, Medicaid. (Refer to the Children's Waiver Program [CWP] Prior Authorization subsection for details regarding the prior authorization process.) Prior authorization will not be given for items and services that exceed quantity/frequency limits as published in the MDHHS CMHSP Children’s Waiver Database in effect at the time the service is authorized. Pursuant to prior authorization by the MDHHS CWP Clinical Review Team and provision of the items or service, Medicaid payment will be at the rate prior authorized.

- (1) Specialized medical equipment, not otherwise specified, waiver (**HCPCS T2029**). This code is used to bill Medicaid for environmental safety and control devices that enable the child to be as independent as possible. These devices may assist in controlling the environment or assuring safety in conjunction with programs designed to teach safety awareness or skills. The child’s individual plan of services must address the use of the device and include any training that the child requires for its use. Environmental safety and control devices do not include items of general utility such as standard smoke detectors, fire extinguishers, home security systems, and storage cabinets. This service is limited to five environmental safety and control devices or sets of devices per quarter. A set is considered a group of like items that must be purchased in a quantity to meet the child’s needs, e.g., outlet plug covers.

- (2) Repair or non-routine service for durable medical equipment other than oxygen requiring the skill of a technician, labor component, per 15 minutes (**HCPCS K0739**). This code is used to bill Medicaid for repairs to specialized medical equipment that are not covered benefits through other insurances. There must be documentation in the child’s individual plan of services that the specialized medical equipment continues to be of direct medical or remedial benefit to the child. All applicable warranty and insurance coverage must be sought and denied before requesting funding for repairs through the CWP. The CMHSP must document that the repair is the most cost-effective solution when compared with replacement or purchase of a new item. If the equipment requires repairs due to misuse or abuse, the CMHSP must provide evidence of training in the use of the equipment to prevent future incidents.

- (3) Vehicle modifications, waiver; per service (**HCPCS T2039**). This code is used to bill Medicaid for modifications to full-size vans, van lifts and wheelchair tie-down systems. Modifications to the family-owned van must be necessary to ensure the accessibility of the child with mobility impairments, and the vehicle must be the child's primary means of transportation. The individual plan of services must specify the child's accessibility needs that will be addressed by these modifications.
- (a) When purchasing new vehicles, many automobile manufacturers offer a rebate of up to \$1,000 to reimburse documented expenditures for modification of a vehicle for accessibility. The CMHSP must request that the family purchasing the vehicle obtain information regarding any rebate programs and apply the rebate toward the cost of the modifications.
 - (b) Other modifications to a full-size van, such as raised doors, which are necessary to meet the child's accessibility needs will be considered. It is expected that the CMHSP will use prudence in considering and processing beneficiary requests for modifications to newly purchased vehicles (e.g., providing evidence that the child's needs were considered in purchasing a full-size van; purchasing a vehicle that has a raised roof). Conversions to mini-vans are limited to the same modification and would not include additional costs required to modify the frame (e.g., lower the floor) to accommodate a lift. Excluded are items such as automatic door openers, remote car starters, custom interiors, etc. The purchase of a vehicle or maintenance to the vehicle is the family's responsibility.
 - (c) If the vehicle is stolen or damaged beyond repair within five years of the purchase, replacement would only be considered with documentation that the existing lift cannot be transferred to a new van and that no other funding source (e.g., automobile insurance, homeowner's insurance, personal liability, judgment settlement, etc.) is available to cover the replacement.
- (4) Durable medical equipment, miscellaneous (**HCPCS E1399**). This code is used to bill Medicaid for durable medical equipment as described below:
- (a) Window air-conditioning unit for the room where the child spends the majority of his time (e.g., sleeping area). The child must have a documented medical diagnosis of one of the following specific medical diagnoses or conditions:
 - (i) temperature regulation dysfunction due to brain injury or other medical diagnosis;
 - (ii) severe respiratory distress secondary to asthma, permanent lung
 - (iii) damage, or other medical conditions which are exacerbated by heat and humidity;
 - (iv) severe dehydration resulting from a medical diagnosis (e.g., diabetes insipidus) which may result in hospitalization; or
 - (v) severe cardiac problems which may result in hospitalization unless the environmental temperature is carefully controlled.
 - (b) Generator for a child who is ventilator-dependent or requires daily use of oxygen via a concentrator. The size of a generator will be limited to the wattage required to provide power to essential life-sustaining equipment (typically 5,000 watts) and is not intended to provide power for the entire home. The request for prior approval of a generator must include a documented history of power outages, including frequency and duration.

