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CHAPTER: Board Services and Program Administration		
SECTION: Assessment, Service Planning and Documentation		
SUBJECT: Children's Waiver Program		
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I. **PURPOSE:** To establish policy and procedures for ensuring that the West Michigan Community Mental Health (WMCMH) practices for the Children's Waiver Program is consistent with the requirements outlined by the Medicaid Provider Manual.

II. **APPLICATION:** All mental health service providers involved in direct care operated by or contracting with the West Michigan Community Mental Health Governing Body.

III. **REQUIRED BY:** ACT 258, Public Acts of 1974, the Department of Health and Human Services Contract and Home and Community Based Waivers (inclusive of the Children's Waiver) are authorized under Section 1915 of the Social Security Act via Section 2176 of the Omnibus Budget Reconciliation Act of 1981 (OBRA 1981). These waivers allow states to provide services to individuals (children) who without such services, require or are at risk of ICF/IID placement. The Children's Waiver Program is approved by the Centers for Medicare and Medicaid Services under these provisions.

IV. **DEFINITIONS:**

Active Treatment: A combination of and sequence of specialized, interdisciplinary treatment services that are of an extended duration and aggressively directed toward the acquisition and/or maintenance of skills and behaviors necessary for the child to function with as much self-determination as possible. A condition of participation for ICF/ID. Refer to Code of Federal Regulations (42CFR483.440).

Administrative Hearing, also called a Fair Hearing: An impartial state level review of a Medicaid beneficiary's appeal of an action presided over by a MDHHS Administrative Law Judge.

Ancillary Supplies: Supplies necessary to aid in the use of life supporting equipment.

Application: The Children's Waiver application is the process of applying for the waiver once a pre-screen form has been submitted to MDHHS, scored and determined to have priority status. The CMHSP will receive a written notification from MDHHS informing them of priority status and provide instructions to proceed with the application.

Assessment: Refers to the process of identifying a child's specific strengths, developmental needs and desires for service. This should include: Identification of the child's present developmental level, health status, and where possible, the cause of the disability. Areas for assessment should be determined by the expressed needs

and desires of the child and his or her family; and the environmental conditions that would facilitate or impeded the child's growth, development and performance.

Behavioral Treatment Committee (BTC): A formal mechanism by which persons with specific knowledge, training and expertise in applied behavioral analysis review and approve (or disapprove) all service plans which include the generalized use of intrusive or restrictive techniques.

Center for Medicaid and Medicare (CMS): The federal agency that administers Medicaid.

Certificate of Medical Necessity (CMN): A document written by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under Michigan law that contains all of the following:

- Beneficiary's name and address
- Practitioner's signature, date of signature and telephone number
- The supplier's name and address
- The expected start date of the order (if different from the date of signature)
- A complete description of the item or service
- The amount and length of time the item or service is needed
- Beneficiary's diagnosis
- The medical necessity of the item or service

If required by Medicare or other insurer, the CMN may replace a prescription as an order for an item or service. If a CMN is completed, a separate prescription is not required.

Children's Special Health Care Services (CSHCS): A program within the Department of Health and Human Services for children and young adults less than 21 years of age with special health care needs. Persons age twenty-one (21) and over with Cystic Fibrosis or certain blood clotting disorders may also qualify for services. The child's medical condition, not parental income qualifies for this program.

Children's Waiver Program (CWP): A home and community based waiver for children with intellectual/developmental disabilities under the age of 18 who require services and supports beyond regularly covered state plan Medicaid in order to remain at home with their family and who, without waiver services, would be at risk of admission to an ICF/IID.

Choice Voucher System: An arrangement that gives the parent(s) of the child who is receiving services and support from the CWP, control within specified conditions and limitations over the resources allotted for services agreed upon in the individual plan of service (IPOS) and indicated in an individual service budget. The parent, by becoming the employer, hires the staff to work with his/her child. A fiscal intermediary acts as the payer of costs incurred by the child. Its use shall be guided by the Choice Voucher System Technical Advisory provided that no conflict of interest is present.

Clinical Review Team (CRT): MDHHS staff that review new waiver applications for eligibility requirements, recertification of enrolled waiver participants and requests requiring prior approval. The CRT may also provide technical and clinical assistance to the CMHSPs. The team is comprised of a physician, registered nurse, master's level social worker, psychologist, occupational therapist, and housing specialist.

Community Mental Health Services Program (CMHSP): A program operated under Chapter 2 of the Mental Health Code as a county community mental health agency, community mental health authority or community mental health organization.

Decision Guide for Determining Amount of Community Living Support Hourly Care (Decision Guide Table): A table or grid used by CMHSP and MDHHS to help determine the amount of publicly supported hourly care necessary to meet the identified CLS staffing needs of the child enrolled in the CWP.

Decision Guide for Establishing Maximum Amount of Private Duty Nursing (PDN) to be authorized on a Daily Basis: A table or grid used to determine the amount of PDN hours to be provided under Medicaid state plan services.

Developmental Disability (DD): A condition as defined by the Federal Developmental Disabilities Assistance and Bill of Rights Act (P.L. – 496) and the Michigan Mental Health Code 330.1100a, Section 100a(20).

