

MI Coordinated Health (MICH)
Home and Community Based Services (HCBS) Waiver Requirements
Resource Document

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1. HCBS Waiver Eligibility

In order to be eligible for the MI Coordinated Health (MICH) Home and Community Based Services (HCBS) Waiver, the MICH Enrollee must meet nursing facility level of care as determined by Michigan's Medicaid Nursing Facility Level of Care Determination (LOCD). In addition, the Enrollee must have a need for one or more of the 13 services listed below:

- Adaptive Medical Equipment and Supplies
- Adult Day Program
- Assistive Technology
- Chore Services
- Environmental Modifications
- Expanded Community Living Supports
- Fiscal Intermediary
- Home Delivered Meals
- Individual Goods and Services
- Non-Medical Transportation
- Personal Emergency Response System
- Preventive Nursing Services
- Private Duty Nursing
- Respite
- Vehicle Modifications

Enrollees must receive at least one waiver service each month to remain enrolled in the MICH HCBS Waiver. If the individual no longer receives at least one waiver service per month (in addition to Fiscal Intermediary services, as applicable), the HIDE SNP must immediately disenroll the individual in CHAMPS as soon as the HIDE SNP is aware the individual no longer requires waiver services or has not received waiver services. Note: When a waiver Enrollee is admitted to a nursing facility, the admission entered by the facility will automatically end date the waiver enrollment. For the first 60 days of nursing facility stay, the HIDE SNP can continue to provide the following waiver services if necessary:

- Chore Services (e.g. snow removal, lawncare)
- Fiscal Intermediary (when the Enrollee participates in a self- determination arrangement for chore services.)

If the HIDE SNP continues to provide waiver services during the long-term care facility stay, they must note this on the new waiver enrollment upon discharge. When an Enrollee is discharging from a long-term care facility, the HIDE SNP may enter a new waiver enrollment in CHAMPS on the day of facility discharge.

If an individual is enrolled in the HCBS Waiver and is admitted to a hospital for one or more full calendar months, unless there is at least one day of waiver services during the month, the HIDE SNP must disenroll the member from the waiver. A Disenrollment entered by an HIDE SNP can only be dated the last date of the current month or the last date of the previous month.

Examples for disenrolling related to hospitalization:

- a. An individual is in the community receiving waiver services on 5/1/2017, goes into the hospital on 5/2/2017. Discharge occurs on 5/31/2017, and the individual receives waiver services again on 6/1/2017. The HIDE SNP **does not** need to disenroll from the waiver because there is at least one day of waiver services received during the calendar month.

- b. An individual is in the community receiving waiver services through 5/15/2017, goes into the hospital on 5/16/2017. Discharge occurs on 6/15/2017, and the individual receives waiver services again on 6/16/2017. The HIDE SNP **does not** need to disenroll from the waiver because there is at least one day of waiver services received during the calendar months of May and June.
- c. An individual is in the community receiving waiver services on 5/1/2022, goes into hospital on 5/2/2022. Discharge occurs on 7/31/2022, and the individual receives waiver services again on 8/1/2022. The HIDE SNP **does** need to disenroll the individual. If the individual has not discharged from the hospital by 6/30/2022, The HIDE SNP must enter the disenrollment effective 5/31/2022. **This must be completed by 6/30/2022.** The HIDE SNP will need to re-enroll the individual in the waiver upon discharge from the hospital 8/1/2022 if indicated. **This enrollment can be entered effective 8/1/2022 by 8/31/2022.**

Note: If an Enrollee has an exposure or condition for which a federal, state, or local public health or gov't official(s) has released applicable quarantine or isolation guidelines, care coordination contacts and activities may be made via HIPAA compliant virtual method (video only) in lieu of in person during the quarantine or isolation period only if the Enrollee has an exposure or condition for which a federal, state, or local public health or gov't official(s) has released applicable quarantine or isolation guidelines. If assessments are completed via virtual method (video only) during quarantine/isolation, any sections of the assessment(s) related to physical function that normally require in person observation by the assessor must be reviewed at the next in person visit to ensure accuracy.

The HIDE SNP does not need to submit annual recertifications in CHAMPS. However, the HIDE SNP must conduct an annual LOCD and complete all required documents/ assessments on an annual basis.

2. HCBS Waiver Enrollment

Each HIDE SNP should assign no more than five individuals to complete the waiver enrollment/disenrollment process within CHAMPS. These individuals are expected to review all waiver enrollment materials prior to submission to MDHHS to ensure completeness of the enrollment and all required materials are included in the submission. When a MICH Enrollee is interested in participating in the MICH HCBS waiver, the HIDE SNP will enter HCBS waiver enrollments in CHAMPS pursuant to the 'HCBS in CHAMPS User Guide'. Additionally, the HIDE SNP must upload an enrollment packet to MDHHS. The following materials must be included in the enrollment packet. **(Note: HIDE SNPs should limit document uploads to two files. One file containing power of attorney/durable power of attorney, or guardianship papers, and a separate file with the remaining required documents included under the admission/enrollment form.):**

- Completed (or adopted) Nursing Facility Level of Care Determination (LOCD) tool in CHAMPS including the cover sheet checklist (see Appendix 3)
- Completed Freedom of Choice form (Section 1 by person conducting or adopting the tool, Section 2 by the Enrollee)
- Completed MICH HCBS Waiver Consent Form (dated within 30 days prior to enrollment)
 - Enrollee must sign this form stating he or she is consenting to participate in the waiver and has been given information about various services and available providers
- Home Care Assessment information
- Integrated Care Plan (ICP) (signature page dated within 30 days prior to enrollment).
- E-mail from MDHHS indicating residential and/or non-residential setting is compliant if applicable.
 - Note: Prior to submitting waiver enrollment in CHAMPS, the HIDE SNP must verify that the residential and/or non-residential setting is compliant. This verification inquiry should be e-mailed to MDHHS-MICH-Waiver@michigan.gov mailbox with the name and address of the setting. Once MDHHS confirms that the setting is compliant, the HIDE SNP may proceed with entering the enrollment in CHAMPS. For these cases, the HIDE SNP should include the e-mail from MDHHS indicating the setting(s) are compliant with the enrollment packet upload when entering the enrollment in CHAMPS. If the HIDE SNP needs to complete a setting survey, it must be completed in person. Refer to the "HCBS Final Rule Requirements for Residential and Non-Residential Settings" section below in this document for details.
- Any active Power of Attorney, Durable Power of Attorney, guardianship papers if the individual cannot make decisions on his/her own.
- Acknowledgement Form for any member transitioning directly from MI Choice or PACE.

The HIDE SNP will be notified by MDHHS if the enrollment packet is identified to be missing information, or additional information is required. MDHHS will communicate this information to each individual at the applicable HIDE SNP that has been identified by the HIDE SNP to complete waiver enrollment/dis-enrollments in CHAMPS.

Note: If an HIDE SNP is enrolling someone in the HCBS waiver during the deeming period, the HIDE SNP must alert MDHHS by sending an email to MDHHS-MICH-Waiver@michigan.gov and MDHHS-MICH-ENROLL-SR-ASST@michigan.gov with the HCBS service start date. The HIDE SNP is responsible for completing all required assessments during the deeming period.

If the member is in deeming and it is determined that the member is eligible, MDHHS will enter the HCBS enrollment date, which will be determined on a case-by-case basis depending on the date that the member regains eligibility.

In addition, if eligibility is restored, MDHHS will enter the HCBS enrollment into CHAMPS and inform the HIDE SNP of a deadline to upload the waiver packet to the case. If eligibility is not restored, MDHHS will notify the HIDE SNP with the outcome and any needed next steps.

Non-Residential Settings: After a waiver enrollment has been entered, the HIDE SNP does not need to send additional waiver service requests to MDHHS except when the waiver participant requests an Adult Day Program. Before the HIDE SNP may provide Adult Day Program services, the name and address of the setting must be sent securely to MDHHS through the MDHHS-MICH-Waiver@michigan.gov mailbox. If there is no current Non-Residential Provider survey for that setting, MDHHS will notify the HIDE SNP to conduct the survey. The HIDE SNP must submit the completed survey to MDHHS-MICH-Waiver@michigan.gov mailbox and wait for MDHHS to determine whether the setting is compliant with the HCBS Final Rule. If the setting is compliant, MDHHS will notify the HIDE SNP and Adult Day services may be provided in that setting. If the setting is not compliant, the Enrollee will need to choose a different Adult Day setting. MDHHS must also determine whether the new setting is compliant before any services may be provided there. When a setting survey is due within the next month, MDHHS will notify the HIDE SNP via email that the annual survey needs to be conducted. MDHHS will include the setting name, due date and the setting survey template.

Residential Settings: If a waiver participant chooses to move into a provider-owned and controlled setting (such as an Adult Foster Care or Home for the Aged), the HIDE SNP must notify MDHHS of the upcoming move at least 30 calendar days prior to the move-in date. If the HIDE SNP has less notice, the HIDE SNP should notify MDHHS of the upcoming move as soon as possible. Before the HIDE SNP may provide any waiver services in the new setting, the name and address of the setting must be sent securely to MDHHS through the MDHHS-MICH-Waiver@michigan.gov mailbox. If there is no current Residential Provider survey for that setting, MDHHS will notify the HIDE SNP to conduct the survey. The HIDE SNP must submit the completed survey to MDHHS-MICH-Waiver@michigan.gov mailbox and wait for MDHHS to determine whether the setting is compliant with the HCBS Final Rule. If the setting is compliant, MDHHS will notify the HIDE SNP and waiver services may be provided in that setting. If the setting is not compliant, the Enrollee may either choose to move to different setting, or he or she may choose to stop receiving waiver services in order to live in the noncompliant residential setting. Transitions from long term care facility to waiver: The HIDE SNP may enter the waiver enrollment in CHAMPS on the date of long term care facility discharge. When a setting survey is due within the next month, MDHHS will notify the HIDE SNP via email that the annual survey needs to be conducted. MDHHS will include the setting name, due date and the setting survey template (the template can be found on the MDHHS MICH Website).

3. HCBS Waiver Disenrollment

When the HIDE SNP believes the individual no longer requires waiver services, the HIDE SNP must follow up with the Enrollee to determine if additional services are needed before disenrolling from the waiver. If additional services are not needed, the HIDE SNP must update the ICP accordingly and the ICP must be signed by the Enrollee (or his/her legal representative) and care coordinator.

When an Enrollee is no longer receiving HCBS Waiver services for whatever reason, the HIDE SNP must submit a disenrollment through CHAMPS. The HIDE SNP must include the last date member received waiver services and (when indicated) the date of admission to either NF or hospital in the remarks box. The HIDE SNP must upload the required supporting documentation. The HIDE SNP cannot submit disenrollments until the appeal timeframe has been completed. HIDE SNPs should refer to MICH LOCD Resource Document for additional disenrollment guidance.

Possible reasons for HCBS Waiver disenrollment may be (not an exhaustive list):

- Death
- No longer requires waiver services due to change in condition or nature of the waiver services requested
- No longer enrolled with the HIDE SNP
- Has not received waiver services after approval for the waiver
- Residing in a long term care facility or admitted to a hospital for one or more full months.

When submitting the disenrollment when it has been determined the individual does not need additional services, the HIDE SNP must upload the updated ICP including signature page in CHAMPS. For cases in which there was a death or HIDE SNP disenrollment, the HIDE SNP does not need to submit the updated ICP.

4. HCBS Waiver Provider Qualifications

The HIDE SNP must complete the state-approved assessment instrument for each Enrollee according to established standards prior to beginning home-based supports and services. Direct providers of home-based supports and services must avoid duplicating assessments of individual Enrollees to the maximum extent possible. Providers of home-based supports and services must accept assessments conducted by the HIDE SNP and begin supports and services without having to conduct a separate assessment. The HIDE SNP must make every attempt to supply the providers of home-based services with enough information about each Enrollee served by that organization to properly provide needed services.

Home-based service providers include those for Expanded Community Living Supports, Chore Services, Respite provided in the home, Personal Emergency Response System, Private Duty Nursing, Preventive Nursing Services, and Home Delivered Meals. Other community-based service providers are those for Adult Day Program, Environmental Modifications, Respite services provided outside the home, Adaptive Medical Equipment and Supplies, and Non-Medical Transportation.

Home-based service provider requirements:

- Home-based providers must have a supervisor available to direct care workers at all times while the worker is furnishing services to Enrollees. The provider may offer supervisor availability by telephone. Home-based service providers must conduct in-home supervision of their staff at least twice per year. A qualified professional must conduct the supervisory visit.
- The HIDE SNP and direct provider agencies of home-based services must require and thoroughly check references of paid staff that will enter homes of Enrollees. Reference checks must be conducted prior to beginning services.
- The HIDE SNP and/or providers of home-based services must conduct a criminal history screening through the Michigan State Police via ICHAT or some other method, and in accordance with Michigan Medicaid policy, for each paid or unpaid direct access staff or other provider who will be entering homes of Enrollees. Criminal history screenings must be completed prior to beginning service delivery. HIDE SNPs must follow additional Medicaid policy once MDHHS systems are ready.
- HIDE SNP staff and direct providers of home-based services must receive in-service training as often as needed to ensure person-centered practices. The HIDE SNP and providers must design the training so that it increases staff knowledge and understanding of the program and its Enrollees and improves staff skills at tasks performed in the provision of service. Training sessions and materials developed and offered by MDHHS must be utilized before training developed by the HIDE SNP or its providers. The HIDE SNPs and direct providers of home-based services must maintain comprehensive records identifying dates of training and topics covered in an agency training log, and/or in each employee's personnel file. The employer shall develop an individualized in-service training plan for each employee when performance evaluations indicate a need.
- Each HIDE SNP and direct provider of home-based services will assure MDHHS that employees or volunteers who enter and work within Enrollee homes abide by the following additional conditions and qualifications:
 - Service providers must have procedures in place for obtaining Enrollee signatures on the time sheets (or similar document) of direct care workers to verify the direct service worker provided the work ordered by the HIDE SNP.

- Direct service workers are prohibited from smoking in Enrollee's homes.
- Direct service workers must be able to communicate adequately and appropriately, both orally and in writing, with their employers and the Enrollees they serve. This includes the ability to properly follow product instructions in carrying out direct service responsibilities (i.e. read grocery lists, identify items on grocery lists, and properly use cleaning and cooking products.)
- Direct service workers must not threaten or coerce Enrollees in any way. Failure to meet this standard is grounds for immediate termination.
- Service contractors and direct service workers will be promptly informed of new service standards or any changes to current services standards.
- Other Community-Based Service providers:
 - Enrollee Records
 - Each direct provider of community-based services must maintain Enrollee records that contain, at a minimum:
 - A copy of the request for services.
 - Pertinent medical, social, and/or functional Enrollee information as necessary to the proper delivery of the requested service.
 - A description of the provided service, including the number of units and cost per unit, as applicable.
 - The date(s) of service provision.
 - The total cost of each service provided.
- Direct providers of community-based services must keep all Enrollee records (written, electronic, or other) confidential in controlled access files for ten years from end of contract.
 - Notifying Enrollee of Rights: Each HIDE SNP or direct provider of home-based services must notify each Enrollee, in writing, at the time service is initiated of his or her right to comment about service delivery or appeal the denial, reduction, suspension, or termination of services. Such notice must also advise the Enrollee that they may file complaints of discrimination with the respective HIDE SNP, the U.S. Department of Health and Human Services Office of Civil Rights, or the Michigan Department of Civil Rights.

Provider No-Shows and Gaps in Services:

The HIDE SNP must have requirements in place for a contingency plan in the event of provider no-shows or unexpected gaps in service. Providers may be allowed to refuse to go to a house that is perceived to be structurally unsafe (e.g., imminent risk of the roof falling in, unsafe entrance/exit). The HIDE SNP and/or providers must have rules and protocol (e.g., notifying appropriate authorities like Adult Protective Services, or other state or local services) for certain situations that may cause the caregiver to refuse to enter the home.

Provider Qualifications for Specific HCBS Waiver Services

There may be specific provider requirements for certain HCBS Waivers services, in accordance with the MICH 1915(c) Waiver Application as approved by CMS. See below.

a. Adaptive Medical Equipment and Supplies

Agency: Enrolled Medicaid and Medicare DMEPOS Provider

- License: N/A
- Certification: N/A
- Other:
 - Each direct service provider must enroll in Medicare and Medicaid as a Durable Medical Equipment/POS provider, pharmacy, etc., as appropriate.
- Entity Responsible for Verification: HIDE SNP
- Frequency of Verification: Prior to delivery of service and annually thereafter.

Agency: Retail Store

- License: N/A
- Certificate: N/A
- Other:
 - Items purchased from retail stores must meet the Adaptive Medical Equipment and Supplies service definition. HIDE SNPs must be prudent with their purchases and may have a business account with the retail store.
- Entity Responsible for Verification: HIDE SNP
- Frequency of Verification: Prior to delivery of service and annually thereafter.

b. Adult Day Program

Agency: Adult Day Program

- License: N/A
- Certificate: N/A
- Other:
 - Each provider shall employ a full-time program director with a minimum of a bachelor's degree in a health or human services field or be a qualified health professional. The provider shall continually provide support staff at a ratio of no less than one staff person for every ten Enrollees. The provider may only provide health support services under the supervision of a registered nurse. If the program acquires either required or optional services from other individuals or organizations, the provider shall maintain a written agreement that clearly specifies the terms of the arrangement between the provider and other individuals or organizations.
 - The provider shall require staff to participate in orientation training as specified in the operating standards document(s) which will be provided to HIDE SNPs. Additionally, program staff shall have basic first-aid training. The provider shall require staff to attend in-service training at least twice each year. The provider shall design this training specifically to increase their knowledge and understanding of the program and

Enrollees, and to improve their skills at tasks performed in the provision of service. The provider shall maintain records that identify the dates of training, topics covered, and persons attending.