The local power company must be notified in writing of the need to restore power on a priority basis due to the child's needs.

- (c) Therapeutic items, assistive technology, and other durable medical equipment for a child who has sensory, communication, or mobility needs when the item is reasonably expected to enable the child to perceive, control or communicate with the environment in which the child lives, to have a greater degree of independence than would be possible without the item or device, or to benefit maximally from a program designed to meet physical or behavioral needs.
- (5) Specialty Services include:
 - a. Music Therapies;
 - b. Recreation Therapies;
 - c. Art Therapies;
 - d. Massage Therapies;
- (a) Specialty Services may include the following activities: Child and family training, coaching and supervision of staff; monitoring or progress related to goals and objectives; and recommending changes in the plan. This may be used in addition to the traditional professional therapy model included in Medicaid.
- (b) Services must be directly related to an identified goal in the plan of service and approved by the physician. Service providers must meet the CMHSP provider qualifications, including appropriate licensure/certification. Services are limited to four sessions per therapy per month.
- (c) The CMHSP must maintain a record of all Specialty Service costs for audit purposes.
- (d) Hourly care services are not covered under Specialty Services.
- h. Providers are encouraged to offer evidence-based and promising practices as part of the Medicaid covered specialty services where applicable. Providers shall assure that these practices are provided by staff that have been appropriately trained in the model, and if required be State of Michigan licensed or certified in the model(s), and are provided to the population for which the model was intended.
- i. When MDHHS prior authorization is required, the CMHSP must complete and submit to the MDHHS CWP an original Prior Review and Approval Request (PRAR) form and the following documentation for each prior authorization request:
 - ii. Original current (within 365 days) prescription signed by a physician.
 - iii. Narrative justification of need completed by an appropriate professional.
 - iv. Documentation that the requested item, device, or modification is essential to the implementation of the child's IPOS and is of direct medical or remedial benefit to the child.
 - v. A copy of the habilitation program (i.e., goals, objections and methodologies) as related to the request and identified in the IPOS.
 - vi. Written denial of funding from other sources, including private insurance, Medicaid or CSHCE when applicable, charitable or community organizations, and housing grant programs. If the private insurance carrier requires prior authorization to determine coverage, a request for prior authorization must be submitted to the carrier before submitting the PRAR to the MDHHS CWP.
 - vii. Three similar bids for requests costing equal to or more than \$1,000; only one bid is required for requests costing less than \$1,000. If fewer than three bids are obtained for requests costing equal to or more than \$1,000, documentation must describe what efforts were made to secure the bids, and why fewer than three bids were obtained.

- j. Provider will be in compliance with the principles of person-centered planning as outlined in the MDHHS Mental Health and Person-Centered Planning Policy and Practice Guideline.
- k. MDHHS encourages the use of natural supports to assist in meeting an Individual's needs to the extent that the family or friends who provide the natural supports are willing and able to provide this assistance. The use of natural supports must be documented in the Individual's individual plan of service.

3. Credentialing Requirements (*Refer to current Medicaid Provider Manual for updated requirements.*)

- a. Provider will assure that professional staff licensed and/or registered in the State of Michigan provide services at the level authorized by the Payor. Licensed professionals shall act within the scope of practice defined by their license.
- b. Provider shall assure that all staff providing services are qualified and trained to provide services at the level authorized by the Payor.
- c. Providers of CWP services must meet the staff qualifications as defined by the MDHHS Michigan PIHP/CMHSP Provider Qualification per Medicaid Services and HCPCS/CPT Codes.
- d. Provider shall ensure that all vehicles used for transporting the Individual(s) under this agreement are in safe operating condition and contain first aid equipment.
- e. Provider shall permit only responsible staff with an appropriate valid driver's license and insurance, as required by State law, to operate motor vehicles while transporting Individual(s) as evidenced by annual driving record and insurance checks.
- f. Provider shall maintain a copy of training records for each staff person for review if requested by the Payor, the LRE, or an external review team.
- g. Providers of services must:
 - i. Be at least 18 years of age.
 - ii. Be able to practice prevention techniques to reduce transmission of any communicable diseases in the environment where they are providing support.
 - iii. Have a documented understanding and skill in implementing the individual plan of services and report on activities performed.
 - iv. Be in good standing with the law as outlined in the MDHHS/PIHP contract.
- h. Provider Qualifications – Individuals Who Provide Respite and CLS must:
 - i. Be at least 18 years of age.
 - ii. Be able to practice prevention techniques to reduce transmission of any communicable diseases from themselves to others in the environment where they are providing support.
 - iii. Have a documented understanding and skill in implementing the individual plan of services and report on activities performed.
 - iv. Be in good standing with the law (i.e., not a fugitive from justice, a convicted felon, or an illegal alien).
 - v. Be able to perform basic first aid and emergency procedures
 - vi. Be trained in recipient rights.
 - vii. Be an employee of the CMHSP or its contract agency, or an employee of the parent who is paid through a Choice Voucher arrangement. The Choice Voucher System is the designation or set of arrangements that facilitate and support accomplishing self-determination through the use of an individual budget, a fiscal intermediary and direct consumer-provider contracting.
- i. Provider Qualifications - Individuals Performing Case Management Functions.
Individuals performing case management functions must meet the requirements for a Qualified Intellectual Disability Professional (QIDP) and have:
 - i. A minimum of a Bachelor's degree in a human services field.