Direct Medical or Remedial Benefit: A prescribed specialized treatment and its associated equipment or environmental accessibility adaptations that is essential to the implementation of the IPOS. The IPOS must include documentation that, as a result of the treatment and its associated equipment or adaptation, institutionalization of the child will be prevented.

Electronic Health Record: The official, confidential clinical record of services provided to individuals who are served by WMCMH.

Enrollment Date: The date of the signature by The Children's Waiver Program Director and/or Chair of the CWP clinical review team.

Enrollment Period: Begins on the effective enrollment date and typically continues for one year.

Exception for Hourly Care: The need for additional CLS or PDN staffing beyond the maximum hours allowed in the child's Category of Care or Intensity of Care level requires an exception. An exception is limited to situations outside the family's control that places the child at risk of serious injury or significant deterioration of health status and must be prior approved by MDHHS.

Experimental: The validity of use of the item has not been supported in one or more studies in a referred professional journal.

Family Centered Practice (FCP): The MDHHS has advocated and supported a family approach to service delivery for children and their families. This approach recognizes the importance of the family and the fact that supports and services impact the entire family. Therefore, in the case of minors, the child is the focus of service planning, and family members are integral to the planning process and its success. The wants and needs of the child/family are considered in the development of the PCP.

Federal Financial Participation: The federal portion of Medicaid funding.

Fiscal Intermediary: A fiscal intermediary is an independent legal entity (organization or individual) that acts as a fiscal agent of WMCMH for the purpose of assuring fiduciary accountability for the funds comprising some or all of a CWP budget. A fiscal intermediary shall perform its duties as specified in a contract with WMCMH or its designated subcontractor. The purpose of the fiscal intermediary is to receive funds from WMCMH making up a CWP budget, and make payments as authorized to providers and other parties to whom an individual using the CWP budget may be obligated. A fiscal intermediary may provide a variety of supportive services that assist the individual in selecting, employing, and directing individual and agency providers. Examples of entities that might serve in the role of a fiscal intermediary include: bookkeeping or accounting firms; local ARC or other advocacy organizations; if no conflict of interest exists.

Freedom of Choice: This is a documented assurance that a waiver candidate or participant can accept or reject waiver services instead of services provided in an ICF/IID and that the family has a choice of qualified service providers.

Funding Authorization: Initial and annual funding caps issued to the CMHSP by MDHHS for individual waiver participants based on the submitted budget.

Guardian: A person appointed by the court to exercise specific powers over an individual who is a minor, legally incapacitated, or developmentally disabled.

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICR/IID): Refer to Code of Federal Regulations (42CFR483, Subpart I), an institution (or distinct part of an institution) that:

- Is primarily for the diagnosis, treatment, or rehabilitation of persons with intellectual disabilities or persons with related conditions, and
- Provides active treatment, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or rehabilitative services to help each individual function at his/her greatest ability.

Lease/Rental Agreement: A document signed by the landlord and the resident (and/or his or her legal representative, if applicable) of a rental until (apartment, room house).

Life Support: Equipment necessary to sustain an individual's life.

Medicaid: State and federal funded program created by Title XIX of the Social Security Act (SSA) that provides a method for eligible families and individuals to receive assistance for necessary medical care.

Medicaid Health Plan (MHP): In general, MHPs are responsible for outpatient mental health in the following situations: The beneficiary is experiencing or demonstrating mild or moderate psychiatric symptoms or signs of sufficient intensity to cause subjective distress or mildly disordered behavior, with minor or temporary functional limitations or impairments; or the beneficiary was formerly significantly or seriously mentally ill at some point in the past. Signs and symptoms of the former serious disorder have substantially moderated or remitted and prominent functional disabilities or impairments related to the condition have largely subsided (there has been no serious exacerbation of the condition within the last 12 months). The beneficiary

currently needs ongoing routine medication management without further specialized services and supports.

Medical Necessity: Determination that a specific service is medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomology and functional impairments, is the most cost-effective option in the least restrictive environment, and is consistent with clinical standards of care.

Michigan Department of Health and Human Services (MDHHS): A state agency that determines Medicaid financial eligibility for and administers the Children's Waiver Program.

Negative Action: A termination, suspension or reduction of Medicaid eligibility or covered services.

Parent/Agency Agreement: A written document that specifies individual objectives and timelines related to achieving a permanent relationship.

Individual Plan of Service: This service is required by Section 712 of the Michigan Mental Health Code, and is referred to as the person centered plan. The responsible mental health agency for each child shall ensure that a person-centered planning/ family centered practice process is used to develop a written PCP in partnership with the child. The PCP shall be developed within 7 days of the commencement of service, or if an individual is hospitalized, before discharge or release. The PCP shall consist of a treatment plan, a support plan, or both, and shall establish meaningful and measurable goals with the child. The plan shall be kept current and modified when indicated.

Person Centered Planning (PCP): The Michigan Mental Health Code established the right for all individuals to have their individual plan of service (person centered plan) developed through a person-centered planning process regardless of age, disability, or residential setting. Person-centered planning is a highly individualized process designed to plan and support the individual receiving services by building upon the individual's capacity to engage in activities that promote community life and honors the individual's preferences, choices and abilities. The PCP process involves families, friends, and professionals as the individual desires or requires. Health and safety needs are addressed in the person centered plan with supports listed to accommodate those needs.