- If the provider operates its own vehicle for transporting Enrollees to and from the program site, the provider shall meet the following transportation minimum standards:
 - All drivers must be properly licensed, and all vehicles registered, by the Michigan Secretary of State. All vehicles shall be appropriately insured.
 - All paid drivers shall be physically capable and willing to assist persons requiring help to get in and out of vehicles. The provider shall make such assistance available unless expressly prohibited by either a labor contract or an insurance policy.
 - All paid drivers shall be trained to cope with medical emergencies unless expressly prohibited by a labor contract.
 - Each program shall operate in compliance with P.A. 1 of 1985 regarding seat belt usage.
- Each provider shall have first-aid supplies available at the program site. The provider shall make a staff person knowledgeable in first-aid procedures, including CPR, present at all times when Enrollees are at the program site.
- Each provider shall post procedures to follow in emergencies (fire, severe weather, etc.) in each room of the program site. Providers shall conduct practice drills of emergency procedures once every six months. The program shall maintain a record of all practice drills.
- Each day program center shall have the following furnishings:
 - At least one straight back or sturdy folding chair for each Enrollee and staff person.
 - Lounge chairs or day beds as needed for naps and rest periods.
 - Storage space for Enrollees' personal belongings.
 - Tables for both ambulatory and non-ambulatory Enrollees.
 - A telephone accessible to all Enrollees.
 - Special equipment as needed to assist persons with disabilities.
- The provider shall maintain all equipment and furnishings used during program activities or by program Enrollees in safe and functional condition.
- Each day program center shall document that it is in compliance with:
 - Barrier-free design specification of State of Michigan and local building codes.
 - Fire safety standards.
 - Applicable State of Michigan and local public health codes.
- **Entity Responsible for Verification:** HIDE SNP
- **Frequency of Verification:** Prior to delivery of service and annually thereafter

c. Assistive Technology

Agency: Enrolled Medicaid and Medicare DMEPOS Provider

- **License:** N/A
- **Certificate:** N/A
- **Other:**
 - Each direct service provider must enroll in Medicare and Medicaid as a DMEPOS provider, pharmacy, etc., as appropriate.

- **Entity Responsible for Verification:** HIDE SNP
- **Frequency of Verification:** Prior to delivery of service and annually thereafter.

Agency: Retail Stores

- **License:** N/A
- **Certificate:** N/A
- **Other:**
 - Items purchased from retail stores must meet the Assistive Technology service definition. HIDE SNPs must be prudent with their purchases and may have a business account with the retail store.
- **Entity Responsible for Verification:** HIDE SNP
- **Frequency of Verification:** Prior to delivery of service and annually thereafter.

Agency: Other Contracted or Subcontracted Provider

- **License:** N/A
- **Certificate:** N/A
- **Other:**
 - The contracted/subcontracted providers must have written policies and procedures compatible with requirements as specified in the contract between MDCH and the HIDE SNPs. Contracted/subcontracted providers must have any appropriate state licensure or certification required to complete or provide the service or item.
- **Entity Responsible for Verification:** HIDE SNP
- **Frequency of Verification:** Prior to delivery of service and annually thereafter.

d. Chore Services

Agency: Contracted or subcontracted provider other than individuals

- **License:** N/A
- **Certificate:** N/A
- **Other:**
 - Only properly licensed suppliers may provide pest control services. Contracted/subcontracted providers must have any appropriate state licensure or certification required to complete or provide the service or item.
 - Each HIDE SNP must develop working relationships with the Home Repair and Weatherization service providers, as available, in their program area to ensure effective coordination of efforts.
 - Ability to communicate effectively both verbally and in writing as well as to follow instructions.
- **Entity Responsible for Verification:** HIDE SNP
- **Frequency of Verification:** Prior to delivery of service and annually thereafter.

Agency: Individuals chosen by the Enrollee who meet qualification standards

- **License:** N/A
- **Certificate:** N/A
- **Other:**
 - Providers must be at least 18 years of age, have the ability to communicate effectively

both orally and in writing and follow instructions, be able to prevent transmission of communicable disease (as applicable for job duties), and be in good standing with the law as validated by a criminal history review conducted by the HIDE SNP.

- Previous relevant experience and training to meet MDCH operating standards.
- Must be deemed capable of performing the required tasks by the HIDE SNP.
- **Entity Responsible for Verification:** HIDE SNP
- **Frequency of Verification:** Prior to delivery of service and annually thereafter.

e. Environmental Modifications

Individual/Agency: Contracted Provider, Licensed Building Contractors

- **License:** MCL 339.601(1), MCL 339.601.2401, MCL 339.601.2403(3)
- **Certificate:** N/A
- **Other:** N/A
- **Entity Responsible for Verification:** HIDE SNP
- **Frequency of Verification:** Prior to execution of contract.

f. Expanded Community Living Supports

Individual/ Agency: Individuals chosen by the Enrollee who meet the qualification standards

- **License:** N/A
- **Certificate:** N/A
- **Other:**
 - Providers must be at least 18 years of age, have ability to communicate effectively both orally and in writing and follow instructions, be trained in first aid and cardiopulmonary resuscitation, be able to prevent transmission of communicable disease and be in good standing with the law as validated by a criminal history review. If providing transportation incidental to this service, the provider must possess a valid Michigan driver's license.
 - Individuals providing Expanded Community Living Supports must have previous relevant experience or training and skills in housekeeping, household management, good health practices, observation, reporting, recording information, and reporting and identifying abuse and neglect. The individual(s) must also be trained in the Enrollee's ICP. Additionally, skills, knowledge, and experience with food preparation, safe food handling procedures are highly desirable.
 - Previous relevant experience and training to meet MDCH operating standards. Refer to the HIDE SNP contract for more details.
 - Must be deemed capable of performing the required tasks by HIDE SNP.
- **Entity Responsible for Verification:** HIDE SNP
- **Frequency of Verification:** Prior to delivery of services and annually thereafter.

Agency: Home Care Agency

- **License:** N/A
- **Certification:** N/A
- **Other:**
 - Providers must be at least 18 years of age, have the ability to communicate effectively

both orally and in writing and follow instructions, be trained in first aid, be trained in universal precautions and blood-borne pathogens, and be in good standing with the law as validated by a criminal history review.

- A registered nurse licensed to practice nursing in the State shall furnish supervision of Expanded Community Living Support providers. At the State's discretion, other qualified individuals may supervise Expanded Community Living Supports providers. The direct care worker's supervisor shall be available to the worker at all times the worker is furnishing Expanded Community Living Support services.
 - The HIDE SNP and/or provider agency must train each worker to properly perform each task required for each Enrollee the worker serves before delivering the service to that Enrollee. The supervisor must assure that each worker can competently and confidently perform every task assigned for each Enrollee served. MDCH strongly recommends each worker delivering Expanded Community Living Support services complete a certified nursing assistance training course.
 - Expanded Community Living Support providers may perform higher-level, non-invasive tasks such as maintenance of catheters and feeding tubes, minor dressing changes, and wound care if the direct care worker has been individually trained and supervised by an RN for each Enrollee who requires such care. The supervising RN must assure each workers confidence and competence in the performance of each task required.
 - Individuals providing Expanded Community Living Support services must have previous relevant experience or training and skills in housekeeping, household management, good health practices, observation, reporting, and recording information, be trained in the Enrollee's ICP, and reporting and identifying abuse and neglect. Additionally, skills, knowledge, and/or experience with food preparation, and safe food handling procedures are highly desirable.
 - Effective December 18, 2023, agencies and fiscal intermediaries that pay direct care workers who provide PCS must obtain a National Provider Identifier (NPI) and enroll in the Community Health Automated Medicaid Processing System (CHAMPS), in accordance with MDHHS Bulletin MMP 23-76.
- **Entity Responsible for Verification:** HIDE SNP
 - **Frequency of Verification:** Prior to delivery of services and annually thereafter.

g. Fiscal Intermediary

Agency: Fiscal Intermediary (FI) Agency

- **License:** N/A
- **Certificate:** N/A
- **Other:**
 - Provider must be bonded and insured.
 - Insured for an amount that meets or exceeds the total budgetary amount the fiscal intermediary is responsible for administering. Demonstrated ability to manage budgets and perform all functions of the Fiscal Intermediary including all activities related to employment taxation, worker's compensation and state, local and federal regulations. Fiscal Intermediary services must be performed by entities with demonstrated competence in managing budgets and performing other functions and responsibilities of a fiscal intermediary. Neither providers of other covered services to the Enrollee, the family or guardians of the Enrollee may provide fiscal intermediary services to the

Enrollee. Fiscal Intermediary service providers must pass a readiness review and meet all criteria sanctioned by the state. Fiscal intermediaries will comply with all requirements.

- Effective December 18, 2023, agencies and fiscal intermediaries that pay direct care workers who provide PCS must obtain a National Provider Identifier (NPI) and enroll in the Community Health Automated Medicaid Processing System (CHAMPS), in accordance with MDHHS Bulletin MMP 23-76.
- **Entity Responsible for Verification:** HIDE SNP
- **Frequency of Verification:** Prior to delivery of services and annually thereafter.

h. Home Delivered Meals

Agency: Home Delivered Meals Provider

- **License:** Health Code Standards (PA 368 of 1978)
- **Certification:** N/A
- **Other:**
 - Each home delivered meals provider shall have the capacity to provide three meals per day, which together meet the Dietary Reference Intakes (DRI) and recommended dietary allowances (RDA) as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences. Each provider shall have meals available at least five days per week.
 - Each provider shall develop and have available written plans for continuing services in emergency situations such as short term natural disasters (e.g., snow or ice storms), loss of power, physical plant malfunctions, etc. The provider shall train staff and volunteers on procedures to follow in the event of severe weather or natural disasters and the county emergency plan.
 - Each provider shall carry product liability insurance sufficient to cover its operation.
 - The provider shall deliver food at safe temperatures as defined in Home Delivered Meals service standards.
- **Entity Responsible for Verification:** HIDE SNP
- **Frequency of Verification:** Prior to delivery of services and annually thereafter.

Agency: Meal Delivery Kit Providers

- **License:** Health Code Standards (PA 368 of 1978)
- **Certification:** N/A
- **Other:**
 - Each Home Delivered Meals provider shall have the capacity to provide three meals per day, which together meet the Dietary Reference Intakes (DRI) and recommended dietary allowances (RDA) as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences. Each provider shall have meals available to cover at least five days per week.
 - Each provider shall develop and have available written plans for continuing services in emergency situations such as short-term natural disasters (e.g., snow or ice storms), loss of power, physical plant malfunctions, etc. In Lieu of the meal delivery kit provider meeting this requirement, the HIDE SNP can establish an individualized back up plan to ensure that the Enrollee receives meals from an alternate source in the event there is a disruption to the meal kit delivery.

- Each provider shall carry product liability insurance sufficient to cover its operation.
- The provider shall ensure food is delivered at safe temperatures as defined in Home Delivered Meals service standards.
- **Entity Responsible for Verification:** HIDE SNP
- **Frequency of Verification:** Prior to delivery of services and annually thereafter.

i. Individual Goods and Services

Agency: Retail Stores

- **License:** N/A
- **Certificate:** N/A
- **Other:**
 - Items purchased from retail stores must meet the Goods and Services definition.
 - HIDE SNPs must be prudent with their purchases and may have a business account with the retail store.
- **Entity Responsible for Verification:** HIDE SNP
- **Frequency of Verification:** Prior to delivery of services and annually thereafter.

Individual: Contracted Provider

- **License:** N/A
- **Certificate:** N/A
- **Other:**
 - Provider must be reputable and able to provide the good or service necessary.
 - Providers must be at least 18 years of age, have the ability to communicate effectively, have previous relevant experience or training to provide the good or service and be deemed capable of providing the good or service by the HIDE SNP.
- **Entity Responsible for Verification:** HIDE SNP
- **Frequency of Verification:** Prior to provision of services/execution of contract and annually if service is ongoing in nature.

j. Non-Medical Transportation

Agency: Contracted Provider

- **License:** Valid Michigan Driver’s License
- **Other:**
 - The Secretary of State must appropriately license all drivers and register all vehicles used for transportation supported by MICH waiver funds. The provider must cover all vehicles used with liability insurance.
 - All paid drivers for transportation providers supported entirely or in part by waiver funds shall be physically capable and willing to assist persons requiring help to and from and to get in and out of vehicles. The provider shall offer such assistance unless expressly prohibited by either a labor contract or insurance policy.
 - The provider shall train all paid drivers for transportation programs supported entirely or in part by waiver funds to cope with medical emergencies, unless expressly prohibited by a labor contract or insurance policy.
 - Each provider shall comply with Public Act 1 of 1985 regarding seat belt usage.

- **Entity Responsible for Verification:** HIDE SNP
- **Frequency of Verification:** Prior to delivery of services and annually thereafter.

Individual/Agency: Individual NMT Provider

- **License:** Valid Michigan Driver's License
- **Other:**
 - The Secretary of State must appropriately license all drivers and register all vehicles used for transportation supported by MICH waiver funds. The provider must cover all vehicles used with liability insurance.
 - All paid drivers for transportation providers supported entirely or in part by waiver funds shall be physically capable and willing to assist persons requiring help to and from and to get in and out of vehicles.
 - Each provider shall operate in compliance with Public Act 1 of 1985 regarding seat belt usage.
- **Entity Responsible for Verification:** HIDE SNP
- **Frequency of Verification:** Prior to delivery of services and annually thereafter.

k. Personal Emergency Response System

Agency: Personal Emergency Response System Provider

- **License:** N/A
- **Other:**
 - The Federal Communication Commission must approve the equipment used for the response system. The equipment must meet UL® safety standards 1637 specifications for Home Health Signaling Equipment.
 - The provider must staff the response center with trained personnel 24 hours per day, 365 days per year. The response center will provide accommodations for persons with limited English proficiency.
 - The response center must maintain the monitoring capacity to respond to all incoming emergency signals.
 - The response center must have the ability to accept multiple signals simultaneously. The response center must not disconnect calls for a return call or put in a first call, first serve basis.
- **Entity Responsible for Verification:** HIDE SNP
- **Frequency of Verification:** Prior to delivery of services and annually thereafter.

l. Preventive Nursing Services

Agency: Home Care Agency

- **License:** Nursing MCL 333.17201-17242
- **Other:**
 - All nurses providing nursing services to Enrollees must meet licensure requirements and practice the standards found under MCL 333.17201-17242 and maintain a current State of Michigan nursing license.
 - Each direct service provider must have written policies and procedures compatible with the operating standards document(s) which will be provided to HIDE SNPs.

- This service may include medication administration as defined under the referenced statutes.
- **Entity Responsible for Verification:** HIDE SNP
- **Frequency of Verification:** Prior to delivery of services and annually thereafter.

Individual: Licensed Practical Nurse or Registered Nurse

- **License:** Nursing MCL 333.17201 ... 333.17242
- **Other:**
 - All nurses providing Preventive Nursing Services to Enrollees must meet licensure requirements and practice the standards found under MCL 333.17201-17242 and maintain a current State of Michigan nursing license.
 - This service may include medication administration as defined under the referenced statutes.
 - It is the responsibility of the LPN to secure the services of an RN to supervise his or her work.
- **Entity Responsible for Verification:** HIDE SNP
- **Frequency of Verification:** Prior to delivery of services and annually thereafter.

m. Private Duty Nursing

Agency: private duty nursing agency, home care agency

- **License:** Nursing MCL 333.17201 ... 333.17242
- **Certificate:** N/A
- **Other:**
 - All nurses providing private duty nursing to Enrollees must meet licensure requirements and practice the standards found under MCL 333.17201-17242 and maintain a current State of Michigan nursing license.
 - This service may include medication administration as defined under the referenced statutes.
- **Entity Responsible for Verification:** HIDE SNP
- **Frequency of Verification:** Prior to delivery of services and annually thereafter.

Individual: Private Duty Nurse (Licensed Practical Nurse or Registered Nurse)

- **License:** Nursing MCL 333.17201 ... 333.17242
- **Certificate:** N/A
- **Other:**
 - All nurses providing Private Duty Nursing to Enrollees must meet licensure requirements and practice the standards found under MCL 333.17201-17242 and maintain a current State of Michigan nursing license.
 - This service may include medication administration as defined under the referenced statutes.
 - It is the responsibility of the LPN to secure the services of an RN to supervise his or her work.
- **Entity Responsible for Verification:** HIDE SNP
- **Frequency of Verification:** Prior to delivery of services and annually thereafter.

n. Respite

Agency: Home Care Agency

- **When providing care in the home of the Enrollee:**
 - When Chore Services or Expanded Community Living Supports are provided as a form of respite care, these services must also meet the requirements of the respective service category.
 - Each direct service provider shall establish written procedures that govern the assistance given by staff to Enrollees with self-medication. These procedures shall be reviewed by a consulting pharmacist, physician, or registered nurse and shall include, at a minimum:
 - The provider staff authorized to assist Enrollees with taking their own prescription or over-the-counter medications and under what conditions such assistance may take place. This must include a review of the type of medication the Enrollee takes and its impact upon the Enrollee.
 - Verification of prescription medications and their dosages.
 - Instructions for entering medication information in Enrollee files.
 - A clear statement of the Enrollees and responsibilities of the Enrollee's family member(s) regarding medications taken by the Enrollee and the provision for informing the Enrollee and the Enrollee's family of the provider's procedures and responsibilities regarding assisted self-administration of medications.
 - Each direct service provider shall employ a professionally qualified supervisor that is available to staff while staff provide respite.
- **When providing respite in a licensed setting:**
 - **License:** Adult Foster Care: Act 218 of 1979; Homes for the Aged: MCL 333.21311; Nursing Home: MCL 333.21711
 - **Certificate:** Nursing home beds must be dually certified by Medicare and Medicaid
 - **Other:**
 - Each out of home respite service provider must be either a Medicaid certified hospital or a licensed group home as defined in MCL 400.701 ff, which includes adult foster care homes and homes for the aged.
 - Each direct service provider shall employ a professionally qualified program director that directly supervises program staff.
 - Each direct service provider shall demonstrate a working relationship with a hospital or other health care facility for the provision of emergency health care services, as needed. With the assistance of the Enrollee or Enrollee's caregiver, the HIDE SNP or direct service provider shall determine an emergency notification plan for each Enrollee, pursuant to each visit.
 - Effective December 18, 2023, agencies and fiscal intermediaries that pay direct care workers who provide PCS must obtain a National Provider Identifier (NPI) and enroll in the Community Health Automated Medicaid Processing System (CHAMPS), in accordance with MDHHS Bulletin MMP 23-76.
 - **Entity Responsible for Verification:** HIDE SNP
 - **Frequency of Verification:** Prior to delivery of service and annually thereafter.