- ii. One year experience working with people with developmental disabilities.

4. Service Requirements

- a. Provider's supports and services will be based upon the Individual's Plan of Service, and in coordination with any additional plans of the Individual (e.g., nursing, occupational therapy, physical therapy, behavior support plans). Said documents are to be present (hard copy or electronically) at the service site, and accessible to Provider's staff responsible for delivering the supports and services.
- b. Provider shall provide services in the least restrictive and most integrated settings, unless the less restrictive levels of treatment, service or support have been unsuccessful or cannot be safely provided for that Individual.
- c. Provider shall ensure coordination of care occurs between the Individual(s) primary health care physician and Medicaid Health Plan (as appropriate). Coordination of care shall include the full array of primary and acute physical health services, behavioral health care, natural or community supports to provide effective treatment, and as specified in an Individual's plan of service.
- d. Provider shall ensure language interpretation, translation services, and hearing interpreter services are provided as needed, and at no cost to the Individual. Provider shall be responsive to the particular needs of Individuals with sensory or mobility impairments, and provide necessary accommodations.
- e. Provider shall complete service documentation and records that meet the PIHP/CMHSP's requirements for reimbursement. Provider's services and documentation/records shall comply with the standards of the PIHP, CMHSP, accreditation bodies, MDHHS, any applicable licensing Department or Agency of the State of Michigan, Medicaid and Medicare regulations and/or any third-party payers.
- f. The Individual's record must contain sufficient information to document the provision of services, including the nature of the service, the date, and the location of contacts, including whether the contacts were face-to-face. The frequency and scope of contacts must take into consideration the health and safety needs of the Individual.

5. Training Requirements

- a. See Attachment I: Training Requirements for specific training requirements and frequency of trainings.
- b. Provider will ensure and document that each staff is trained on the Individual's IPOS and ancillary plans, prior to delivery of service.

6. Eligibility Criteria/Access Requirements/Authorization Procedures

- a. The following eligibility requirements must be met:
 - i. The child must have a developmental disability (as defined in Michigan State Law), be less than 18 years of age, and in need of habilitation services.
 - ii. The child must have a score on the Global Assessment of Functioning (GAF) Scale of 50 or below.
 - iii. The child must reside with his birth or legally adoptive parent(s) or with a relative who has been named the legal guardian for that child under the laws of the State of Michigan, provided that the relative is not paid to provide foster care for that child.
 - iv. The child is at risk of being placed into an ICF/IID facility because of the intensity of the child's care and the lack of needed support, or the child currently resides in an ICF/IID facility but, with appropriate community support, could return home.
 - v. The child must meet, or be below, Medicaid income and asset limits when viewed as a family of one (the parent's income is waived).

- vi. The child's intellectual or functional limitations indicate that he/she would be eligible for health, habilitative and active treatment services provided at the ICF/IID level of care. Habilitative services are designed to assist Individuals in acquiring, retaining and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. Active treatment includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services. Active treatment is directed toward the acquisition of the behaviors necessary for the beneficiary to function with as much self-determination and independence as possible, and the prevention or deceleration of regression or loss of current optimal functional status.
- b. Individuals presenting for mental health services will be engaged in a person-centered planning process through which diagnostic information and service eligibility will be determined. Eligibility tools may be used in conjunction with the person-centered planning process to determine and document medical/clinical necessity for the requested service.
- c. Waiver eligibility requires verification of no change in waiver status.
- d. The [PIHP Guide to Services](#) provides a summary of service eligibility, access to services, and service authorization. Additional information related to policies, procedures and Provider Manuals may be found by accessing the specific CMHSP websites.