Physician (M.D. or D.O): An individual who possesses a current license to practice medicine in the State of Michigan, a Michigan Controlled Substance license, and a Drug Enforcement Agency (DEA) Registration.

Pre-Screen: A document submitted by the CMHSP to MDHHS, via the Waiver Support Application (WSA) that outlines the pertinent information regarding a Children's Waiver Program candidate. The information in this document is used to determine priority for assigning waiver when there is an opening.

Prescription: A written order for a service or item by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under Michigan law that contains all of the following:

- Prescription
- Beneficiary's name
- Prescribing practitioner's name, address and telephone number
- Prescribing practitioner's signature (a stamped signature is not acceptable)
- The date the prescription was written
- The specific service or item being prescribed
- The expected start date of the order (if different from the prescription date)
- The amount and length of time that the service or item is needed

Prior Authorization for Equipment and Supplies: Written authorization obtained from the MDHHS to purchase and bill for a Medicaid state plan-covered item or service.

Prior Authorization Letter: Monthly authorization letters issued by either the CMHSP or MDHHS that identify types and frequencies of waiver services for a waiver participant.

Prior Review and Approval (PRAR) for Equipment/Home Modifications: Written authorization obtained from the MDHHS prior to the purchase of enhanced medical equipment, supplies and home modifications. The prior approval must be obtained in order to bill for a Children's Waiver covered item or service.

Prior Review and Approval (PRAR) for Exception Hours: Written prior authorization obtained from the MDHHS to use additional Community Living Support or Private Duty Nursing hours above the maximums established by the Decision Guides.

Priority Status: This occurs when a child on the Children's Waiver Program Priority Weighing List has the highest score at the time that a waiver opening occurs. That child receives the opportunity to proceed with the waiver application process.

Priority Weighing Criteria: Procedures for decision-making by MDHHS to determine the priority status for application to the CWP.

Priority Weighing List: A list updated weekly, includes the names of all children who have had pre-screen forms submitted and scored by MDHHS, but have not yet received priority status to apply for the CWP. The list also includes the child's age, pre-screen score, and the date of completion of the original pre-screen. The score is revised with all updated pre-screen applications.

Qualified Intellectual Disability Professional (QIDP): Individual with specialized training or one year experience in treating or working with a person who has an intellectual disability; and is a psychologist, physician, educator with a degree in education from an accredited program, social worker, physical therapist, occupational therapist, speech pathologist, audiologist, registered nurse, therapeutic recreation specialist, licensed professional counselor, or an individual with a human service degree hired, and performing in the role of QIDP prior to January 1, 2008.

Quality Management and Planning (QMP): A division of the MDHHS that reviews CMHSP compliance with Medicaid program standards.

Recipient Rights: In addition to the rights, benefits, and privileges guaranteed by other provisions of law, a recipient of mental health services shall have their rights guaranteed by the Michigan Mental Health Code, unless otherwise restricted by law.

Responsible Mental Health Agency (RMHA): The hospital, center, or community mental health services program that has primary responsibility for the child's care or for the delivery of services or supports to that child.

Responsible Relative: Parent or legal guardian of a minor child (under 18 year of age), who, under most circumstances, may not be paid for the provision of CWP services to that child

Scope of Service: The parameters within which the service will be provided, including:

- Who (e.g., professional, paraprofessional, aide supervised by a professional)
- How (e.g., face-to-face, telephone, taxi or bus, group or individual)

- Where (e.g., community setting, office, beneficiary's home)

Specialized Medical Equipment and Supplies: An item or set of items that enables the child to increase his or her ability to perform activities of daily living with a greater degree of independence than without them; and to perceive, control, or communicate with the environment in which he/she lives. These are items that are not available through other Medicaid coverage or through other insurances. These items must be specified in the individual person centered plan. All items must be ordered by a physician on a prescription or Certificate of Medical Necessity. An order is valid for one year from the date it was signed.

Spend-Down: Medicaid beneficiary must incur medical expenses each month equal to, or in excess of an amount determined by the local DHS worker to qualify for Medicaid.

Support Plan: A written plan that specifies the personal support services or any other support that is to be developed with and provided for the child.

Targeted Case Management: Targeted case management is a covered service that assists beneficiaries to design and implement strategies for obtaining services and supports that are goal-oriented and individualized. Services include assessment, planning, linkage, advocacy, coordination and monitoring to assist beneficiaries in gaining access to needed health and dental services, financial assistance, housing, employment, education, social services, and other services and natural supports developed through the person-centered planning process. Targeted case management is provided in a responsive, coordinated, effective and efficient manner focusing on process and outcomes.

Termination: Status of a waiver participant (child) who has exited the waiver.

Third Party Liability: A payment resource available from both private and public insurance and other liable third parties that can be applied toward the beneficiary's health care expenses.

Transfer: Movement of a waiver participant (child) from one CMHSP to another.

Waiver Support Application (WSA): Accessed through the State of Michigan Single Sign-On tool: https://sso.state.mi.us. The WSA is a state wide data base where all

information about CWP enrollee information is kept. Documentation required by the CWP is submitted electronically to MDHHS.