Individual: Individual chosen by the Enrollee who meets qualification standards

- When Chore Services or Expanded Community Living Supports services are provided as a form of

respite care, these services must also meet the requirements of the respective service category.

- Family members who provide respite services must meet the same standards as providers who are unrelated to the Enrollee.
- Providers must be at least 18 years of age, have the ability to communicate effectively both verbally and in writing, and be able to follow instructions.
- **Entity Responsible for Verification:** HIDE SNP
- **Frequency of Verification:** Prior to delivery of service and annually thereafter.

o. Vehicle Modifications

- **License:** N/A
- **Other:** Must adhere to any state and federal requirements for vehicle accessibility adaptations and installation.
- **Entity Responsible for Verification:** HIDE SNP
- **Frequency of Verification:** Prior to delivery of service and annually thereafter.
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5. HCBS Waiver Provider Monitoring

HIDE SNPs are responsible for conducting monitoring of their waiver service providers to ensure compliance with provider qualifications and standards. HIDE SNPs are responsible to ensure provider compliance prior to delivery of service and annually thereafter. HIDE SNPs complete monitoring reviews on all new providers prior to delivery of service. HIDE SNPs ensure on an annual basis through a contract renewal or review or other methodology (additional methodologies may include but would not be limited to obtaining a provider attestation of compliance with all applicable qualifications or reviewing provider documents to assure the provider meets qualification requirements for the delivery of MICH services and confirm provider has active licenses and certification) that all providers can continue to meet the applicable qualifications and standards. Additionally, HIDE SNPs complete monitoring reviews for a percentage of their waiver service providers annually. The minimum percentage of waiver service providers that must be reviewed is listed in the annual MICH 1915c Waiver Application. See below for the complete Provider Monitoring Plan.

1. Provider Reviews

HIDE SNPs are responsible for conducting monitoring of their waiver service providers to ensure compliance with provider qualifications and standards. HIDE SNPs are responsible for ensuring provider compliance prior to delivery of service and annually thereafter. HIDE SNPs complete monitoring reviews on all new providers prior to delivery of service. HIDE SNPs ensure on an annual basis through a contract renewal or review or other methodology (Additional methodologies may include but would not be limited to obtaining a provider attestation of compliance with all applicable qualifications or reviewing provider documents to assure the provider meets qualification requirements for the delivery of MICH services and confirm provider has active licenses and certification) that all providers can continue to meet the applicable qualifications and standards. Additionally, HIDE SNPs complete monitoring reviews for a percentage of their waiver service providers annually. The minimum percentage of waiver service providers that must be reviewed is listed in the annual MICH 1915c Waiver Application.

2. Methodology

The HIDE SNP assigns one or two staff that has primary responsibility for conducting provider reviews.

3. New Providers

The HIDE SNP conducts initial monitoring prior to the delivery of services when contracting with a new waiver service provider. The HIDE SNP must complete the following forms related to this activity:

- MICH Provider Monitoring Cover Page
- Provider Qualifications Form (specific to the type of provider)
 - If the HIDE SNP can make a determination using the Provider Qualifications Form that the provider meets all applicable standards through an off-site record review that is acceptable. However, there may be instances when the HIDE SNP will need to conduct an on-site review.

The HIDE SNP notifies the provider of their findings within 30 days of conducting the monitoring utilizing the MDHHS provided letter template. This notification must indicate whether the

provider has been determined by the HIDE SNP to be compliant or non-compliant with the applicable qualifications. If the provider has been determined to be non-compliant, the provider shall not provide waiver services until the HIDE SNP has confirmed compliance. Additionally, for a provider that is non-compliant their notification must clearly indicate the findings and provide recommendations for corrective action. The HIDE SNP must establish due dates when the provider should be expected to be in full compliance with the qualifications and a date when the HIDE SNP will re-evaluate the provider's status. Once the HIDE SNP has determined the provider is compliant, they shall send a notification utilizing the MDHHS letter template to the provider.

The HIDE SNP must at the initial findings and provider notification letter within 30 days to the Michigan Department of Health and Human Services (MDHHS) via the HIDE SNP FTP utilizing the file name "provider monitoring." Additionally, the HIDE SNP must submit any additional communication/findings related to the monitoring including the final compliance letter.

4. All Providers

Annually, the HIDE SNP ensures either through their contract renewal process or a contract review with the provider that the provider continues to be compliant with all applicable provider qualifications. If a provider is determined to not be compliant, the HIDE SNP must notify the provider and MDHHS following the same process as noted above for 'new providers'. This process should be reflected in the HIDE SNP's Provider Monitoring Policy.

5. Sampled Subset of Providers

HIDE SNPs complete monitoring reviews for a minimum sample of their waiver service providers annually. The HIDE SNP develops a yearly schedule of provider monitoring reviews to conduct monthly throughout the calendar year, January 1 to December 31. The schedule for the upcoming year is submitted to MDHHS by December 1st of each year via the FTP utilizing the file name "provider monitoring schedule." When developing the annual schedule, the HIDE SNP should consider prior year(s) schedule(s) and ensure that the types of providers selected for monitoring reviews vary and the same providers are not repeated year after year.

The HIDE SNP must complete the following forms related to this activity:

- MICH Provider Monitoring Cover Page
- Provider Qualifications Form (specific to the type of provider)
 - If the HIDE SNP can make a determination using the Provider Qualifications Form that the provider meets all applicable standards through an off-site record review that is acceptable. However, there may be instances when the HIDE SNP will need to conduct an on-site review.
- Billing Audit
 - The HIDE SNP develops a sample of Enrollee records to review for the Billing Audit. The sample should be 5 records or 10% of the records for the HIDE SNP's Enrollees served by the provider (whichever is greater.) The HIDE SNP will establish a timeframe (a three month period is adequate though may need to be expanded to

capture service dates if there are a limited number of HIDE SNP Enrollees served by the provider. The Billing Audit can be on-site at the provider's location, or through off-site record review.

- Two (2) MICH Enrollee Contact Forms per provider monitored
 - The Enrollee contact form allows the HIDE SNP to obtain comments regarding service provision from the perspective of the Enrollee. Additionally, the contact allows for a comparison between the ICP and the services delivered per the Enrollee. The Enrollee Contact Form can be completed in-person or telephonically.

The HIDE SNP notifies the provider of their findings within 30 days of conducting the monitoring utilizing the MDHHS provided letter template. This notification must indicate whether the provider has been determined by the HIDE SNP to be compliant or non-compliant with the applicable qualifications.

Additionally, for a provider that is non-compliant their notification must clearly indicate the findings and provide recommendations for corrective action. The HIDE SNP must establish due dates when the provider should be expected to be in full compliance with the qualifications and a date when the HIDE SNP will re-evaluate the provider's status. Once the HIDE SNP has determined the provider is compliant, they shall send a notification utilizing the MDHHS letter template to the provider.

The HIDE SNP must submit the initial findings and provider notification letter within 30 days to the Michigan Department of Health and Human Services (MDHHS) via the HIDE SNP FTP utilizing the file name "provider monitoring." Additionally, the HIDE SNP must submit any additional communication/findings related to the monitoring including the final compliance letter.

6. Corrective Action

When findings warrant immediate action to protect the Enrollee's health or welfare the HIDE SNP will suspend new referrals to the provider agency or transfer Enrollees to another provider.

When Billing Audit findings reveal non-compliance, the HIDE SNP must adjust provider billings using individual adjustments to date of service or gross adjustment. Deduct overpayments made to a provider from the next warrant issued the provider from the HIDE SNP. Additionally, encounter data submitted to the Community Health Automated Medicaid Payment System (CHAMPS) must be corrected to accurately reflect adjustments made to provider billing.

HIDE SNP must suspend or terminate the providers who demonstrate a failure to correct deficiencies identified through this process. The HIDE SNP can reinstate providers after verifying the provider corrected deficiencies and/or changed procedural practices as required.

7. Coordination with Care Coordinators

The HIDE SNP reviewer ensures the Enrollee's care coordinator is aware of pertinent information such as concerns regarding service delivery that the reviewer gathers during the home visit interviews. Care coordinators follow-up with Enrollee concerns identified during the home visits.

6. Coordination with Other HIDE SNPs

Any time an HIDE SNP finds rationale to terminate a provider from the provider network the HIDE SNP must notify MDHHS of the findings and the reason for terminating the contract. This notification to MDHHS should be uploaded to the FTP utilizing the file name “provider monitoring.” MDHHS will notify other HIDE SNPs as warranted. This is to mitigate potential harm to other MICH Enrollees.

7. Integrated Care Plan (ICP) Requirements for HCBS Wavier Applicants and Enrollees

The ICP is the most important care coordination tool in the MICH program. It is a comprehensive document that allows the Enrollee, HIDE SNP Care Coordinator, providers, and others to stay current with the Enrollee's overall status and the progress of his/her goals and treatments.

The following information may be placed in the ICP in any order as long as all required pieces are present. The basis for the following requirements is found in the State Medicaid Agency Contract (SMAC) and the HCBS Final Rule.

1. Section 1: Required Content for all Waiver ICPs

- a. Understandable, plain language. Make sure to simplify medical terms and write out acronyms (example: Write "high blood pressure" instead of hypertension or HTN). The ICP must also be understandable to persons with disabilities or limited English proficiency (example: Use large print for vision problems).
- b. ICP completion date- also include on separate documents that are part of the plan.
- c. Contact information for the HIDE SNP Care Coordinator, primary care physician, and personal care workers. If applicable, include contact information for the legal representative.
- d. Health status summary including all of the Enrollee's needs. Include medical, social, behavioral health, supports, service, dietary, and other needs. The Enrollee's needs must be addressed in the goals/objectives.
- e. Residential status including the type of home the Enrollee lives in, whether the home is owned or rented, and a statement showing that the Enrollee chooses to live there.
- f. Preferences about supports, services, caregivers, religious and cultural practices, social activities, contact with the Care Coordinator, and any other preferences.
- g. Strengths chosen by the Enrollee (examples: good appetite, positive outlook, exercises twice per week).
- h. Concerns expressed by the Enrollee (examples: keeping BP under control, staying independent as long as possible, wants to keep living in current home). Concerns must be addressed in the goals/objectives.
- i. Risk factors and the interventions that will help to reduce the Enrollee's risks. Include a backup plan for caregiver absences, severe weather, fires, or other emergencies. Include the name of the backup caregiver or agency. Risk reduction must be addressed in the goals/objectives.
- j. Monitoring that will help to manage the Enrollee's health conditions, risks, concerns, and other issues. List each specific monitoring task with its due date and the name of whoever will be doing that monitoring task. Include the due date of the next ICP review and the name of the person responsible for monitoring the ICP.
- k. The Enrollee's goals, objectives, and desired outcomes written in a measurable and achievable form. Include interventions that will help the Enrollee to meet

his/her goals, objectives and outcomes. List each specific intervention with its due date and the name of whoever is responsible for that intervention.

- l. ALL supports and services. Include a brief description of the service, how much of each service will be provided, how often, and for how long. Include the reasons that the Enrollee needs each service and the names of the service providers.
- m. When the Enrollee needs Personal Care services, list the Activities of Daily Living and other activities that the Enrollee will get help with. Include the total number of Personal Care units that the Enrollee is approved for per week, with a breakdown of the number of units for each specific activity. The care plan must state how much help the Enrollee needs for each activity (examples: limited assistance, extensive assistance, total assistance).
- n. A list of due dates for reassessments and the name(s) of whomever is responsible for the reassessments.
- o. A Nursing Facility Transition Plan if providing Community Transition Services to transition to Waiver.
- p. Per 42 CFR 441.301(c)(2)(ix) The final copy of the ICP must be signed by the Enrollee, the care coordinator, and all providers involved in the implementation of the ICP. This includes those providing the services contained in the ICP (applicable to direct providers). Direct providers (for the purposes of ICP signatures) are defined as those providing services in which they have ongoing direct contact with the Enrollee and include: adult day program, ECLS, preventive nursing services, private duty nursing, respite, and personal care services. When an agency/entity is involved, a representative of the agency/entity may sign the ICP. Note: an example of an entity would be an AFC home.

Additionally, a Fiscal Intermediary (FI) is not a direct service provider. An FI handles the business end of securing services and supports. The FI is not responsible for implementing the ICP and is not able to sign the ICP on behalf of a caregiver. An FI is facilitating the employment of the service worker, and the service worker is responsible for implementing and signing the ICP.

Per 42 CFR 441.301(c)(2)(x) The person-centered service plan must be distributed to the individual and other people involved in the plan. It is the HIDE SNP's responsibility to distribute the ICP to the designated representative for an agency/entity that will be rendering services and not to each individual employee of that entity. It is the entity's responsibility to inform staff in a manner that ensures they have the critical information to render services, respect the individual and ensure his/her health and welfare.

It is the expectation that the entire care plan is provided. If the individual requests a provider not receive the full plan it must be documented in the plan and the individual must sign that they have requested the action. However, when that occurs the HIDE SNP must confirm with the individual that they have selected this specific provider for services.

The HIDE SNP may use the MDHHS-5515 (Consent to Share Behavioral Health Information for Care Coordination Purposes) as applicable in conjunction with ICP development to give the Enrollee freedom of choice with how any behavioral health and/or substance use disorder related information in the ICP is shared.

Individuals that are providing informal or natural supports must receive information (either from the Enrollee or the care coordinator) on the services they are responsible for delivering, an understanding of how these services fit into the larger plan, and emergency information so that the health and welfare of the Enrollee is protected.

- a. If the Enrollee/representative will be taking responsibility to notify the supports of their responsibilities, this must be indicated in the care plan and the Enrollee must sign
- b. If the Enrollee is delegating to the care coordinator the task of notifying the supports of their responsibilities, this must be indicated in the care plan and the care coordinator must document that it has been done.

2. Section 2: Required ICP Content for Specific Waiver Services

- a. When the Adult Day Program is requested, include:
 - i. How the Enrollee will be transported to and from the Adult Day Program.
 - ii. The days and times that the Enrollee will attend the program every week.
 - iii. Documentation about whether the Enrollee got to choose an Adult Day Program from multiple options. If no, why?
 - iv. Documentation about whether the Enrollee was given information on how to request a new Adult Day Program. If no, why?
 - v. Documentation about whether all individuals at the setting have a documented, person-centered service plan. If no, why?
- b. When Assistive Technology is requested, include:
 - i. A detailed description of the item(s) that will be covered through this service.
- c. When Chore Services are requested, include:
 - i. Documentation that no other person, including a landlord or a person living in the Enrollee's home, is responsible for providing Chore Services.
 - ii. Documentation that no other person is able and willing to provide Chore Services for the Enrollee.
- d. When Environmental Modifications are requested, include:
 - i. Documentation that the landlord is not responsible for providing Environmental Modifications (for rental properties only).
- e. When Expanded Community Living Supports (ECLS) is requested, include:
 - i. When the Enrollee needs ECLS, list the Activities of Daily Living and other activities that the Enrollee will get help with. Include the total number of ECLS units that the Enrollee is approved for per week, with a breakdown of the number of units for each specific activity. The care plan must state how much help the Enrollee needs for each activity (examples: supervision, prompting, cueing).
- f. When the Fiscal Intermediary is requested, include:

- i. The Enrollee's individual budget and the waiver services that the Enrollee will buy using the budget.
 - ii. Documentation about what responsibilities the Enrollee wants the Fiscal Intermediary to have.
 - iii. Indicate that the individual has chosen to participate in an arrangement that supports self-determination.
- g. When Home Delivered Meals are requested, include:
 - i. Documentation showing that the Enrollee is unable to obtain food or prepare complete meals.
 - ii. Information about special dietary needs.
 - iii. Documentation showing that the enrollee must be able to prepare the meals at home or have a caregiver that can prepare the meals on the enrollee's behalf.
- h. When Non-Medical Transportation is requested, include:
 - i. A list of the types of activities this service will be used for (i.e. shopping, church, visiting family, etc).
 - ii. Documentation that the Enrollee does not have any other transportation for those activities.
- i. When the Personal Emergency Response System is requested, include:
 - i. The risks that are causing the Enrollee to need a PERS.
 - ii. Information about the regular periods of time that the Enrollee is alone at home, OR information showing that any other person living in the home is not able to call for help in an emergency.
- j. When Preventive Nursing is requested, include:
 - i. A description of the health condition that will be managed using Preventive Nursing visits. The ICP must state why the Enrollee needs this health condition monitored.
 - ii. A list of the assessments or other monitoring that will be done during each visit.
 - iii. Descriptions of the nursing interventions that will be carried out during each visit to manage the Enrollee's chronic health condition.
 - iv. Descriptions of any other nursing tasks that will be carried out during visits.
 - v. Information telling the Enrollee what to do if his/her health condition worsens in between Preventive Nursing visits.
- k. When Private Duty Nursing is requested, include:
 - i. A description of the Medical Criteria that qualify the Enrollee for this service (see the Minimum Operating Standards for MICH).
 - ii. The number of hours that the nurse will spend at the Enrollee's home each day.
 - iii. Descriptions of the interventions that the nurse will complete for the Enrollee.
- l. When Respite is requested, include:

- i. Information about the name and responsibilities of the caregiver who is being replaced by the Respite caregiver. This information must show that the regular caregiver is not paid for the services he/she provides. If the regular caregiver provides both paid and unpaid care, list the times when unpaid care is provided. Only the unpaid care may be replaced using the Respite service.
- ii. Documentation showing that the Enrollee needs supervision during the time Respite is being provided, OR that the Enrollee needs a different caregiver when his/her regular caregiver is not available.
- iii. Documentation showing that the Enrollee needs help with at least one Activity of Daily Living.
- iv. The location where the Enrollee will receive Respite.
- v. An estimate of how often Respite will be used.

3. Section 3: Required ICP Content for Enrollees Living in a Provider Owned/Controlled Residential Setting

- a. A provider owned/controlled residential setting is a place in the community, such as an Adult Foster Care or Home for the Aged, where both housing and healthcare services are provided to the residents. By choosing to live in this type of setting, a MICH Enrollee is choosing to receive services from the provider who owns the setting.
- b. When an Enrollee lives in a provider owned/controlled setting, the ICP must contain:
 - i. The name of the setting
 - ii. Information about the Enrollee's financial resources. The Enrollee's preferences about how he/she lives. This includes preferences about his/her daily schedule, bathroom schedules, roommates, and more.
 - iii. The Enrollee's preferences for taking part in community activities. State what activities the Enrollee wants to take part in, how he/she will get there, and whether the Enrollee needs support to take part in the activities. State whether the Enrollee needs help getting transportation or finding work.
 - iv. Any risks that affect the Enrollee's ability to take part in community activities without supervision. Include interventions that will reduce the risks. Example: an Enrollee with dementia has a companion so that he can go out to dinner safely.
 - v. Documentation showing that when the Enrollee requires accommodations or restrictions that are contrary to HCBS Final Rule requirements and federal regulations, the accommodations or restrictions are based on the Enrollee's needs as found through his/her assessments. The ICP must set up timeframes for periodic reviews of the accommodations or restrictions.
 - vi. Documentation stating whether the Enrollee got to choose a place to live from multiple options. If no, why?

- vii. Documentation stating whether the Enrollee had the chance to choose housing with a private bedroom. If no, why?
 - viii. Documentation stating whether the Enrollee was given information on how to request new housing. If no, why?
 - ix. Documentation stating whether all individuals in the setting have a documented, person-centered service plan. If no, why?
- c. The following seven conditions apply to waiver participants living in provider owned/controlled settings. Sometimes, these conditions may need to be modified in order to meet the Enrollee's personal needs. These conditions can only be modified if the Enrollee's needs are documented in his/her assessments and ICP.
- i. The Enrollee owns, rents, or occupies his/her living unit under a legal agreement, and the Enrollee has the same responsibilities and protections from eviction that tenants have under the landlord/tenant law. For settings in which landlord/tenant laws do not apply, a written residency agreement is in place for the Enrollee that provides protections that address eviction processes and appeals comparable to those provided under the landlord/tenant law.
 - ii. The Enrollee has privacy in his/her sleeping or living unit.
 - iii. The Enrollee can lock the entrance door to his/her unit. Only appropriate staff have keys to this door.
 - iv. If the Enrollee chooses to live in a setting with shared units, the Enrollee is able to choose his/her roommate, if possible. If this isn't possible immediately upon moving into the setting, it still should be identified as something the Enrollee wishes to pursue in the future if the opportunity arises.
 - v. The Enrollee has the freedom to furnish and decorate his/her sleeping or living unit as allowed by the lease or other residency agreement.
 - vi. The Enrollee has the freedom and support to control his/her own schedule and activities. The Enrollee also has access to food at any time.
 - vii. The Enrollee is able to have visitors of his/her choosing at any time.
- d. When any of the seven conditions from 3.c.i-vii are changed, the ICP must contain:
- i. Documentation showing that the change was based on the Enrollee's personal needs as found during his/her assessments. Example: Gladys lives in an Adult Foster Care. During the Level I assessment, the Care Coordinator learns that Gladys tries to cook on the stove and burns herself every time she goes into the kitchen. Her "need" is to remain safe while in the kitchen.
 - ii. Documentation about the positive interventions and supports that were tried before changing any of the conditions. Example: The Adult Foster Care staff and the HIDE SNP Care Coordinator tried multiple times to teach Gladys how to use the stove safely. The staff reviewed the lessons every time Gladys wanted to cook.

- iii. Documentation about less restrictive ways of meeting the Enrollee's need that were tried but did not work. Example: The Adult Foster Care staff began checking on Gladys every 5-10 minutes whenever she was in the kitchen. They continued to explain how to use the stove safely.
- iv. A description of the condition that is being changed and why the Enrollee needs it to be changed. Example: Gladys was unable to learn safe cooking skills after many lessons. Her kitchen access is restricted to times that staff are able to supervise her. The condition that needs a change in this case is "The Enrollee has the freedom and support to control his/her own schedule and activities. The Enrollee also has access to food at any time". The reason that Gladys needs this change is that she cannot use the stove alone without being harmed and staff are not always available to assist her.
- v. Documentation showing that the HIDE SNP Care Coordinator is regularly checking to see if the change is working for the Enrollee. The results of these checks must be included in the ICP.
- vi. Due dates for periodic reviews to see if the change is still necessary. Example: The HIDE SNP Care Coordinator checks every three months to see if Gladys still needs supervision when in the kitchen. This is included in the ICP as one of the Care Coordinator's monitoring responsibilities.
- vii. Document the informed consent of the Enrollee (or legal representative) to the changed condition.
- viii. A statement from the HIDE SNP Care Coordinator that none of the interventions or supports that are used will cause harm to the Enrollee. Example: The ICP includes a statement that Gladys will not lose weight or have any other negative effects due to her restricted kitchen access.

8. HCBS Waiver Services Minimum Service Delivery Standards

a. Adaptive Medical Equipment and Supplies

1. It must be documented on the ICP or case record that the item is the most cost-effective alternative to meeting the Enrollee's needs.
2. Items must meet applicable standards of manufacture, design, and installation.
3. There must be documentation on the ICP or case record that the best value in warranty coverage was obtained at the time of purchase.
4. Items must be of direct medical or remedial benefit to the Enrollee, and this benefit must be documented in the ICP.
5. Liquid nutritional supplement orders must be renewed every six months by a physician, physician's assistant, or nurse practitioner (in accordance with scope of practice).
6. Each direct service provider must enroll in Medicare and/or Medicaid as a Durable Medical Equipment provider, pharmacy, etc., as appropriate. This must be verified at the beginning of service delivery and annually thereafter.
7. The HIDE SNP may obtain some items directly from a retail store that offers the item to

the general public (i.e. Wal-Mart, K-mart, Meijer, Costco, etc.). When utilizing retail stores, the HIDE SNP must assure the item purchased meets the service standards. The HIDE SNP may choose to open a business account with a retail store for such purchases. The HIDE SNP must maintain the original receipts and maintain accurate systems of accounting to verify the specific Enrollee who received the purchased item.

8. Where feasible, the HIDE SNP and/or direct service provider shall seek confirmation of the need for the item from the Enrollee's physician.
9. The HIDE SNP shall not authorize waiver payment for herbal remedies, nutraceuticals, and/or other over-the-counter medications for uses not authorized by the FDA.
10. Some examples (not an exhaustive list) of covered items would be non-standard shower chairs/benches (standard shower chair, covered by state plan effective 1/1/2024), lift chairs, reachers, jar openers, transfer seats, bath lifts/room lifts, swivel discs, bath aids such as long handle scrubbers, telephone aids, automated telephones or watches that assist with medication reminders, button hooks or zipper pulls, modified eating utensils, modified oral hygiene aids, modified grooming tools, heating pads, sharps containers, exercise items and other therapy items, voice output blood pressure monitor, nutritional supplements such as Ensure, specialized turner or pointer, mouthstick for TDD, foot massaging unit, talking timepiece, adaptive eating or drinking device, book holder, medical alert bracelet, adapted mirror, weighted blanket, and back knobber.
11. If an HIDE SNP is considering use of a personal position change alarm as an intervention in an Enrollee's fall prevention strategy the use must be based on assessment of the Enrollee and monitored for efficacy (both beneficial and detrimental) on an ongoing basis. The alarm must be evaluated and assessed individually for each Enrollee to determine if the alarm has unintended consequences such as decreased mobility, sleep disturbances, incontinence, decreased freedom of movement, or infringement of dignity. The use of an alarm as part of the ICP cannot be restrictive in nature and does not eliminate the need for adequate supervision, nor does it replace individualized, person-centered care planning.

b. Adult Day Program

1. Enrollees cannot receive personal care services or Expanded Community Living Supports during the time spent at the Adult Day Program facility. Payment for Adult Day Program includes all services provided while at the facility. Personal care services and Expanded Community Living Supports may be used in conjunction with Adult Day Program services but cannot be provided at the exact same time unless the specific component of the service includes laundry, housecleaning, etc., that does not require the Enrollee to be present.
2. Adult Day Program should only be authorized if the Enrollee meets at least one of the following criteria:
 - a. Requires regular supervision to live in his or her own home or the home of a relative
 - b. If he or she has a caregiver, the Enrollee must require a substitute caregiver while his or her regular caregiver is unavailable
 - c. Has difficulty or is unable to perform ADLs without assistance
 - d. Capable of leaving his or her residence with assistance to receive services
 - e. In need of intervention in the form of enrichment and opportunities for social activities to prevent and/or postpone deterioration that may lead to institutionalization
 - f. A referral from an HIDE SNP for a waiver Enrollee shall replace any screening or

assessment activities performed for other Adult Day Program Enrollees at the setting. The direct adult day program service provider shall accept copies of the HIDE SNP's assessments and ICP to eliminate duplicate assessment and service planning activities.

3. Each program shall provide directly or arrange for the provision of the following services.
 - a. Transportation
 - b. Personal Care
 - c. Nutrition: one hot meal per eight-hour day which provides one- third of the recommended daily allowances and follows the meal pattern specified in the home delivered meals service standard. Enrollees in attendance from eight to fourteen hours per day shall receive an additional meal to meet a combined two-thirds of the recommended daily allowances. Modified diet menus should be provided where feasible and appropriate. Such modifications shall take into consideration Enrollee choice, health, religious and ethnic diet preferences
 - d. Recreation: consisting of planned activities suited to the needs of the Enrollee and designed to encourage physical exercise, to maintain or restore abilities and skill, to prevent deterioration, and to stimulate social interaction
 - e. If the program arranges for provision of any service at a place other than program operated facilities, a written agreement specifying supervision requirements and responsibilities shall be in place. For MICH HCBS Enrollees, the HIDE SNP shall provide care coordination.
4. Each program shall maintain comprehensive and complete files that include, at a minimum:
 - a. Details of the Enrollee's referral to the adult day program.
 - b. Intake records.
 - c. Assessment of individual need or copy of assessment (and reassessments from referring program).
 - d. ICP and any other service plan developed by the program site.
 - e. Listing of Enrollee contacts and attendance.
 - f. Progress notes in response to observations (at least monthly).
 - g. Notation of all medications taken on premises, including:
 - i. The medication;
 - ii. The dosage;
 - iii. The date and time of administration;
 - iv. The initials of the staff person assisting with administration; and comments
 - h. Notation of basic and optional services provided to the Enrollee.
 - i. Notation of any and all release of information about the Enrollee.
 - j. Signed release of information form.
5. Each program shall keep all Enrollee files confidential in controlled access files. Each program shall use a standard release of information form that is time limited and specific as to the released information.
6. Each provider shall employ a full-time program director with a minimum of a bachelor's degree in a health or human services field or be a qualified health professional. The provider shall continually provide support staff at a ratio of no less than one staff person for every ten participants. The provider may only provide health support services under the supervision of a registered nurse. If the program acquires either required or optional services from other individuals or organizations, the provider shall maintain a written agreement that clearly specifies the terms of the arrangement between the provider and other individual or organization.
7. Each program shall establish written procedures (reviewed and approved by a

consulting Pharmacist, Physician, or Registered Nurse) that govern the assistance given by staff to Enrollees taking their own medications while participating in the program. The policies and procedures must minimally address:

- a. Written consent from the Enrollee or Enrollee's representative, to assist in taking medications.
 - b. Verification of the Enrollee's medication regiment, including the prescriptions and dosages.
 - c. The training and authority of staff to assist Enrollees with taking their own prescribed or non-prescription medications and under what conditions such assistance may take place.
 - d. Procedures for medication set up.
 - e. Secure storage of medications belonging to and brought in by Enrollees. Medications must be returned to the Enrollee.
 - f. Instructions for entering medication information in Enrollee files, including times and frequency of assistance.
8. Program staff shall have basic first-aid training and any other training as required by MDHHS and the HIDE SNP.
9. If the provider operates its own vehicles for transporting Enrollees to and from the program site, the provider shall meet the following transportation minimum standards.
- a. The Secretary of State shall appropriately license all drivers and vehicles and all vehicles shall be appropriately insured.
 - b. All paid drivers shall be physically capable and willing to assist persons requiring help to get in and out of vehicles. The provider shall make such assistance available unless expressly prohibited by either a labor contract or an insurance policy.
 - c. All paid drivers shall be trained to cope with medical emergencies unless expressly prohibited by a labor contract.
 - d. Each program shall operate in compliance with P.A. 1 of 1985 regarding seat belt usage.
10. Each adult day program center shall have the following furnishings:
- a. At least one straight back or sturdy folding chair for each Enrollee and staff person.
 - b. Lounge chairs and/or day beds as needed for naps and rest periods.
 - c. Storage space for Enrollees' personal belongings.
 - d. Tables for both ambulatory and non-ambulatory Enrollees.
 - e. A telephone accessible to all Enrollees.
 - f. Special equipment as needed to assist persons with disabilities.
- The provider shall maintain all equipment and furnishings used during program activities or by program Enrollees in safe and functional condition.
11. Each provider shall post procedures to follow in emergencies (fire, severe weather, etc.) in each room of the program site. Providers shall conduct practice drills of emergency procedures once every six months. The program shall maintain a record of all practice drills.
12. Each adult day program center shall document that it is in compliance with:
- a. Barrier-free design specification of Michigan and local building codes.
 - b. Fire safety standards.
 - c. Applicable Michigan and local public health codes.
13. HCPCS codes S5101 and S5102 are limited to one unit per day.
14. Adult Day Program settings must be compliant with the HCBS Final Rule. Refer to the "HCBS Final Rule Requirements for Residential and Non- Residential Settings" section within this document.

c. Assistive Technology

1. Assistive technology (AT) includes:
 - a. The evaluation of the assistive technology needs of an Enrollee, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the Enrollee in the customary environment of the Enrollee. Evaluation should include a description of the Enrollee's needs, a description of their abilities without AT, a description of how the assistive technology will meet their needs and a list of all assistive technology and services that would be most effective to meet the needs of the Enrollee.
 - b. Services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for Enrollees; This does not include paying for or leasing vehicles, vehicle insurance and vehicle repairs.
 - c. Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
 - d. Coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the service plan;
 - e. Training or technical assistance for the Enrollee, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the Enrollee; and
 - f. Examples include, but are not limited to, hand controls, computerized voice system, communication boards, voice activated door locks, power door mechanisms, adaptive or specialized communication devices, assistive dialing device, adaptive door opener, specialized alarm or intercom. Items like cell phones, internet service, full-home wiring systems would be excluded from this benefit.
2. It must be documented in the ICP that the item is the most cost-effective alternative to meeting the Enrollee's needs.
3. Items must meet applicable standards of manufacture, design, and installation.
4. There must be documentation that the best value in warranty coverage was obtained at the time of purchase.
5. Items must be of direct medical or physical benefit to the Enrollee.
6. \$5000 yearly (waiver year) maximum for all other assistive technology devices.
7. Each direct service provider must enroll in Medicare and Medicaid as a DMEPOS provider, pharmacy, etc., as appropriate. Verification of provider qualifications must be conducted prior to service delivery and annually thereafter.
8. The HIDE SNP may obtain some items directly from a retail store that offers the item to the general public (i.e. Wal-Mart, K-mart, Meijer, Costco, etc.). When utilizing retail stores, the HIDE SNP must assure the item purchased meets the service standards. The HIDE SNP may choose to open a business account with a retail store for such purchases. The HIDE SNP must maintain the original receipts and maintain accurate systems of accounting to verify the specific Enrollee who received the purchased item.
9. Other contracted or subcontracted providers must have written policies and procedures compatible with requirements as specified in the SMAC.
10. Contracted/subcontracted providers must have any appropriate state licensure or certification required to complete or provide the service or item. Verification of provider qualifications must be conducted prior to service delivery and annually thereafter.
11. Where feasible, the HIDE SNP and/or direct service provider shall seek confirmation of the need for the item from the Enrollee's physician.

12. The Enrollee's privacy must be protected while utilizing assistive technology. Video recording is not allowed. The HIDE SNP should support individuals who need assistance with using the technology required for virtual video contacts through education and training. Consent and education for virtual visits (during quarantine/isolation) may be obtained at any point ahead of virtual technology being utilized. HIDE SNP Care Coordinator should identify and discuss potential risks with the Enrollee during the assessment and reassessments i.e. assistive technology related to privacy for Enrollees.

d. Chore Services

1. The HIDE SNP may also use waiver funds to purchase or rent the equipment or tools used to perform chore tasks for waiver Enrollees.
2. Each HIDE SNP must develop working relationships service providers, as available, in their program area to ensure effective coordination of efforts.
3. Pest control suppliers must be properly licensed.
4. Providers must be able to communicate effectively both orally and in writing. Verification of provider qualifications must be conducted prior to service delivery and annually thereafter.

For self-determined Chore Services:

1. Providers must have previous relevant experience and/or training for the tasks specified and authorized in the ICP.
2. The HIDE SNP must deem the chosen provider capable of performing the required tasks.

e. Environmental Modifications

1. Environmental Modifications include the installation of ramps and grab bars (suction cup grab bars are prohibited), widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the Enrollee. Complex kitchen and bathroom modifications may be competed if medically necessary for the Enrollee. Environmental modifications are those which are installed in the residence versus enhanced equipment or assistive technology which are portable from residence to residence.
 - a. Note: If installation of a piece of equipment requires being screwed into a wall (e.g., E0241/E0243), the HIDE SNP can use S5165 with standard remark '5005: Equipment Installation Charge' to provide waiver coverage for the installation.
2. Porch/patio/stair railings may be provided as long as it is directly related to enhancement of the Enrollee's mobility.
3. Patios, decks, stairs or walkways may be installed or restructured if directly related to enhancement of the Enrollee's mobility.
4. Environmental modifications such as ramps, etc., are NOT limited to individuals in wheelchairs. Ramps may be provided for anyone who has mobility challenges with trouble entering and exiting the residence. For example, an Enrollee who does walk but has difficulty climbing stairs to get into and out of the home may benefit from a ramp.
5. The case record must contain documented evidence that the modification is the most cost effective and reasonable alternative to meet the Enrollee's need. An example of a reasonable alternative, based on the results of a review of all options, may include

changing the purpose, use or function of a room within the home or finding alternative housing. The Enrollee must use Medicaid state plan, Medicare, or other available payers first.