V. **POLICY:** It is the policy of West Michigan Community Mental Health that the Children's Waiver Program is based on legislation found in Title XIX of the Social Security Act. As a Medicaid funded, fee-for-service program, services covered under the Children's Waiver Program are available to individuals under 18 years of age who meet the Children's Waiver Program eligibility criteria and qualify for Medicaid as a family of one. WMCMH is responsible for the outreach and prescreening of children who may be eligible for the CWP and submitting the prescreen information via the WSA to MDHHS. The MDHHS is responsible for scoring the prescreen document and making a determination to place the child on the eligibility list by the prescreen score.

VI: **PROCEDURES**:

A. Eligibility Determination:

1. The CWP is based on legislation found in the Title XIX of the Social Security Act. This legislation allows the state to provide waiver services to a targeted population who, without waiver services, would be at risk of placement into and ICF/IID. Legislation also allows, for those children who are not Medicaid eligible in their own right, the state to waive parental income, viewing the waiver candidate as a family of one. This CWP candidate then becomes eligible for Medicaid coverage while residing with their family.
2. A child must have a developmental disability as defined in Michigan state law.
3. If the child is under age 9, the child must either meet the developmental disability definition or must have a substantial developmental delay or a specific congenital or acquired condition with a high probability of resulting in developmental disability, if services are not provided.
4. A child must meet criteria for admission to an ICF/IID and be at risk of out-of-home placement.
5. The child must reside with their birth or adoptive parents; in a specialized foster care (with a permanency plan to return home within 30 days); with a relative of the child when that relative has been named the legal guardian for that child under the laws of the State of Michigan and is not a paid foster parent for that child; or in an ICF/IID facility, but with appropriate community support, could return to their birth or adoptive home or to the home of a relative.
6. The child's intellectual or functional limitations indicate that he would be eligible for health, habilitative and active treatment services provided at the ICR/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.

7. The child must be under age 18.
8. The family is willing and able to:
    a. Participate in the development of an IPOS.
    b. Allow services to be provided in the family home.
    c. Provide care and supervision beyond the services authorized in the Category of Care/Intensity of Care Decision Guides.
    d. Obtain and submit required documentation (e.g., annual Medical Examination Form DHS-19, signing the IPOS and the annual DHS financial determination form).
9. The child must meet or be below Medicaid income and asset limits when viewed as a family of one (the family income is waived).
10. No eligibility determination is made until the following occurs:
    a. A CWP pre-screen application is completed by WMCMH, and submitted to MDHHS for review and scoring.
    b. The pre-screen score places the child on the top of the Priority Weighing List.
    c. An opening occurs within the CWP.
    d. The MDHHS receives a completed application packet for the child from WMCMH. (The CWP Waiver Certification form is required with the initial application.)

B. Pre-Screen Process:

1. If WMCMH determines that a child is at risk of out-of-home or ICF/IID placement and a CWP pre-screen is appropriate, that child falls within the priority population mandated for service under the Michigan Mental Health Code.
2. Prior to the completion of a CWP pre-screen, WMCMH must have reviewed the child's needs and presenting eligibility against all Mental Health Code and MDHHS contract mandated service provision requirements and be providing all

services and supports indicated in the amount, duration, and scope required and exhaust all available and appropriate Medicaid state plan and MDHHS covered services appropriate for the child.

3. Each pre-screen must be completed in its entirety to obtain a maximum score to assure that all possible issues have been considered and thus all possible points have been assigned.
4. The completed pre-screen must be submitted electronically by WMCMH via the WSA.
5. Only the prescreen data entry information listed on the prescreen document or in an update will be considered when scoring.
6. If significant changes occur for the child or family after the initial pre-screen has been submitted, the WMCMH care manager must submit an update containing the new information to the CWP for re-scoring via the WSA. An update is required minimally every 6 months.
7. When the scoring of the pre-screen is completed by MDHHS, a copy of the report may be printed from the WSA by WMCMH to share with the family. If the family feels there are errors in the report, an updated pre-screen can be submitted to MDHHS via the WSA.
8. Priority status to apply for the CWP is based on the score resulting from the information provided in the pre-screen.
9. The MDHHS uses the Priority Weighing Criteria for scoring the pre-screen document submitted by the WMCMH care manager.
10. The child is placed on the CWP Priority Weighing List until the next available CWP slot becomes available (priority status).
11. Prescreen details can be updated after the prescreen is scored and before the date eleven months after initial submission. After eleven months, the annual prescreen is required.

C. Application and Renewal Process:

1. When a child is given priority status to apply for the CWP, the MDHHS notifies the responsible care manager within two (2) working days, and by written notification within five (5) working days. An application packet is sent by MDHHS to the care manager confirming the invitation to apply. The packet includes instructions to access the following documents on the WSA: a Waiver Certification form (CWP Technical Assistance Manual Appendix 7a), a Demographic Intake Form, the DHS 49 Medical Examination Form, and the Budget.

2. The care manager contacts the child's parent(s) to confirm that the need is still present, confirm that the child currently resides with the parents or a permanency plan is in place for return within 30 days and that the family is willing and able to assist in obtaining the necessary documentation to complete the CWP application within 30 days of the date of priority status.
3. Enrollment in the CWP will exclude the child from eligibility for any of the specialty services and supports program services.
4. The care manager works with the family to identify the child's most urgent need(s) and obtain assessments by the appropriate clinicians (e.g., nursing assessment for a child with medical needs and/or a behavioral assessment for a child with challenging behavior).
5. The CWP Certification Form must be completed by a QIDP. The form and application packet is completed electronically via the WSA. MDHHS will also sign the form. A copy of the form must be printed and retained in the WMCMH ECR.
6. The care manager works with the family to complete the Demographic Intake form. This form must be completed in its entirety and submitted with the application packet.
7. The family must make application for Medicaid with the local Department of Human Services (DHS) once written notification is provided by DHS in how to apply.
8. The application must be completed on the WSA and submitted to the CWP within 30 days from the date priority status is deemed.
9. If the application is not completed on the WSA by the due date, the invitation to apply expires. If the family remains interested in receiving the CWP, a new pre-screen must be submitted.
10. The MDHHS Clinical Review Team reviews the application and certifies eligibility.
11. If the application is incomplete or inaccurate, it will be returned to the WMCMH for completion and resubmission within the initial 30-day application period.
12. Once the Clinical Review Team has determined clinical approval, WMCMH may begin to provide waiver services when the IPOS has been completed. A retroactive Medicaid effective date can be issued by the local DHS, upon request, up to the date of clinical approval for the CWP. However, if services are provided prior to the Medicaid effective date or if Medicaid eligibility is denied, general fund dollars must be used for the services provided.
13. Once the IPOS is completed, the CWP budget must be developed, reflecting the identified services and the amount of service to be provided. Only those services identified in the IPOS should appear on the budget. If the Category of

Care or Intensity of Care has changed since submission of the original waiver application, the waiver certification form must be modified to reflect the change and be resubmitted.

14. Annual renewal process. Prior to the anniversary of the original CWP Certification form the care manager must complete electronically via the WSA and submit to MDHHS the following annual renewal documents.
    1. Budget for each child enrolled in the CWP. The budget must be based on the services identified in the current PCP.
    2. Waiver certification form must be completed on the WSA within 12 months of the previous Waiver Certification. The date of the WMCMH completion is considered the renewal date.
    3. Copy of the Medical Examination Form (DHS 49).
    4. Update Demographic Intake form (highlight changes, if necessary).
15. The MDHHS Clinical Review Team will review and approve the completed Waiver Certification form. A copy of the signed must be retained in the child's EHR. It can be printed from the WSA data base.

D. Hiring of In-Home Personnel:

1. Having a choice of providers is a core element of the Children's Waiver Program. This means that the child/parent may use a variety of means, to select their providers of services and supports. WMCMH shall design and implement alternative approaches that child/parent enrolled in the Children's Waiver Program may use to obtain consumer-selected and directed provider arrangements using the Choice Voucher System for Children.

    a. Within prudent purchaser constraints, a parent shall be able to access any willing and qualified provider entity that is available to provide needed/authorized services and supports via the children's waiver program.
    b. Approaches shall provide for a range of control options up to and including the direct retention of child/family-preferred providers through choice voucher agreements between the parent and the provider. Options shall include, upon the parent's request and in line with their preference:
        i. Services/supports to be provided by an entity or individual currently operated by or under contract with WMCMH.

ii. Services/supports to be provided by a qualified provider if no conflict of interest exists, chosen by the consumer, with WMCMH agreeing to enter into a contract with that provider.

iii. Services/supports to be provided by a parent-selected provider (where no conflict of interest exists) with whom the parent executes a direct choice voucher agreement. WMCMH shall provide guidance and assistance to assure that agreements to be executed with family-selected providers are consistent with applicable federal regulations governing provider contracting and payment arrangements.

c. Parents (supported by care management staff) shall be responsible for assuring those individuals and entities selected and retained meet applicable provider qualifications as outlined by WMCMH and the CWP guidelines. Methods that lead to consistency and success must be developed and supported by WMCMH. Parents shall assure that written agreements are developed with each provider entity or individual that specifies the type of service or support, the rate to be paid, and the requirements incumbent upon the provider.

d. Copies of all agreements shall be kept current, and shall be made available by the parent, for review by authorized representatives of WMCMH. WMCMH must retain one copy of the original contract with each provider.

e. The parent, in collaboration with WMCMH, within the boundaries of the child's authorized individual budget, shall negotiate fees and rates paid to providers with a choice voucher agreement with the consumer. WMCMH shall provide guidance as to the range of applicable fees.

f. Parents shall have access to alternative methods for choice , control and direct personnel necessary to provide direct support, including:

i. Acting as the employer of record of personnel.

ii. Access to a provider entity that can serve as employer of record for personnel selected by the parent.

iii. WMCMH contractual language with provider entities that assumes consumer selection of personnel, and removal or reassignment of personnel who fail to meet parental preferences.

iv. Use of WMCMH employed direct support personnel, as selected and retained by the parent.

g. A parent shall not be obligated to utilize WMCMH employed direct support personnel or a WMCMH operated or contracted program/service.
h. All employees selected by the parent, whether she or he is acting as employer of record or not, shall meet applicable provider requirements for direct support personnel outlined in the Medicaid Provider Manual, or the requirements pertinent to the particular professional services offered by the provider.
i. A parent shall not be required to select and direct needed provider entities or his/her direct support personnel if she or he does not desire to do so.
j. Provider qualifications for the children's waiver are: must be at least 18 years old; 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; have a documented understanding and skill in implementing the individual plan of services and report on activities performed; be in good standing with the law; current training in First Aid and emergency procedures; and trained in Recipient Rights. Training will occur at the frequency required.