6. The Enrollee, with the direct assistance of the care coordinator, when necessary, must make a reasonable effort to access all available funding sources, such as housing commission grants, Michigan State Housing Development Authority (MSHDA) and community development block grants. The Enrollee's record must include evidence of efforts to apply for alternative funding sources and the acceptances or denials of these funding sources. The MICH waiver is a funding source of last resort.
 - a. Care Coordinators must document any attempts they make to secure alternate funding (discussion with family on resources, internet research, phone calls, emails, etc.) in their case notes.
 - b. A signed and dated statement by the care coordinator that they have made diligent attempts and were unable to find and/or secure alternative payment sources will satisfy this requirement for the Environmental Modification Service.
 - c. If, in the Care Coordinator's assessment, the process to secure alternate funding sources (once initiated) will create a barrier to timely access to needed services that will have a negative impact on the Enrollee's health and welfare, the care coordinator should document this assessment and may proceed with implementing the environmental modification.
7. This service shall not be used for upgrades to the home or for additions to homes (adding square footage, etc.). Modifications/adaptations shall only be used to modify existing spaces or structures. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).
8. The modification/adaptation must be for a primary residence but may include additional residences subject to prior authorization by the HIDE SNP. Physical adaptations to the primary residence or the Enrollee's family residence if applicable, required by the Enrollee's service plan, that are necessary to ensure the health and welfare of the Enrollee or that enable the Enrollee to function with greater independence in the home. Examples of additional residences might be a family member's cottage or the Enrollee's second home or cottage so the Enrollee can go there and be with family.
9. The HIDE SNP may use MICH funds for labor costs and to purchase materials used to complete the modification to prevent or remedy a safety hazard. The direct service provider shall provide the equipment or tools needed to perform the tasks unless another source can provide the equipment or tools at a lower cost or free of charge and the provider agrees to use those tools.
10. Assessments and specialized training needed in conjunction with the use of such environmental modifications are included as part of the cost of the service.
11. This service does not include modifications to rental properties if the rental agreement states that it is the responsibility of the landlord to provide such modifications.
12. Prior to the start of the modification of a rental property or unit, the landlord must approve the modification plan. A written agreement between the landlord, the Enrollee, and the HIDE SNP must specify any requirements for restoration of the property to its original condition if the occupant moves. If the HIDE SNP is experiencing a scenario in which the landlord is refusing to allow reasonable modifications for individuals with disabilities to be completed on their properties, the landlord may have an obligation to allow the reasonable accommodation. Please refer to the federal Fair Housing Act for details.
13. Repairs, modifications, or adaptations shall not be performed on a condemned structure

- or a home in the foreclosure process. A home is considered in the foreclosure process once the Sheriff's sale date is scheduled and published in the county newspaper.
14. The modification must incorporate reasonable and necessary construction standards, excluding cosmetic improvements.
 15. Excluded are those adaptations or improvements to the home that:
 - a. Are of general utility;
 - b. Are considered to be standard housing obligations of the Enrollee or homeowner; and (See examples in specific exclusions listed below of modifications that would be general utility and a standard obligation of the Enrollee.
 - c. Are not of direct medical or remedial benefit to the Enrollee. For example, a kitchen modification required for the Enrollee to prepare his or her own meals is a modification with a direct remedial benefit. Whereas a general kitchen remodel is of general utility and a standard housing obligation of the Enrollee.
 16. Examples of exclusions include, but are not limited to, carpeting, roof repair, sidewalks, driveways, heating, central air conditioning (unless it is the most cost effective and reasonable alternative), garages, raised garage doors, storage and organizers, hot tubs, whirlpool tubs, swimming pools, landscaping and general home repairs unless directly related to the adaptations/modifications being made due to a medical or remedial benefit.
 17. Environmental adaptations shall exclude costs for improvements exclusively required to meet local building codes and not directly related to an Enrollee's medical or physical condition.
 18. The infrastructure of the home involved in the funded adaptations (e.g., electrical system, plumbing, well or septic, foundation, heating and cooling, smoke detector systems, or roof) must be in compliance with any applicable local codes.
 19. Environmental adaptations required to support proper functioning of medical equipment, such as electrical upgrades, are limited to the requirements for safe operation of the specified equipment and are not intended to correct existing code violations in an Enrollee's home.
 20. The existing structure must have the capability to accept and support the proposed changes.
 21. The HIDE SNP shall not cover general construction costs in a new home or additions to a home purchased after the Enrollee is enrolled in the waiver. If an Enrollee or the Enrollee's family purchases or builds a home while receiving waiver services, it is the Enrollee's or family's responsibility to assure the home will meet basic needs, such as having a ground floor bath or bedroom if the Enrollee has mobility limitations. However, MICH funds may be authorized to assist with the adaptations noted above (e.g. ramps, grab bars, widening doorways, bathroom modifications, etc.) for a home recently purchased. If modifications are needed to a home under construction that require special adaptation to the plan (e.g. roll-in shower), the HIDE SNP may fund the difference between the standard fixture and the modification required to accommodate the Enrollee's need.
 22. A ramp or lift will be covered for only one exterior door or other entrance unless otherwise approved by MDHHS.
 23. Contracted providers such as licensed building contractors, must have appropriate certification or licensure under Michigan regulations and law such as MCL 339.601(1), MCL 339.601.2401, or MCL 339.601.2403(3).
 24. Verification of certification, licensure, or other provider qualifications must be done prior to execution of the contract related to the modification project to be done.
 25. The HIDE SNP must assure that there is a signed contract or bid proposal with the builder or contractor prior to the start of an environmental modification. It is the

responsibility of the HIDE SNP to work with the Enrollee and builder or contractor to ensure the work is completed as outlined in the contract or bid proposal. All services must be provided in accordance with applicable state or local building codes.

f. Expanded Community Living Supports

1. Expanded Community Living Supports (ECLS) include:
 - a. To qualify for this service, the Enrollee MUST have a need for prompting, cueing, supervision for at least one ADL (eating, bathing, dressing, toileting, personal hygiene, etc.).
 - b. If and only if the Enrollee qualifies for ECLS based on ADL needs, he or she may also receive hands-on assistance or prompting, cueing, supervision for at least one IADL (laundry, meal preparation, transportation, money management, help with medication, shopping, attending medical appointments, and other household tasks). Also covered are assistance, support, and/or guidance with such activities as:
 - c. Money management
 - ii. Non-medical care (not requiring nursing or physician intervention)
 - iii. Social participation, relationship maintenance, and building community connections to reduce personal isolation
 - iv. Transportation (excluding to and from medical appointments) from the Enrollee's residence to community activities, among community activities, and from the community activities back to the Enrollee's residence
 - v. Participation in regular community activities incidental to meeting the Enrollee's community living preferences
 - vi. Attendance at medical appointments
 - vii. Acquiring or procuring goods and services necessary for home and community living
 - d. Reminding, cueing, observing, and/or monitoring of medication administration
 - e. Staff assistance with preserving the health and safety of the Enrollee in order that he/she may reside and be supported in the most integrated independent community setting.
 - f. Training or assistance on activities that promote community participation, such as using public transportation, using libraries, or volunteer work.
 - g. Dementia support, including but not limited to redirection, reminding, modeling, socialization activities, and activities that assist the Enrollee as identified in the Enrollee's ICP.
 - h. Observing and reporting to the care coordinator any changes in the Enrollee's condition and the home environment.
 - i. If the Enrollee has an exposure or condition for which a federal, state, or local public health or gov't official(s) has released applicable quarantine or isolation guidelines, ECLS services that only require verbal cueing may be provided via HIPAA compliant virtual method (audio and video only; cannot be only audio) in lieu of in person during the quarantine or isolation period only. Approval of remote support must be reflected on the individual integrated care and support plan. If virtual method is utilized, the Enrollee's privacy must be protected during virtual visits. Video recording is not allowed. The HIDE SNP should support individuals who need assistance with using the technology required for virtual video contacts through education and training. Written or electronic consent must be obtained from the Enrollee for use of the virtual option. Consent and

education for virtual visits (during quarantine/isolation) may be obtained at any point ahead of the virtual method being utilized.

2. Individual providers who are chosen by the Enrollee must meet the following provider qualifications (qualifications must be verified prior to initial service delivery and annually thereafter):
3. Providers must be at least 18 years of age, have ability to communicate effectively both orally and in writing and follow instructions, be trained in first aid and cardiopulmonary resuscitation, be able to prevent transmission of communicable disease and be in good standing with the law as validated by a criminal history review. If providing transportation related to this service, the provider must possess a valid Michigan driver's license.
 - a. Individuals providing ECLS must have previous relevant experience or training and skills in housekeeping, household management, good health practices, observation, reporting, recording information, and reporting and identifying abuse and neglect. The individual(s) must also be trained in the Enrollee's ICP. Additionally, skills, knowledge, and experience with food preparation, safe food handling procedures are highly desirable.
 - b. Previous relevant experience and training to meet MDHHS operating standards. Refer to the HIDE SNP contract for more details.
 - c. Must be deemed capable of performing the required tasks by HIDE SNP.
4. Home Care agency providers must meet the following provider qualifications (qualifications must be verified prior to initial service delivery and annually thereafter):
 - a. Providers must be at least 18 years of age, have the ability to communicate effectively both orally and in writing and follow instructions, be trained in first aid, be trained in universal precautions and blood-borne pathogens, and be in good standing with the law as validated by a criminal history review.
 - b. A registered nurse licensed to practice nursing in the State shall furnish supervision of ECLS providers. At the State's discretion, other qualified individuals may supervise ECLS providers. The direct care worker's supervisor shall be available to the worker at all times the worker is furnishing ECLS services.
 - c. The HIDE SNP and/or provider agency must train each worker to properly perform each task required for each Enrollee the worker serves before delivering the service to that Enrollee. The supervisor must assure that each worker can competently and confidently perform every task assigned for each Enrollee served. MDHHS strongly recommends each worker delivering ECLS services complete a certified nursing assistance training course.
 - d. ECLS providers may prompt, cue, or supervise the Enrollee to perform higher-level, non-invasive tasks such as maintenance of catheters and feeding tubes, minor dressing changes, and wound care if the direct care worker has been individually trained and supervised by an RN for each Enrollee who requires such care. The supervising RN must assure each workers confidence and competence in the performance of each task required.
 - e. Individuals providing ECLS services must have previous relevant experience or training and skills in housekeeping, household management, good health practices, observation, reporting, and recording information. Additionally, skills, knowledge, and/or experience with food preparation, safe food handling procedures, and reporting and identifying abuse and neglect are highly desirable.
5. When the ECLS services provided to the Enrollee include transportation, the following standards apply:
 - a. The HIDE SNP may not use MICH funds to purchase or lease vehicles for providing transportation services to waiver Enrollees.

- b. The Secretary of State must appropriately license all drivers and register all vehicles used for transportation supported all or in part by MICH funds. The provider must cover all vehicles used with liability insurance.
 - c. All paid drivers for transportation providers supported entirely or in part by MICH funds shall be physically capable and willing to assist persons requiring help to and from and to get in and out of vehicles. The provider shall offer such assistance unless expressly prohibited by either a labor contract or insurance policy.
 - d. The provider shall train all paid drivers for transportation programs supported entirely or in part by MICH funds to cope with medical emergencies, unless expressly prohibited by a labor contract or insurance policy.
 - e. Each provider shall operate in compliance with P.A. 1 of 1985 regarding seat belt usage.
 - f. Additionally, transportation on behalf of the Enrollee during the quarantine or isolation period to allow others to obtain items required for the Enrollee is also acceptable. Plans may use this service to authorize MICH HCBS funds to reimburse individuals (ECLS providers) to run errands for Enrollees when the Enrollee does not accompany the driver of the vehicle during only an applicable quarantine or isolation period. The purpose of expanding the ECLS service is for the Enrollee to gain access to the community as needed during these temporary periods when the Enrollee is required to isolate due to their condition. For example, while the Enrollee is isolated, the provider may complete a task such as shopping that they would normally accompany the Enrollee to do when the Enrollee is not required to be isolated.
6. Each direct service provider who chooses to allow staff to assist Enrollees with self-medication shall establish written procedures that govern the assistance given by staff. These procedures shall be reviewed by a consulting pharmacist, physician, or RN and shall include, at a minimum:
- a. The provider staff authorized to assist Enrollees with taking their own prescription or over-the-counter medications and under what conditions such assistance may take place. This must include a review of the type of medication the Enrollee takes and its impact upon the Enrollee.
 - b. Verification of prescription medications and their
 - c. dosages. The Enrollee shall maintain all medications in their original, labeled containers.
 - d. Instructions for entering medication information in Enrollee files.
 - e. A clear statement of the Enrollee's and his/her family's responsibility regarding medications taken by the Enrollee and the provision for informing the Enrollee and his/her family of the provider's procedures and responsibilities regarding assisted self-administration of medications.
7. ECLS providers may only administer medications in compliance with Michigan Administrative Rule 330.7158:
- a. A provider shall only administer medication at the order of a physician and in compliance with the provisions of section 719 of the act, if applicable.
 - b. A provider shall assure that medication use conforms to federal standards and the standards of the medical community.
 - c. A provider shall not use medication as punishment, for the convenience of the staff, or as a substitute for other appropriate treatment.
 - d. A provider shall review the administration of a psychotropic medication periodically as set forth in the Enrollee's ICP and based upon the Enrollee's clinical status.

- e. If an Enrollee cannot administer his or her own medication, a provider shall ensure that medication is administered by or under the supervision of personnel who are qualified and trained.
 - f. A provider shall record the administration of all medication in the Enrollee's record. The HIDE SNP may do this electronically or via paper format, but the records must be readily available if requested by MDHHS.
 - g. A provider shall ensure that medication errors and adverse drug reactions are immediately and properly reported to a physician and recorded in the Enrollee's record.
8. ECLS cannot be provided in circumstances where they would be a duplication of services available through MICH. The distinction must be apparent by unique hours and units in the approved ICP.
 9. ECLS does not include the cost associated with room and board.
 10. ECLS may be furnished outside the Enrollee's home.
 11. The Enrollee oversees and supervises individual providers on an on-going basis when participating in arrangements that support self-determination. This may also include transportation to allow people to get out into the community when it is incidental to the ICP. When transportation incidental to the provision of ECLS is included, the
 12. HIDE SNP shall not also authorize transportation as a separate waiver service for the Enrollee.
 13. ECLS services cannot be provided in circumstances where they would be a duplication of services available under the state plan or elsewhere.
 14. ECLS excludes nursing and skilled therapy services.
 15. Members of an Enrollee's family may provide ECLS to the Enrollee. Family members who provide this service must meet the same standards as providers who are unrelated to the Enrollee. Spouses and legally responsible adults are allowed to be paid providers of ECLS when the Enrollee requires extraordinary care and it is in the best interest of the enrollee. The legally responsible individual must be hired by a homecare agency that will provide supervision and oversight to ensure services are being delivered and that payment is made for the services rendered. Spouses and legally responsible adults must not be hired via self-determination. Refer to the MICH 1915c waiver application Appendix C Section 2 Subsection d for details related to what constitutes extraordinary care and best interest of enrollee. Roommates or other individuals who live with the Enrollee may provide ECLS services, but payment for services must be pro-rated by one-half if the service will also benefit the person performing the service (i.e. meal preparation, laundry, housecleaning, etc.). Paid ECLS services are only for the benefit of the Enrollee receiving the services.
 16. In shared living arrangements where there is more than one person in the home receiving the service by the same caregiver, payment for services must be based on a pro-rated percentage/fraction relative to the care each person receives. When services can be clearly documented separately from other individuals in the home, payment need not be pro-rated. Providers must be trained to perform each required task prior to service delivery. The supervisor must assure the provider can competently and confidently perform each assigned task.
 17. ECLS may be provided in addition to Medicaid State Plan Personal Care Services if the Enrollee requires hands-on assistance with some ADLs and/or IADLs, as covered under the State Plan service, but requires prompting, cueing, guiding, teaching, observing, reminding, or other support (not hands-on) to complete other ADLs or IADLs independently, but to ensure safety, health, and welfare of the Enrollee. ECLS and Personal Care Services may not both be provided for the same ADL or IADL at the same time during the day. For example, supervision/prompting/cueing for Bathing should

not be provided at the same time as the hands-on assistance for Bathing. If hands-on assistance is needed at this time, the billing should be for Personal Care Services instead of ECLS.

18. It is okay for ECLS and Personal Care Services to be used for the same ADL or IADL during the same day but at different times during the day. For example, the individual may need prompting/cueing/supervision in the morning and more hands-on assistance in the evening due to being more tired at the end of the day. This is an acceptable use of the services as long as they are assessed, billed and paid according to appropriate service code.
19. Some activities under ECLS may also fall under activities in other waiver services. If other waiver services are used for these activities, this must be clearly identified in the ICP and other documentation and billed under the appropriate procedure codes to avoid duplication of services.
20. With the assistance of the Enrollee and/or Enrollee's caregiver, the HIDE SNP or direct service provider shall determine an emergency notification plan for each Enrollee, pursuant to each visit for emergencies and provider no-shows or late arrivals.

Additional Standards for Enrollees Who Reside in Licensed Settings

1. ECLS provided in a licensed setting includes only those supports and services that are in addition to, and shall not replace, usual and customary care furnished to residents in the licensed setting.
2. Documentation in the Enrollee's record must clearly identify the Enrollee's need for additional supports and services not covered by licensure.
3. The ICP must clearly identify the portion of the Enrollee's supports and services covered by ECLS.

Minimum Standards for Self-Determined Service Delivery

1. When authorizing ECLS for Enrollees choosing the self-determination option, the HIDE SNP must comply with service definitions described in the Minimum Standards for Traditional Service Delivery specified above.
2. Each chosen provider furnishing transportation as a component of this service must have a valid Michigan driver's license.
3. Providers must meet the same qualifications as those under the traditional service delivery model.
4. When the ECLS services provided to the Enrollee include tasks specified in #1 above, under Minimum Standards for Traditional Service Delivery, the individual furnishing ECLS must also be trained in cardiopulmonary resuscitation. This training may be waived when the provider is furnishing services to an Enrollee who has a "Do Not Resuscitate" order.

g. Fiscal Intermediary

1. Fiscal Intermediary services are available only to Enrollees participating in arrangements that support self-determination. Additionally, Fiscal Intermediary services may not be provided by the Enrollee's family, guardian, or providers of other services for the same Enrollee.
2. FI services include, but are not limited to, the facilitation of the employment of service workers by the Enrollee, including federal, state, and local tax withholding/payments,

unemployment compensation fees, wage settlements; fiscal accounting; tracking and monitoring Enrollee- directed budget expenditures and identify potential over and under expenditures; assuring compliance with documentation requirements related to management of public funds. The FI helps the Enrollee manage and distribute funds contained in the individual budget. The FI also assists with training the Enrollee and providers, as necessary, in tasks related to the duties of the FI including, but not limited to, billing processes and documentation requirements.

3. Each FI must be bonded and insured. The insured amount must exceed the total budgetary amount the FI is responsible for administering.
4. Each FI must demonstrate the ability to manage budgets and perform all functions of the FI including all activities related to employment taxation, worker's compensation, and state, local, and federal regulations.
5. Each FI must demonstrate competence in managing budgets and performing other functions and responsibilities of a fiscal intermediary.
6. Each FI will provide four basic areas of performance:
7. Function as the employer agency for Enrollees directly employing workers to assure compliance with payroll tax and insurance requirements;
8. Ensure compliance with requirements related to management of public funds, the direct employment of workers by Enrollees, and contracting for other authorized supports and services;
9. Facilitate successful implementation of the self-determination arrangements by monitoring the use of the budget and providing monthly budget status reports to each Enrollee and HIDE SNP; and
10. Offer supportive services to enable Enrollees to self-determine and direct the supports and services they need.
11. The HIDE SNP and fiscal intermediary must abide by the Self-Determination Implementation Technical Advisory and any other requirements set forth by MDHHS.

h. Home Delivered Meals

1. Each HIDE SNP must have written eligibility criteria for persons receiving home delivered meals through the waiver which include, at a minimum:
 - a. The Enrollee must be unable to obtain food or prepare complete meals.
 - b. The provider can appropriately meet the Enrollee's special dietary needs and the meals available would not jeopardize the health of the Enrollee.
 - c. The Enrollee must agree to be home when meals are delivered, or contact the program when absence is unavoidable. In the case of an occasional temporary absence, such as a doctor's appointment, the provider may leave the meals with a designated caregiver or household member if approval for such is reflected on the ICP.
2. Each home delivered meals provider shall have the capacity to provide three meals per day, which together meet the Dietary Reference Intakes (DRI) and recommended dietary allowances (RDA) as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences. Each provider must have meals available at least five days per week. Enrollees may select to have up to two meals per day, which means they could receive breakfast and lunch, lunch and dinner, or breakfast and dinner.
3. Federal regulations prohibit from providing three meals per day to Enrollees. Meal service should be offered in relation to variable availability of allies or formal caregivers and changes in the Enrollee's condition. When the HIDE SNP provides home delivered

meals less than seven days per week, the HIDE SNP shall identify and/or document in the Care Bridge Record or ICP, the alternative source of all meals that are not provided by the HIDE SNP. Please Note: HIDE SNPs are allowed to provide two home delivered meals through the c-waiver and supplement a third meal with the hands-on personal care service of 'meal preparation' when needed.

4. HIDE SNPs must offer a variety of meal options to suit the Enrollee's needs and desires. For example, if an Enrollee prefers to have meals that do not need to be warmed, these should be provided. Similarly, if an Enrollee prefers to have frozen meals that require warming via whatever means the Enrollee has available, these should be provided.
5. The program may offer liquid meals to Enrollees when ordered by a physician. The regional dietitian must approve all liquid meal products used by the provider. The provider or care coordinator must provide instruction to the Enrollee and/or the Enrollee's caregiver and family in the proper care and handling of liquid meals. The HIDE SNP and provider must meet the following requirements when liquid meals are the sole source of nutrition:
 - a. Diet orders shall include Enrollee weight and specify the required nutritional content of the liquid meals.
 - b. The care coordinator must ensure the Enrollee's physician renews the diet orders every three months
 - c. The HIDE SNP and Enrollee must develop the plan of care for the Enrollee receiving liquid meals in consultation with the Enrollee's physician. This plan must be included in the Enrollee's ICP.
6. The provider may furnish frozen meals when feasible and appropriate. When furnishing frozen meals, the following standards must be met:
 - a. The care coordinator must verify and maintain records (Care Bridge Record or ICP) that indicate each Enrollee receiving frozen meals has and maintains the ability to store and handle frozen meals properly.
 - b. The provider may only provide frozen meals in situations where it is not logistically feasible to provide the Enrollee with a hot meal, with the exception of holidays, weekends, or emergencies.
 - c. Providers shall not furnish more than a two-week supply of frozen meals to an Enrollee during one home delivery visit.
7. Each provider shall develop and have available written plans for continuing services in emergency situations such as short-term natural disasters (e.g., snow and/or ice storms), loss of power, physical plant malfunctions, etc. The provider shall train staff and volunteers on procedures to follow in the event of severe weather or natural disasters and the county emergency plan.
8. The meals authorized under this service shall not constitute a full nutritional regimen.
9. Providers shall not solicit donations from waiver Enrollees.
10. Dietary supplements are not covered under this service.
11. Home Delivered Meals is not intended to provide food for Enrollees solely for financial reasons in which the Enrollee or his or her caregivers or family cannot afford to buy food.
12. If the Enrollee has an exposure or condition for which a federal, state, or local public health or gov't official(s) has released applicable quarantine or isolation guidelines, HDMs may be left at the Enrollee's door in lieu of in person during the quarantine or isolation period only. Approval of door drop off must be reflected on the individual integrated care and support plan.
13. When meal delivery kits are utilized (Hello Fresh, Blue Apron, etc.), they constitute no more than the equivalent of 2 meals/day. The ICP must reflect the need and whether the home delivery kit meets the needs of the Enrollee (e.g., Enrollee has a need to access to groceries or a preference for meal delivery kits and individual is capable of (or has

- assistance) completing the level of preparation required with the meal delivery kit meals). Enrollees have a choice of all willing and qualified providers. The option for prepared meals through a traditional home delivered meals provider remains available.
14. If an Enrollee has been receiving Meals on Wheels or home delivered meals through sources external to the HIDE SNP (i.e., grants, Older Americans Act funding, not covered by Medicaid) and wishes to continue receiving them and meets nursing facility level of care (as evidenced by the LOCD tool), the Enrollee may receive the meals through the Home Delivered Meals waiver service. A MICH HCBS Waiver enrollment must be submitted to CHAMPS. Criteria in #11 above still applies. The HIDE SNP must be the payer source in order for this to qualify as the HCBS waiver service.
 - a. The Enrollee may choose to keep receiving services through the same entity and not through the HIDE SNP and HCBS Waiver. This is fine, but the HIDE SNP is not required to pay for it. If the HIDE SNP does not pay for it, this does not qualify as the Home Delivered Meals waiver service.
 15. HDM also includes service or membership fees for grocery delivery services.

Grocery delivery services:

 - a. Must not include payment for the food
 - b. Must have difficulty with one or more of the following or quarantine due to illness or public health emergency:
 1. getting to the grocery store
 2. selecting groceries in the store
 3. transporting groceries from store to home
 15. Refer to the 'MICH Home Delivered Meals Service Guidelines Resource Document' for additional information.

i. Individual Goods and Services

1. Individual goods and services are only available if the Enrollee does not have the funds to purchase the item or service or the item or service is not available through another source.
2. Goods and Services are only approved by CMS for self-direction Enrollees. Experimental or prohibited treatments are excluded. Goods and Services must be documented in the individual plan of services and must be clearly linked to an assessed Enrollee need in the ICP.
3. Goods and services purchased under this coverage may not circumvent other restrictions on the claiming of FFP for waiver services, including the prohibition against claiming for the costs of room and board. The specific goods and services that are purchased under this coverage must be documented in the service plan.
4. Where applicable, the Enrollee must use Medicaid state plan, Medicare, or other available payers first. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

j. Non-Medical Transportation

1. Whenever possible, the HIDE SNP shall utilize family, neighbors, friends, or community agencies that can provide this service free of charge. If the service is provided at no cost to the HIDE SNP, the Enrollee would not qualify for this service.
2. Direct service providers shall be a centrally organized transportation company or agency. The provider may provide transportation utilizing any of the following methods:

- a. Demand/Response: Characterized by scheduling of small vehicles to provide door-to-door or curb-to-curb service on demand. The provider may include a passenger assistance component and either or both of the following variations:
 - i. Route Deviation Variation: A normally fixed- route vehicle leaves the scheduled route upon request to pick up the Enrollee.
 - ii. Flexible Routing Variation: Providers constantly modify routes to accommodate service requests.
 - b. Public Transit: Characterized by partial or full payment of the cost for an Enrollee to use an available public transit system. (This can be either a fixed route or demand/response). The provider may include a passenger assistance component.
 - c. Volunteer: Characterized by reimbursement of out-of-pocket expenses for individuals who transport Enrollees in their private vehicles. The provider may include a passenger assistance component.
 - d. Ambu-cab: Characterized by a wheelchair-equipped van to provide door-to-door service on demand. The provider shall include a passenger assistance component.
3. Transportation vehicles must be properly licensed and registered by the State and must be covered with liability insurance.
 4. MICH funds may not be used to purchase or lease vehicles for providing transportation services to waiver Enrollees.
 5. All paid drivers for transportation providers supported entirely or in part by MICH funds shall be physically capable and willing to assist persons requiring help to and from and to get in and out of vehicles. The provider shall offer such assistance unless expressly prohibited by either a labor contract or insurance policy.
 6. The provider shall train all paid drivers for transportation programs supported entirely or in part by waiver funds to cope with medical emergencies, unless expressly prohibited by a labor contract or insurance policy.
 7. Each provider shall operate in compliance with P.A. 1 of 1985 regarding seat belt usage.
 8. This service must not be used to take an Enrollee to the pharmacy unless that pharmacy is also a place where the Enrollee is also purchasing groceries or other non-medical items/supplies in the same trip.

k. Personal Emergency Response System

1. The Federal Communication Commission must approve the equipment used for the response system. The equipment must meet UL® safety standards 1637 specifications for Home Health Signaling Equipment.
2. The provider may offer this service for cellular or mobile phones and devices. The device must meet industry standards. The Enrollee must reside in an area where the cellular or mobile coverage is reliable. When the Enrollee uses the device to signal and otherwise communicate with the PERS provider, the technology for the response system must meet all other service standards.
3. The provider must assure at least monthly testing of each PERS unit to assure continued functioning.
4. PERS does not cover monthly telephone charges associated with phone service.
5. PERS is limited to persons who either live alone or who are left alone for significant periods of time on a routine basis and who could not summon help in an emergency without this device. The HIDE SNP may authorize PERS units for persons who do not live alone if both the waiver Enrollee and the person with whom they reside would

require extensive routine supervision without a PERS unit in the home. An example of this is two individuals who live together, and both are physically and/or cognitively unable to assist the other individual in the event of an emergency.

6. The provider must staff the response center with trained personnel 24 hours per day, 365 days per year. The response center will provide accommodations for persons with limited English proficiency.
7. The response center must maintain the monitoring capacity to respond to all incoming emergency signals.
8. The response center must have the ability to accept multiple signals simultaneously. The response center must not disconnect calls for a return call or put in a first call, first serve basis.
9. The provider will furnish each responder with written instructions and provide training, as appropriate.

I. Preventive Nursing Services

1. When the Enrollee's condition is unstable, could easily deteriorate, or when significant changes occur, the HIDE SNP covers nurse visits for observation and evaluation. The purpose of the observation and evaluation is to monitor the Enrollee's condition and report findings to the Enrollee's physician or other appropriate health care professional to prevent additional decline, illness, or injury to the Enrollee.
2. The care coordinator shall communicate with both the nurse providing this service and the Enrollee's health care professional to assure the nursing needs of the Enrollee are being addressed.
3. Enrollees must meet at least one of the following criteria to qualify for this service:
 - a. Be at high risk of developing skin ulcers or have a history of resolved skin ulcers that could easily redevelop.
 - b. Require professional monitoring of vital signs when changes may indicate the need for modifications to the medication regimen.
 - c. Require professional monitoring or oversight of blood sugar levels, including Enrollee-recorded blood sugar levels, to assist with effective pre-diabetes or diabetes management.
 - d. Require professional assessment of the Enrollee's cognitive status or alertness and orientation to encourage optimal cognitive status and mental function or identify the need for modifications to the medication regimen.
 - e. Require professional evaluation of the Enrollee's success with a prescribed exercise routine to assure its effectiveness and identify the need for additional instruction or modifications when necessary.
 - f. Require professional evaluation of the Enrollee's physical status to encourage optimal functioning and discourage adverse outcomes.
 - g. Have a condition that is unstable, could easily deteriorate, or experience significant changes AND a lack of competent informal supports able to readily report life-threatening changes to the Enrollee's physician or other health care professional.
4. In addition to the observation and evaluation, a nursing visit may also include, but is not limited to, one or more of the following nursing services:
 - a. Administering prescribed medications that cannot be self-administered (as defined under Michigan Compiled Law (MCL) 333.7103(1)).
 - b. Setting up medications according to physician orders.
 - c. Monitoring Enrollee adherence to his or her medication regimen.

- d. Applying dressings that require prescribed medications and aseptic techniques.
 - e. Providing refresher training to the Enrollee or informal caregivers to assure the use of proper techniques for health-related tasks such as diet, exercise regimens, body positioning, taking medications according to physician's orders, proper use of medical equipment, performing activities of daily living, or safe ambulation within the home.
5. This service is limited to no more than two hours per visit
 6. Enrollees receiving Private Duty Nursing services are not eligible to receive Preventive Nursing Services
 7. All providers must be licensed in the State of Michigan as a Registered Nurse or Licensed Practical Nurse
 8. This service must not duplicate other services offered under Michigan Medicaid State Plan or Medicare. These services must be exhausted first if specific service overlaps exactly with this waiver service.

Minimum Standards for Self-Determined Service Delivery

1. When authorizing Preventive Nursing Services for Enrollees choosing the self-determination option, the HIDE SNP must comply with rules described above in the service definition and Minimum Standards for Traditional Service Delivery.

m. Private Duty Nursing

Private Duty Nursing (PDN) Medical Criteria

1. To be eligible for PDN services, the HIDE SNP must find the Enrollee meets either Medical Criteria I or Medical Criteria II, and Medical Criteria III (see criteria below). Regardless of whether the Enrollee meets Medical Criteria I or II, the Enrollee must also meet Medical Criteria III.
 - a. Medical Criteria I – The Enrollee is dependent daily on technology based medical equipment to sustain life. "Dependent daily on technology-based medical equipment" means:
 - i. Mechanical rate-dependent ventilation (four or more hours per day), or assisted rate dependent respiration (e.g., some models of Bi-PAP); or
 - ii. Deep oral (past the tonsils) or tracheostomy suctioning eight or more times in a 24-hour period; or
 - iii. Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility; or
 - iv. Total parenteral nutrition delivered via a central line, associated with complex medical problems or medical fragility; or
 - v. Continuous oxygen administration (eight or more hours per day), in combination with a pulse oximeter and a documented need for skilled nursing assessment, judgment, and intervention in the rate of oxygen administration. This would not be met if oxygen adjustment is done only according to a written protocol with no skilled assessment, judgment or intervention required. Continuous use of oxygen therapy is a covered Medicaid benefit for Enrollees aged 21 or older when tested at rest while breathing room air and the oxygen saturation rate is 88 percent or

below, or the PO₂ level is 55 mm HG or below.

- b. Medical Criteria II – Frequent episodes of medical instability within the past three to six months, requiring skilled nursing assessments, judgments, or interventions (as described in III below) as a result of a substantiated medical condition directly related to the physical disorder. Definitions:

- i. "Frequent" means at least 12 episodes of medical instability related to the progressively debilitating physical disorder within the past six months, or at least six episodes of medical instability related to the progressively debilitating physical disorder within the past three months.
- ii. "Medical instability" means emergency medical treatment in a hospital emergency room or inpatient hospitalization related to the underlying progressively debilitating physical disorder.
- iii. "Emergency medical treatment" means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services and are needed to evaluate or stabilize an emergency medical condition.
- iv. "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention would result in placing the health of the Enrollee in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
- v. "Directly related to the physical disorder" means an illness, diagnosis, physical impairment, or syndrome that is likely to continue indefinitely, and results in significant functional limitations in 3 or more activities of daily living.
- vi. "Substantiated" means documented in the clinical or medical record, including the nursing notes.