2. WMCMH shall assist a parent who has a child enrolled in the Children's Waiver program to select, employ, and direct his/her support personnel, and shall make reasonably available access to alternative methods for directing and managing support personnel.
    a. WMCMH shall select and make available qualified third-party entities that may function as fiscal intermediaries to perform employer agent functions and/or provide other support management functions, in order to assist the parent in selecting, directing and controlling providers of services and supports.
    b. Fiscal intermediaries shall be under contract to WMCMH. Contracted functions may include:
        i. Payroll agent for direct support personnel employed by the parent, including acting as an employer agent for IRS and other public authorities requiring payroll withholding and employee insurances payments.

ii. Payment agent for parent held Choice Voucher agreements and consultant agreements with providers of services and supports.
iii. Provision of periodic (not less than monthly) financial status reports concerning the employee wages, to both WMCMH and the parent. Reports made to the parent shall be in a format that is user friendly.
iv. Provision of an accounting to WMCMH for the funds transferred to it and used to finance the costs of authorized individual budgets under its management.
v. Assuring timely invoicing, service activity and cost reporting to WMCMH for services and supports provided by individuals and entities that have a direct agreement with the parent.
vi. Other supportive services, as denoted in the contract with WMCMH that strengthen the role of the parent as an employer, or assist with the use of other agreements directly involving the parent in the process of securing needed services.

c. WMCMH shall assure that fiscal intermediary entities are oriented to and supportive of the Children's Waiver Program, and able to work with a range of family styles and characteristics. WMCMH shall exercise due diligence in establishing the qualifications, characteristics and capabilities of the entity to be selected as a fiscal intermediary, and shall manage the use of fiscal intermediaries consistent with MDHHS Technical Assistance Advisories addressing fiscal intermediary arrangements.
d. An entity acting as a fiscal intermediary shall be free from other relationships involving WMCMH or the parent that would have the effect of creating a conflict of interest for the fiscal intermediary in relationship to its role of services/supports transactions. These other relationships typically would include the provision of direct services to the child/parent.
e. WMCMH shall collaborate with and guide the fiscal intermediary and each child/parent enrolled in the Children's Waiver Program to assure compliance with various state and federal requirements and to assist the parent in meeting his/her obligations to follow applicable requirements. It is the obligation of WMCMH to assure that the entities selected to perform intermediary functions are capable of

meeting and maintaining compliance with the requirements associated with their stated functions, including those contained in relevant MDHHS Technical Assistance Advisories.

E. The Medicaid Provider Manual and WSA provides detailed instructions regarding the following procedures and process associated with the CWP, but not necessarily involving every child enrolled in the program:

1. The training, monitoring and supervision of hourly staff when hiring directly through the choice voucher and when using a provider agency.
2. The exception process for community living support and private duty nursing hours.
3. The development of the IPOS and Annual Budget
4. The grievance and appeal procedure
5. The waiver transfer and termination process.
6. The Quality Assurance and Improvement Audit and review process.
7. Services and supports billing directions for finance departments.

F. The prior authorization of specialized medical equipment lies both with MDHHS and the CMHSP. Please see the Medicaid Provider Manual for the items requiring prior authorization from both MDHHS and the CMHSP. The prior authorization procedures are as follows:

1. Requests for specialized medical supplies and equipment and all requests for equipment repairs and environmental accessibility adaptations (EAA), otherwise known as home modifications, require prior authorization from MDHHS.
2. WMCMH is responsible for maintaining copies of all documentation submitted to the CWP.
3. "Standards of value purchasing" as defined in the Medicaid Provider Manual must be followed.
4. WMCMH will maintain documentation that all potentially available first and third party reimbursement (private insurance) have been explored and secured.
5. If a family purchases or builds a home 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.
6. For EEA's, the most cost effective alternative must be identified and specifications must be completed before obtaining three competitive bids.

7. The EEA shall exclude costs for improvements exclusively required to meet local building codes.
8. CMHSP prior authorization for selected Medical Equipment and Supplies:
   a. All locally authorized items must meet medical necessity criteria, be included in the child's IPOS with appropriate amount, intensity and duration identified, be present in the child's budget have supervisory approval and physician approval as outlined in Policy 2.2.1 Service Planning
   b. Items that can be approved by the CMHSP requiring prior approval include: age appropriate toys to address the adaptive or therapeutic need; ADL training aids that enable the child to be as independent as possible in areas of self-care; and allergy control supplies used for the ongoing management of a diagnosed severe reaction to airborne irritants.
   c. WMCMH will offer direct assistance to explore and secure all potentially available first and third party reimbursement.
   d. WMCMH is responsible for assuring that all documentation requirements have been met and documents are available for audit purposes.
   e. WMCMH must purchase items that have been locally authorized using a tax identification number
   f. A physician's prescription is required for a purchase, the prescription must be obtained and a copy maintained in the child's record for audit purposes.
   g. WMCMH will follow the procedures as outlined in the Medicaid Provider Manual for the authorization of locally authorized medical equipment and supplies that are needed by the child enrolled in the waiver.
9. The following process is to be used for all items requiring prior authorizations requests to MDHHS for specialized medical equipment, supplies and environmental accessibility adaptations:
   a. WMCMH staff person completes the Prior Review and Approval Request (PRAR) form. This form must accompany every request for specialized equipment, supplies, and EEA. The PRAR form must be signed and dated by both the care manager and financial representative.
   b. The following documentation is submitted to the CWP, with copies maintained in the child's ECR for audit purposes:
      - Original PRAR form, filled out completely and signed.
      - Original, current prescription (within 365 days) signed by a physician.
      - Narrative justification of need by an appropriate professional. For EEA, an environmental assessment by a professional with expertise in this area is required (usually an OT).

- Documentation that the requested item, device, or modification is essential to the implementation of the child's PCP and is of direct or remedial benefit to the child.
- A copy of the habilitation program (desired outcomes and I wills and methodologies) as related to the request and identified in the PCP.
- Written denials of funding from other sources, including private insurance, Medicaid State Plan or CSHCS when applicable, charitable or community organizations and housing grant programs. A denial from the Trust Fund is not required for any requests through the CWP.

c. If the private insurance carrier requires prior authorizations to determine coverage, a request for prior authorization must be submitted to the carrier before submitting the request to MDHHS.
d. A written denial of coverage from the private insurance carrier is required. If the insurance carrier will not provide prior authorization of coverage, the PRAR packet must document this.
e. If the requested item is authorized by CWP, it is given provisional approval to allow the purchase of the item and submission of a bill to the insurance carrier for final determination.
f. For items and services costing more than $1000.00, three similar bids must be submitted. If less than three bids have been obtained for items and services costing more than $1000.00, WMCMH must submit documentation to show what efforts were made to secure the bids and explain why less than three bids were obtained for review by CWP.
g. For items and services costing less than $1000.00, only one bid is required.
h. If fewer than 3 bids are obtained for requests costing equal to or more than $1000, documentation must describe what efforts were made to secure the bids, and why fewer than 3 bids were obtained.
i. The completed PRAR packet is submitted to the CWP at the offices of MDHHS.

G. Determining Category of Care:

1. The CWP Category of Care Decision Guide is the tool used by the WMCMH care manager to determine the amount of CLS hourly care based on the child's identified health and behavioral needs.
2. The Category of Care determination and assessment must be completed at the time of the annual waiver recertification and as needed to reflect changes in the child's care needs and family resources, as identified in the IPOS.

3. The decision guide is used to determine the amount of CLS hourly care for children with challenging behaviors and children with medical and physical needs that do not meet the criteria for Private Duty Nursing (PDN). Documentation of use of the decision guide is noted in a progress note when used at the time of recertification and other times when needed. Documentation of use is noted in the updated assessment when completed in conjunction with the IPOS.
4. The determination of the amount of hourly care shall result from the IPOS and FCP process that considers the needs of the child and the family.
5. The amount of hourly care is determined by the care needs of the child and the resources available to the family as identified in the PCP.
6. There are four Category of Care definitions for children with challenging behaviors and there are two categories of care definitions for children with medical and physical needs that do not meet criteria for PDN.
7. In addition to identifying the specific behaviors and the family situation as described in the category definitions, the following elements contribute to the overall assessment of need:
    a. Type of behavior identified
    b. Frequency, intensity and duration of the identified behavior
    c. How recently serious behaviors occurred
    d. Specific effects of the behavior on persons in the family and property
    e. Level of family intervention required to prevent behavioral episodes
    f. Extent that family must alter normal routine to address the behavioral needs of the child
    g. Prognosis for change in the child's behavior
    h. Does the child function better in one setting than he does in another setting (e.g., home, school community)?
    i. Age, size and mobility of child.
8. When determining which category is most appropriate to the child's care needs, the definitions of categories should be used to decide whether the needs support the necessity for CLS hourly care. The categories do not, in and of themselves, establish eligibility for publicly funded hourly care.
9. **Category IV:** Demonstrates mild level of behavior that may interfere with the daily routine of the family (see Medicaid Provider Manual for definition).
10. **Category III:** Demonstrates a daily pattern of medium level behaviors including self-injurious, physically aggressive or assaultive behaviors that have not resulted in hospitalization or emergency room treatment for injuries in the past year, or has engaged in occasional, significant property destruction that is not life threatening (see Medicaid Provider Manual for further details).

11. **Category II:** Demonstrates a daily pattern of moderate self-injurious, physically aggressive or assaultive behavior when medical intervention or hospital emergency room treatment has been required for treatment of injuries in the past year without resulting in hospitalization, or if the child has engaged in frequent significant property destruction that is not life-threatening (see Medicaid Provider Manual for further details).
12. **Category I:** Demonstrates a pattern of severe self-injurious, physically aggressive or assaultive behavior, or life-threatening property destruction that has occurred one or more times in the past year. Documented evidence of additional behavioral problems on a frequent basis each day supports a need for 1:1 intensive behavioral treatment. (See Medicaid Provider Manual for additional detailed information.
13. Determining Category of Care for Children with Medical and Physical Needs:
14. **Category IV:** Category IV is for a medical condition that requires significant levels of daily assistance or guidance with ADLs. In addition, medical condition is stable and observations and interventions are required infrequently. Interventions require minimal training and are associated with minimal or no risk to health status (See Medicaid Provider Manual for additional detailed information).
15. **Category III:** A medical condition that routinely requires daily hourly care or support in order to maintain and/or improve health status. Clinical observations and interventions may be intermittent. Medical interventions are typically associated with minimal risk to health status and delayed interventions are not associated with imminent risk to health status (See Medicaid Provider Manual for additional detailed information).
16. The MDHHS CRT will continue to review the IPOS and current assessments and prior authorize waiver services for children who:
    a. Meet the criteria for Category of Care I
    b. Have been approved for CLS exception hours
17. WMCMH, following the CWP Decision Guide, will review and prior authorize waiver services for children who:
    a. Meet the criteria for Categories of Care, II, III and IV.