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

Definitions:

- i. "Continuous" means at least once every 3 hours throughout a 24-hour period, and when delayed interventions may result in further deterioration of health status, in loss of function or death, in acceleration of the chronic condition, or in a preventable acute episode. Equipment needs alone do not create the need for skilled nursing services.
- ii. "Skilled nursing" means assessments, judgments, interventions, and evaluations of interventions requiring the education, training, and experience of a licensed nurse. Skilled nursing care includes, but is not limited to:
 2. Performing assessments to determine the basis for acting or a need for action, and documentation to support the frequency and scope of those decisions or actions;
 3. Managing mechanical rate-dependent ventilation or assisted rate-dependent respiration (e.g., some models of Bi-PAP) that is required by the Enrollee four or more hours per day;
 4. Deep oral (past the tonsils) or tracheostomy suctioning;
 5. Injections when there is a regular or predicted schedule, or injections that are required as the situation demands (prn), but at least once per month (insulin administration is not considered a skilled nursing intervention);
 6. Nasogastric tube feedings or medications when removal and insertion of the

nasogastric tube is required, associated with complex medical problems or medical fragility;

7. Total parenteral nutrition delivered via a central line and care of the central line;
8. Continuous oxygen administration (eight or more hours per day), in combination with a pulse oximeter, and a documented need for adjustments in the rate of oxygen administration requiring skilled nursing assessments, judgments and interventions. This would not be met if oxygen adjustment is done only according to a written protocol with no skilled assessment, judgment or intervention required. Continuous use of oxygen therapy is a covered Medicaid benefit for beneficiaries aged 21 or older when tested at rest while breathing room air and the oxygen saturation rate is 88 percent or below, or the PO₂ level is 55 mm HG or below;
9. Monitoring fluid and electrolyte balances where imbalances may occur rapidly due to complex medical problems or medical fragility. Monitoring by a skilled nurse would include maintaining strict intake and output, monitoring skin for edema or dehydration, and watching for cardiac and respiratory signs and symptoms. Taking routine blood pressure and pulse once per shift that does not require any skilled assessment, judgment or intervention at least once every three hours during a 24-hour period, as documented in the nursing notes, would not be considered skilled nursing.

Minimum Standards for Traditional Service Delivery

1. All nurses providing Private Duty Nursing (PDN) to waiver Enrollees must maintain a current State of Michigan nursing license and meet licensure requirements and standards according to Michigan laws found under MCL 333.17201- 17242.
2. PDN may include medication administration according to MCL 333.7103(1).
3. This service must be ordered by a physician, physician's assistant, or nurse practitioner.
4. Through a person-centered planning process, the HIDE SNP shall determine the amount, scope and duration of services provided.
5. The direct service provider shall maintain close contact with the authorizing HIDE SNP to promptly report changes in each Enrollee's condition and/or treatment needs upon observation of such changes.
6. The direct service provider shall send case notes to the care coordinator on a regular basis, preferably monthly, but no less than quarterly, to update the care coordinator on the condition of the Enrollee.
7. This service may include medication administration as defined under MCL 333.7103(1).
8. The HIDE SNP is responsible for assuring there is a physician order for the private duty nursing services authorized. The physician may issue this order directly to the provider furnishing PDN services. However, the HIDE SNP is responsible for assuring the PDN provider has a copy of these orders and delivers PDN services according to the orders.
9. The HIDE SNP shall maintain a copy of the physician orders in the Care Bridge Record.
10. PDN is limited to 16 hours per day.
11. Enrollees receiving Preventive Nursing Services are not eligible to receive Private Duty Nursing Services.
12. All PDN services authorized must be medically necessary as indicated through the assessment and meet the medical criteria described above.
13. The Enrollee's physician, physician's assistant, or nurse practitioner must order PDN services and work in conjunction with the HIDE SNP and provider agency to assure services are delivered according to that order.
14. Services covered under the waiver shall not replace services that could be provided by the HIDE SNP in accordance with the Medicaid State Plan or Medicare.

Minimum Standards for Self-Determined Service Delivery

1. When authorizing Private Duty Nursing for Enrollees choosing the self-determination option, the HIDE SNP must comply with rules described in the Minimum Standards for Traditional Service Delivery in addition to the rest of the service definition as specified above.

n. Respite (Provided at the Enrollee's home or in the home of another person)

1. Respite care services are provided on a short-term, intermittent basis to relieve the Enrollee's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care.
2. Only the unpaid care may be replaced with respite.
3. Enrollees choosing the traditional method of service delivery may not choose to have respite furnished in the home of another.
4. The HIDE SNP must establish and follow written eligibility criteria for in-home respite that include, at a minimum:
 - a. Enrollees must require continual supervision to live in their own homes or the home of a primary caregiver or require a substitute caregiver while their primary caregiver needs relief or is otherwise unavailable.
 - b. Enrollees have difficulty performing or are unable to perform activities of daily living without assistance.
5. Respite services include:
 - a. Attendant care (Enrollee is not bed-bound) such as companionship, supervision, and/or assistance with toileting, eating, and ambulation.
 - b. Basic care (Enrollee may or may not be bed-bound) such as assistance with ADLs, a routine exercise regimen, and self-medication.
 - c. The direct service provider must obtain a copy of appropriate portions of the assessment conducted by the HIDE SNP before initiating service. The assessment information must include a recommendation made by the assessing RN describing the respite support services the Enrollee needs. Each HIDE SNP or direct service provider shall ensure the skills and training of the respite provider assigned are appropriate for the condition and needs of the Enrollee.
6. With the assistance of the Enrollee and/or Enrollee's caregiver, the HIDE SNP or direct service provider shall determine an emergency notification plan for each Enrollee, pursuant to each visit for emergencies and provider no-shows or late arrivals.
7. Each direct service provider shall establish written procedures that govern the medication assistance given by staff to Enrollees. These procedures shall be reviewed by a consulting pharmacist, physician, or registered nurse and shall include, at a minimum:
 - a. The provider staff authorized to assist Enrollees with taking their own prescription or over-the-counter medications and under what conditions such assistance may take place. This must include a review of the type of medication the Enrollee takes and its impact upon the Enrollee.
 - b. Verification of prescription medications and their dosages. The Enrollee shall maintain all medications in their original, labeled containers.
 - c. Instructions for entering medication information in Enrollee files.
 - d. A clear statement of the Enrollee's and his or her family's responsibility regarding medications taken by the Enrollee and the provision for informing the Enrollee and the Enrollee's family of the provider's procedures and responsibilities regarding assisted self-administration of medications.

8. Each direct service provider shall employ a professionally qualified supervisor that is available to staff during their shift while providing respite care.
9. Members of an Enrollee's family who are not the Enrollee's regular caregiver may provide respite for the regular caregiver. However, the HIDE SNP shall not authorize MICH funds to pay for services furnished to an Enrollee by that person's spouse, guardian or other legally or financially responsible individual. (Legally responsible person includes any person who has a duty under State law to care for another person and typically includes: the parent of a minor child or the guardian of a minor child who must provide care to the child or a spouse of the waiver participant.)
10. Family members who provide respite services must meet the same standards as providers who are unrelated to the Enrollee.
11. The HIDE SNP shall not authorize respite services to relieve a caregiver that receives MICH funds to provide another service to the waiver Enrollee. For example, if the HIDE SNP has authorized a daughter to provide 20 hours per week of expanded community living supports to the Enrollee and pays for this service with MICH funds, the HIDE SNP shall not also authorize additional hours of respite to relieve the daughter of her caregiver duties. Rather, the HIDE SNP should decrease the daughter's paid hours and authorize another caregiver to provide the needed services and support to the Enrollee. This requirement may be waived if:
 - a. The case record demonstrates the Enrollee has a medical need for supports and services in excess of the authorized amount of waiver services (i.e. in the example above the Enrollee has a medical need for 50 hours per week of services); and
 - b. The case record demonstrates the paid caregiver furnishes unpaid supports and services to the Enrollee (i.e. the daughter is paid for 20 hours per week, but actually delivers 50 hours per week of services); and
 - c. The paid caregiver is requesting respite for the supports and services not usually authorized through the waiver (i.e. for all or part of the 20 hours of medically necessary, but unpaid services the daughter regularly furnishes).
12. Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work elsewhere full time.
13. Respite services cannot be scheduled on a daily basis
14. Respite should be used on an intermittent basis to provide scheduled relief of informal caregivers. Respite services shall not be provided by the Enrollee's usual caregiver who provides other waiver services to the Enrollee
15. When a caregiver is unable to furnish unpaid medically- necessary services on a regular basis, the HIDE SNP should work with the Enrollee and caregiver to develop an ICP that includes other waiver services, as appropriate.
16. The costs of room and board are not included.

o. Respite (Provided outside of the Home)

1. Respite care services are provided on a short-term, intermittent basis to relieve the Enrollee's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care.
2. Each out-of-home respite service provider must be a licensed setting as defined in MCL 400.701ff, which includes adult foster care homes and homes for the aged. Respite may also be provided in a nursing facility.
3. Respite may include the cost of room and board if the service is provided in a licensed Adult Foster Care home, licensed Home for the Aged, or nursing facility.

4. Each HIDE SNP must establish and follow written eligibility criteria for out-of-home respite that include, at a minimum:
 - a. Enrollees must require continual supervision to live in their own homes or the home of a primary caregiver or require a substitute caregiver while their primary caregiver needs relief or is otherwise unavailable.
 - b. Enrollees have difficulty performing or are unable to perform activities of daily living without assistance.
5. Respite services include:
 - a. Attendant care (Enrollee is not bed-bound) such as companionship, supervision and/or assistance with toileting, eating, and ambulation.
 - b. Basic care (Enrollee may or may not be bed-bound) such as assistance with ADLs, a routine exercise regimen, and self-medication.
6. The direct service provider must obtain a copy of the assessment conducted by the HIDE SNP before initiating service. The assessment information must include a recommendation made by the assessing RN describing the respite care support services the Enrollee needs.
7. With the assistance of the Enrollee and/or Enrollee's caregiver, the HIDE SNP and/or direct service provider shall determine an emergency notification and contingency plan for each Enrollee for emergencies.
8. Each direct service provider shall establish written procedures to govern assistance given by staff to Enrollees who need help with medications. These procedures shall be reviewed by a consulting pharmacist, physician, or registered nurse and shall include, at a minimum:
 - a. The provider staff authorized to assist Enrollees in taking either prescription or over-the-counter medications and under what conditions such assistance may take place. This must include a review of the type of medication the Enrollee takes and its impact upon the Enrollee.
 - b. Verification of prescription medications and their dosages. The Enrollee shall maintain all medications in their original, labeled containers.
 - c. Instructions for entering medication information in Enrollee files.
 - d. A clear statement of the Enrollee's and his or her family's responsibility regarding medications taken by the Enrollee while at the facility and the provision for informing the Enrollee and his or her family of the program's procedures and responsibilities regarding assisted self-administration of medications.
9. Each direct service provider shall employ a professionally qualified program director that directly supervises program staff.
10. MDHHS does not intend Respite services to be furnished on a continual basis. Respite services should be utilized for the sole purpose of providing temporary, intermittent relief to an unpaid caregiver. When a caregiver is unable to furnish unpaid medically-necessary services on a regular basis, the HIDE SNP should work with the Enrollee and caregiver to develop a plan of service that includes other waiver services, as appropriate.
11. For each Enrollee, the HIDE SNP shall not authorize MICH payment for more than 30 days of out-of-home respite service per calendar year.
12. Respite services cannot be continually scheduled on a daily basis. Out of home respite may be scheduled for several days in a row, depending upon the needs of the Enrollee and the Enrollee's caregivers.
13. The HIDE SNP shall not authorize MICH funds to pay for respite services provided by the Enrollee's usual caregiver.

p. Vehicle Modifications

1. The following are excluded:
 - a. Adaptations or improvements to the vehicle that are of general utility and not of direct medical or remedial benefit to the participant.
 - b. Purchase or lease of the vehicle
 - c. Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.
2. The waiver agency and/or direct service provider must pursue payment by other sources, as applicable, before the waiver agency authorizes payment.
3. \$15,000 maximum for van lifts, including tie downs, for the duration of the 5-year waiver period.
4. Payment may not be made to adapt the vehicles that are owned or leased by paid providers of MICH services.
5. The costs of necessary adaptations to provider vehicles may be compensated in the payment rate for transportation or other services (e.g., Community Living Supports, Adult Day Health, Residential Services) that include the cost of transportation.

9. HCBS Waiver Service Codes

Adaptive Medical Equipment and Supplies	
Description	Devices, controls, or appliances specified in the ICP that enable Enrollees to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment and medical supplies not available through the HIDE SNP under the Medicaid state plan and Medicare that are necessary to address Enrollee functional limitations. All items shall meet applicable standards of manufacture, design, and installation. This will also cover the costs of maintenance and upkeep of equipment. The coverage includes training the Enrollee or caregivers in the operation and/or maintenance of the equipment or the use of a supply when initially purchased.
HCPCS Codes	Please see the list indicated below.
Units	Per item, unless otherwise specified.
Service Delivery Options	<input checked="" type="checkbox"/> Traditional <input type="checkbox"/> Self-Determination

The following HCPCS codes are approved for use under the Adaptive Medical Equipment and Supplies service:

1. **A4931**, Oral Thermometer, Reusable, any type, each
2. **A4932**, Rectal Thermometer, Reusable, any type, each
3. **A9300**, Exercise Equipment
4. **B4100**, Food thickener, administered orally, per ounce
5. **B4150/BO**, Enteral Formulae; Category 1; Semi- synthetic Intact Protein/Protein isolates, administered through an enteral feeding tube, 100 calories=1unit
 - a. The HIDE SNP must use the BO modifier to indicate oral administration. The state plan covers formulae for tube feeding.
 - b. This product may be in any form, liquid, solid, powder, bar, etc.
 - c. For cans of nutritional supplement, one can equals one unit.
 - d. For bars of nutritional supplement, one bar equals one unit.
6. **E0160**, Sitz type bath or equipment, portable, used with or without commode

7. **E0161**, Sitz type bath or equipment, portable, used with or without commode, with faucet attachment
8. **E0210**, Electric heat pad, standard
9. **E0215**, Electric heat pad, moist
10. **E0241**, Bathtub wall rail, each *only covered when installation is completed by a licensed Building Contractor. See section 8.e1a
11. **E0242**, Bathtub rail, floor base
12. **E0243**, Toilet rail, each **only covered when installation is completed by a licensed Building Contractor. See section 8.e1a
13. **E0315**, Bed accessory; board, table, or support device, any type
14. **E0627**, Seat lift mechanism incorporated into a combination lift chair mechanism
15. **E0629**, Separate seat lift mechanism for use with patient owned furniture, non-electric
16. **E0745** Neuromuscular stimulator, electronic shock unit
17. **E1300** Whirlpool, portable (overtub type)
18. **E1310** Whirlpool, non-portable (built-in type)
19. **E1639**, Scale, each
20. **S5162**, Emergency response system; purchase only
21. **S5199**, Personal care item, NOS, each
 - a. Use this code for items that the Enrollee uses to perform ADLs or IADLs, or that assist the Enrollee in the performance of ADLs or IADLs.
 - b. This category shall exclude items such as shampoo, soap, toothpaste, toothbrushes, dent-tips, shaving cream, and razors.
 - c. The HIDE SNP must include a description of this item in the appropriate loop for approval of a claim.
 - d. Standardized remarks are available.
22. **T1999**, Misc. Therapeutic items & supplies, retail purchases, NOC, identify product in "remarks"
 - a. Items in this category have a therapeutic use for the Enrollee.
 - b. The HIDE SNP must include a description of this item in the appropriate loop for approval of a claim.
 - c. Standardized remarks are available.
 - d. Does not include items specified under the Assistive Technology service.
 - e. If an HIDE SNP is considering use of a personal position change alarm as an intervention in an Enrollee's fall prevention strategy the use must be based on assessment of the Enrollee and monitored for efficacy (both beneficial and detrimental) on an ongoing basis. The alarm must be evaluated and assessed individually for each Enrollee to determine if the alarm has unintended consequences such as decreased mobility, sleep disturbances, incontinence, decreased freedom of movement, or infringement of dignity. The use of an alarm as part of the ICP cannot be restrictive in nature and does not eliminate the need for adequate supervision, nor does it replace individualized, person- centered care planning.
23. **T2028**, Specialized supply, NOS
 - a. Items in this category include specialized supplies that the Medicaid state plan does not cover.
 - b. This may include items that do not meet the "medically necessary" standard for state plan coverage, or quantities above state plan coverage.
 - c. The HIDE SNP must include a description of this item in the appropriate loop for

approval of a claim.

d. Standardized remarks are available.

24. T2029, Specialized medical equipment, NOS

a. Items in this category include specialized equipment that the Medicaid state plan does not cover or does not cover for adults.

b. This may include items that do not meet the “medically necessary” standard for state plan coverage.

c. The HIDE SNP must include a description of this item in the appropriate loop for approval of a claim.

d. Standardized remarks are available.