H. Determining Intensity of Care for Private Duty Nursing (PDN):

1. The CWP authorizes PDN for children enrolled in the CWP.
2. Prior authorization is required before PDN services are provided.

3. The child must meet the medical criteria for PDN. Equipment needs alone do not support medical criteria. There are three (3) medical criteria for PDN. The child must meet the medical criteria of either I and III or II and III.
   3.1 Medical Criteria I: The beneficiary is dependent daily on technology-based medical equipment to sustain life. (See PDN chapter of the Medicaid Provider Manual for details and definition).
   3.2 Medical Criteria II: Frequent episodes of medical instability within the past three to six months. (See PDN chapter of the Medicaid Provider Manual for details and definition).
   3.3 Medical Criteria III: The child requires continuous skilled nursing care on a daily basis. (See PDN chapter of the Medicaid Provider Manual for details and definition).
4. All requests for exception hours must be submitted to MDHHS for prior authorization.
5. PDN must be ordered by a physician and provided by a Medicaid enrolled private duty agency, a Medicaid enrolled registered nurse (RN), a Medicaid enrolled licensed practical nurse (LPN) who is working under the supervision of an RN (per Michigan Public Health Code). It is the responsibility of the LPN to secure the RN supervision. Refer to Medicaid Provider Manual for further details.
6. Once WMCMH determines the child meets the criteria for PDN, the next step is to determine the Intensity of Care level. This is a clinical judgment and is based on the following factors:
   a. The child's medical condition;
   b. The type and frequency of needed nursing assessments, judgments and interventions; and
   c. The impact of delayed nursing interventions.
7. **Intensity of Care-High:** Includes children requiring nursing assessments, judgments, and interventions by a licensed nurse (RN/LPN) at least one time each hour throughout a 24-hour period, when delayed nursing interventions could result in further deterioration of health status, in loss of function or death, or in acceleration of the chronic condition.
8. **Intensity of Care-Medium:** Includes children requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time every three hours throughout a 24-hour period, or at least 1 time each hour for at least 12 hours per day, when delayed nursing interventions could result in further deterioration of health status, in loss of function or death, or in acceleration of the chronic condition. This category also includes beneficiaries

with a higher need for nursing assessment and judgments due to an inability to communicate and direct their own care.

9. **Intensity of Care-Low:** Includes children with medical needs requiring nursing assessments, judgments, and interventions by a licensed nurse (RN/LPN) at least 1 time every 3 hours for at least 12 hours per day, as well as those children who can participate in and direct their own care.
10. After the child's team has determined the Intensity of Care level, WMCMH uses the information to identify the appropriate number of PDN hours using the Decision Guide Worksheet. The Decision Guide Worksheet can be found in the Medicaid Provider Manual.
11. WMCMH must determine the Intensity of Care level and number of hours of PDN required through the planning process. The PRAR must be submitted to MDHHS, CRT for review and approval before services begin.
12. The prior authorization process, including how to become a registered provider, is thoroughly outlined in the Medicaid Provider Manual.

I. Children's Waiver Program Training Opportunities:

1. Care Managers who complete assessments and IPOS for children enrolled in the Children's Waiver Program must attend mandatory training sponsored by the MDHHS. Training is required in determining Category of Care, Intensity of Care and the Pre-Screen process before completing needed documentation.
2. Technical assistance and consultation is available on an as needed basis from the CWP staff at MDHHS.

J. Monitoring and Evaluation:

1. The initial and annual application process for each child enrolled in the CWP is monitored and evaluated by the CWP staff at MDHHS on an annual basis. The program staff monitor and evaluate each of the required documents and will not enroll a child in the program until all documents are completed and returned correctly.
2. The clinical documents for the CWP are routinely reviewed for compliance as part of the concurrent review by the clinical team leader or supervisor. Results of the concurrent review will be utilized for individual and program performance activities.
3. Customer satisfaction with the CWP is obtained as a part of the annual PCP planning process and the quarterly review of service provided. The satisfaction process is a part of the PCP and periodic review document.

4. MDHHS conducts a Quality Assurance and Improvement Audit. This Audit may occur as a part of the bi-annual MDHHS Medicaid PIHP site review. This audit is conducted at the PIHP using a tool that evaluates WMCMH compliance to the CWP procedures.

VII. SUPPORTING DOCUMENTS:

Refer to:
Children's Waiver Training Manual WSA, available on line at https://sso.state.mi.us
Choice Voucher System for Children Technical Advisory

2-2-9 Children's Waiver Program; Revised 1-11, 12-11, 11-12, 7/14, 10/14, 4/15, 1/17, 4/19