Adult Day Program

Description	<p>Adult Day Program services are furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, or as specified in the ICP, in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the Enrollee. Meals provided as part of these services shall not constitute a “full nutritional regimen,” i.e., three meals per day. Physical, occupational and speech therapies may be furnished as component parts of this service.</p> <p>Transportation between the Enrollee’s residence and the Adult Day Program center is provided when it is a standard component of the service. Not all Adult Day Program centers offer transportation to and from their location. Adult Day Program centers that do offer transportation may only offer it in a specified area. When the Adult Day Program Center offers transportation, it is a component part of the Adult Day Program service. If the center does not offer transportation, then the HIDE SNP will pay for the transportation to and from the Adult Day Program center separately.</p>
HCPCS Codes	S5100, Day care services, adult, per 15 minutes S5101, Day care services, adult, per half day S5102, Day care services, adult, per diem
Units	<p>S5100 = 15 minutes</p> <p>S5101 = half day, as defined by HIDE SNP and provider</p> <p>S5102 = per diem</p>
Service Delivery Options	<p><input checked="" type="checkbox"/> Traditional</p> <p><input type="checkbox"/> Self-Determination</p>

Assistive Technology

Description	Assistive technology is defined as: An item, piece of equipment, service animal or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of Enrollees. Assistive technology service means a service that directly assists an Enrollee in the selection, acquisition, or use of an assistive technology device. This includes technology items used to increase, maintain, or improve an Enrollee’s functioning and promote independence. The service may include assisting the Enrollee in the selection, design, purchase, lease, acquisition, application, or use of the technology item.
HCPCS Codes	<p>T1999, Misc. Therapeutic items & supplies, retail purchase, any type. Some specific items are:</p> <ul style="list-style-type: none"> - 0204, Adaptive or specialized communication device - 0206, Assistive dialing device - 0208, Adaptive door opener - 0209, Specialized alarm or intercom - 0218, Other adaptive or assistive device <p>V5268, Assistive listening device, telephone amplifier, any type V5269, Assistive listening device, alerting, any type V5270, Assistive listening device, television amplifier, any type</p> <p>Other assistive technology devices not included under Adaptive Medical Equipment and Supplies</p>
Units	Per item unless otherwise specified
Service Delivery Options	<input checked="" type="checkbox"/> Traditional <input type="checkbox"/> Self-Determination

Chore Services

Description	<p>Services needed to maintain the home in a clean, sanitary, and safe environment to provide safe access inside the home and yard maintenance and snow plowing to provide access to and egress outside of the home. This service includes tasks such as heavy household chores (washing floors, windows, and walls), tacking loose rugs and tiles, moving heavy items of furniture, mowing, raking, and cleaning hazardous debris such as fallen branches and trees, and pest control. May include materials and disposable supplies used to complete chore tasks.</p> <p>Chore services are allowed only in cases when neither the Enrollee nor anyone else in the household is able to provide and/or capable of financially paying for chore services, and where no other relative, caregiver, landlord, community or volunteer agency, or third party payer is capable of, or responsible for, their provision. If another person lives in the same household as the Enrollee and is capable of providing chore services, that person is responsible for chore tasks even if he or she does not want to provide them. Household members who do not have time to provide chore services due to work, schooling, or caregiver responsibilities are not considered capable of providing chore services. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.</p>
HCPCS Codes	<p>S5120, Chore Services, per 15 minutes S5121, Chore Services, per diem</p>
Units	<p>S5120 = 15 minutes S5121 = Per diem</p>
Service Delivery Options	<p><input checked="" type="checkbox"/> Traditional <input checked="" type="checkbox"/> Self-Determination</p>

Environmental Modifications	
Description	Physical adaptations to the primary residence or the Enrollee's family residence if applicable, required by the Enrollee's ICP that are necessary to ensure the health and welfare of the Enrollee or that enable the Enrollee to function with greater independence in the home. Such adaptations include the installation of ramps and grab bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the Enrollee.
HCPCS Codes	S5165 , Home modifications, per service
Units	One modification or adaptation
Service Delivery Options	<input checked="" type="checkbox"/> Traditional <input checked="" type="checkbox"/> Self-Determination

Expanded Community Living Supports	
Description	To receive Expanded Community Living Supports (ECLS), Enrollees MUST have a need for prompting, cueing, observing, guiding, teaching, and/or reminding to independently complete activities of daily living (ADLs) such as eating, bathing, dressing, toileting, other personal hygiene, etc. ECLS does not include hands on assistance for ADLs unless something happens to occur incidental to this service. Enrollees may also receive hands-on assistance for instrumental activities of daily living (IADLs) such as laundry, meal preparation, transportation, money management, help with medication, shopping, attending medical appointments, and other household tasks, as needed. ECLS also includes prompting, cueing, guiding, teaching, observing, reminding, and/or other support for the Enrollee to complete the IADLs independently if he or she chooses. ECLS includes social/community participation, relationship maintenance, and attendance at medical appointments.
HCPCS Codes	H2015 , Comprehensive community support services, per 15 minutes
Units	H2015 = 15 minutes
Service Delivery Options	<input checked="" type="checkbox"/> Traditional <input checked="" type="checkbox"/> Self-Determination

Fiscal Intermediary	
Description	Fiscal Intermediary (FI) services assist Enrollees in self- determination by providing assistance to the Enrollee or family member to acquire and maintain services defined in the Enrollee's plan of service, manage and direct the disbursement of funds contained in the Enrollee's individual budget, and choosing the staff to work with the Enrollee. The Enrollee utilizes funds to purchase home and community-based services authorized in the ICP.
HCPCS Codes	T2025 , Waiver Services, not otherwise specified.
Units	As specified in the contract between the Fiscal Intermediary and the HIDE SNP, usually a monthly or bi-weekly fee.
Service Delivery Options	<input type="checkbox"/> Traditional <input checked="" type="checkbox"/> Self-Determination

Home Delivered Meals	
Description	<p>The provision of one to two nutritionally sound meals per day to Enrollees who are unable to care for their nutritional needs.</p> <p>This service must include and prioritize healthy meal choices that meet any established criteria under state or federal law.</p> <p>Meal options must meet Enrollee preferences in relation to specific food items, portion size, dietary needs, and cultural and/or religious preferences.</p> <p>Each provider shall document meals served.</p>
HCPCS Codes	S5170 , Home delivered meals, including preparation, per meal.
Units	One delivered meal
Service Delivery Options	<input checked="" type="checkbox"/> Traditional <input type="checkbox"/> Self-Determination

Individualized Goods and Services	
Description	<p>Individual Directed Goods and Services are services, equipment or supplies not otherwise provided through either MICH waiver or the Medicaid State Plan that address an identified need in the individual plan of services (including improving and maintaining the participant’s opportunities for full membership in the community) and meet the following requirements. The item or service would:</p> <ul style="list-style-type: none"> • Decrease the need for other Medicaid services, • Promote inclusion in the community, and • Increase the participant’s safety in the home environment.
HCPCS Codes	T5999 , Individual Goods and Services
Units	Per item, unless otherwise specified
Service Delivery Options	<input type="checkbox"/> Traditional <input checked="" type="checkbox"/> Self-Determination

Non-Medical Transportation	
Description	Service offered to enable Enrollees to gain access to waiver and other community services, activities, and resources, specified by the ICP.
HCPCS Codes	A0130 , Non-Emergency Transportation; Wheelchair van; per trip S0209 , Wheelchair van, per mile S0215 , Non-Emergency Transportation, mileage, per mile T2003 , Non-Emergency Transportation; encounter/trip T2004 , Non-Emergency Transportation; commercial carrier, multi-pass
Units	A0130 = per mile S0209 = per mile S0215 = per mile T2003 = per encounter or trip T2004 = per pass
Service Delivery Options	<input checked="" type="checkbox"/> Traditional <input checked="" type="checkbox"/> Self-Determination

Personal Emergency Response System (PERS)	
Description	This electronic device enables Enrollees to secure help in an emergency. The Enrollee may also wear a portable “help” button to allow for mobility. The system is connected to the Enrollee’s phone and programmed to signal a response center once a “help” button is activated.
HCPCS Codes	S5160 , Emergency response system; installation and testing S5161 , Emergency response system; service fee, per month (excludes installation and testing)
Units	S5160, per installation S5161, per month
Service Delivery Options	<input checked="" type="checkbox"/> Traditional <input type="checkbox"/> Self-Determination

Preventive Nursing Services	
Description	Preventive Nursing Services are covered on a part-time, intermittent (separated intervals of time) basis for an Enrollee who generally requires nursing services for the management of a chronic illness or physical disorder in the Enrollee's home and are provided by a registered nurse (RN) or a licensed practical nurse (LPN) under the supervision of a RN. Nursing services are for Enrollees who require more periodic or intermittent nursing than otherwise available for the purpose of preventive interventions to reduce the occurrence of adverse outcomes for the Enrollee such as hospitalizations and nursing facility admissions. An Enrollee using this service must demonstrate a need for observation and evaluation.
HCPCS Codes	T1002 , RN Services, up to 15 minutes T1003 , LPN/LVN services, up to 15 minutes
Units	15 minutes
Service Delivery Options	<input checked="" type="checkbox"/> Traditional <input checked="" type="checkbox"/> Self-Determination

Private Duty Nursing	
Description	(PDN) services are skilled nursing interventions provided to an Enrollee aged 21 or older on an individual and continuous basis, up to a maximum of 16 hours per day, to meet the Enrollee's health needs directly related to the Enrollee's physical disability.
HCPCS Codes	T1000 , Private duty/independent nursing service(s); Licensed, up to 15 minutes. * *Use TD modifier to indicate an RN, and TE modifier to indicate an LPN
Units	Up to 15 minutes
Service Delivery Options	<input checked="" type="checkbox"/> Traditional <input checked="" type="checkbox"/> Self-Determination

Respite (provided at the Enrollee's home or in the home of another person)	
Description	Respite care services are provided on a short-term, intermittent basis to relieve the Enrollee's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care.
HCPCS Codes	S5150 , Unskilled respite care, not hospice, per 15 minutes
Units	S5150 = 15 minutes
Service Delivery Options	<input checked="" type="checkbox"/> Traditional <input checked="" type="checkbox"/> Self-Determination

Respite (provided outside of the home)	
Description	Respite care services are provided on a short-term, intermittent basis to relieve the Enrollee's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care.
HCPCS Codes	H0045 , Respite services not in the home, per diem
Units	H0045 = per day
Service Delivery Options	<input checked="" type="checkbox"/> Traditional <input type="checkbox"/> Self-Determination

Vehicle Modifications	
Description	<p>This service covers adaptations or alterations to a vehicle that is the participant's primary means of transportation in order to meet the needs of the participant. Vehicle adaptations are identified in the person-centered service plan as necessary to enable the participant engage in the community, and ensure health, welfare and safety of the participant.</p> <p>The vehicle that is adapted may be owned by the participant, a family member with whom the participant lives or has consistent and ongoing contact, or a non-relative who provides primary long-term support to the participant and is not a paid provider of such services.</p>
HCPCS Codes	T2039 , Vehicle Modifications, waiver
Units	Per service, unless otherwise specified
Service Delivery Options	<input checked="" type="checkbox"/> Traditional <input type="checkbox"/> Self-Determination

Billing and Encounter Procedure Codes

1. Nursing Facilities: Information for provider billing and HIDE SNP encounter submission related to nursing facilities may be found at: [Nursing Facilities](#) Click on the “Revenue Code Table” link.

2. State Plan Personal Care Services
 - Use procedure code T1019 for personal care services, per 15 minute increments.
 - For personal care supplement payment:
 - The HIDE SNP must use the invoice provided by MDHHS. The HIDE SNP must give this invoice to Adult Foster Care and Homes for the Aged providers for billing purposes. This invoice will be returned to the HIDE SNP, and the HIDE SNP will pay the personal care supplement to the provider as appropriate. There must an invoice for each Enrollee residing in one of these settings.
 - The HIDE SNP will need to track the amount and date paid to the Adult Foster Care home or Home for the Aged for each Enrollee.
 - For personal care supplement payments, the HIDE SNP should use procedure code” T1019” (personal care services, per 15-min increments) with modifier “CG” (policy criteria applied).
 - The HIDE SNP may find Place of Service code “14” (Group Home) applicable in Loop 2300.
 - The HIDE SNP must submit encounters for each Enrollee based on the information on the invoice and using the codes provided by MDHHS.
 - Encounters will require a diagnosis code as well. For ICD-9, MDHHS recommends “V60.89” (Other specified housing or economic circumstances) or “V60.4” (No other household member able to render care). For ICD-10, MDHHS recommends “Z74.1” (Need assistance with personal care) or “Z74.2” (No other household member able to render care).

HCPCS/ CPT Code	HCPCS/ CPT Modifier	HCPCS/ CPT Code Description	Standardized Remark	Comment
A0130		Non-emergency transportation; wheelchair van; per trip	7001 Public Transportation	
A0130		Non-emergency transportation; wheelchair van; per trip	7002 Private Transportation	
A0130		Non-emergency transportation; wheelchair van; per trip	7003 Volunteer Transportation	
A4931		Oral Thermometer, Reusable, any type, each		
A4932		Rectal Thermometer, Reusable, any type, each		
A9300		Exercise Equipment		
B4100		Food thickener, administered orally, per ounce		
B4150	BO	Enteral Formulae; Category 1; Semi- synthetic Intact Protein/Protein isolates, administered thru an enteral feeding tube, 100 calories=1unit	8003 Liquid	1 can = 1 unit
B4150	BO	Enteral Formulae; Category 1; Semi- synthetic Intact Protein/Protein isolates, administered thru an enteral feeding tube, 100 calories=1unit	8004 Solid	100 calories = 1 unit
B4150	BO	Enteral Formulae; Category 1; Semi- synthetic Intact Protein/Protein isolates, administered thru an enteral feeding tube, 100 calories=1unit	8005 Bar	1 bar = 1 unit
E0160		Sitz type bath or equipment, portable, used with or without commode		
E0161		Sitz type bath or equipment, portable, used with or without commode, with faucet attachment		
E0210		Electric heat pad, standard		
E0215		Electric heat pad, moist		

HCPCS/ CPT Code	HCPCS/ CPT Modifier	HCPCS/ CPT Code Description	Standardized Remark	Comment
E0241		Bathtub wall rail, each *only covered when policy criteria is met (screwed into the wall)		
E0242		Bathtub rail, floor base		
E0243		Toilet rail, each *only covered when policy criteria is met (screwed into the wall)		
E0315		Bed accessory; board, table, or support device, any type		
E0627		Seat lift mechanism incorporated into a combination lift chair mechanism		
E0629		Separate seat lift mechanism for use with patient owned furniture - nonelectric		
E0745		Neuromuscular stimulator, electronic shock unit		per unit
E1300		Whirlpool, portable (over tub type)		per unit
E1310		Whirlpool, non-portable (built-in type)		per unit - installation charges may fall under another waiver code.
E1639		Scale, each		
H0045		Respite services not in the home, per diem	7500 Adult Foster Care	
H0045		Respite services not in the home, per diem	7501 Hospital	
H2015		Comprehensive community support services, per 15 minutes	5501 Includes transportation	
H2015		Comprehensive community support services, per 15 minutes	5502 Does not include transportation	
S0209		Wheelchair van, mileage, per mile	7001 Public Transportation	

HCPCS/ CPT Code	HCPCS/ CPT Modifier	HCPCS/ CPT Code Description	Standardized Remark	Comment
S0209		Wheelchair van, mileage, per mile	7002 Private Transportation	
S0209		Wheelchair van, mileage, per mile	7003 Volunteer Transportation	
S0215		Non-emergency transportation, mileage, per mile	7001 Public Transportation	
S0215		Non-emergency transportation, mileage, per mile	7002 Private Transportation	
S0215		Non-emergency transportation, mileage, per mile	7003 Volunteer Transportation	
S5100		Day care services, adult, per 15 minutes	5501 Includes transportation	
S5100		Day care services, adult, per 15 minutes	5502 Does not include transportation	
S5101		Day care services; adult; per half day	5501 Includes transportation	
S5101		Day care services; adult; per half day	5502 Does not include transportation	
S5102		Day care services, adult, per diem	5501 Includes transportation	
S5102		Day care services, adult, per diem	5502 Does not include transportation	
S5120		Chore Services; per 15 minutes	6001 Duct Cleaning	
S5120		Chore Services; per 15 minutes	6002 Install Safety Equipment	
S5120		Chore Services; per 15 minutes	6003 Install Smoke Alarm	
S5120		Chore Services; per 15 minutes	6004 Window Installation	
S5120		Chore Services; per 15 minutes	6005 Window Repair	
S5120		Chore Services; per 15 minutes	6006 Replace/Repair Door Lock	

HCPCS/ CPT Code	HCPCS/ CPT Modifier	HCPCS/ CPT Code Description	Standardized Remark	Comment
S5120		Chore Services; per 15 minutes	6007 Replace/Repair Window Catch	
S5120		Chore Services; per 15 minutes	6008 Replace/Repair Electrical	
S5120		Chore Services; per 15 minutes	6009 Replace/Repair Plumbing	
S5120		Chore Services; per 15 minutes	6010 Install Screens or Storm Windows	
S5120		Chore Services; per 15 minutes	6011 Install Storm Door	
S5120		Chore Services; per 15 minutes	6012 Pest Control	
S5120		Chore Services; per 15 minutes	6013 Snow or Ice Removal	
S5120		Chore Services; per 15 minutes	6014 Lawn Mowing or Raking	
S5120		Chore Services; per 15 minutes	6015 Heavy-Duty Household Chores	
S5120		Chore Services; per 15 minutes	6016 Install weather stripping	
S5120		Chore Services; per 15 minutes	6017 Caulk windows	
S5120		Chore Services; per 15 minutes	6018 Remove exterior safety hazard	
S5121		Chore Services; per diem	6001 Duct Cleaning	
S5121		Chore Services; per diem	6002 Install Safety Equipment	
S5121		Chore Services; per diem	6003 Install Smoke Alarm	
S5121		Chore Services; per diem	6004 Window Installation	
S5121		Chore Services; per diem	6005 Window Repair	

HCPCS/ CPT Code	HCPCS/ CPT Modifier	HCPCS/ CPT Code Description	Standardized Remark	Comment
S5121		Chore Services; per diem	6006 Replace/Repair Door Lock	
S5121		Chore Services; per diem	6007 Replace/Repair Window Catch	
S5121		Chore Services; per diem	6008 Replace/Repair Electrical	
S5121		Chore Services; per diem	6009 Replace/Repair Plumbing	
S5121		Chore Services; per diem	6010 Install Screens or Storm Windows	
S5121		Chore Services; per diem	6011 Install Storm Door	
S5121		Chore Services; per diem	6012 Pest Control	
S5121		Chore Services; per diem	6013 Snow or Ice Removal	
S5121		Chore Services; per diem	6014 Lawn Mowing or Raking	
S5121		Chore Services; per diem	6015 Heavy-Duty Household Chores	
S5121		Chore Services; per diem	6016 Install weather stripping	
S5121		Chore Services; per diem	6017 Caulk windows	
S5121		Chore Services; per diem	6018 Remove exterior safety hazard	
S5150		Unskilled Respite Care, not Hospice, per 15 minutes	7502 Home of another	
S5150		Unskilled Respite Care, not Hospice, per 15 minutes	7503 Enrollee's home	
S5160		Emergency response system; installation and testing		

HCPCS/ CPT Code	HCPCS/ CPT Modifier	HCPCS/ CPT Code Description	Standardized Remark	Comment
S5161		Emergency response system; service fee, per month (excludes installation and testing)		
S5162		Emergency response system; purchase only		
S5165		Home modifications, per service	5001 Bathroom Modification	
S5165		Home modifications, per service	5002 Kitchen Modification	
S5165		Home modifications, per service	5003 Specialized Door Locks	
S5165		Home modifications, per service	5004 Doorway Modification	
S5165		Home modifications, per service	5005 Equipment Installation Charge	
S5165		Home modifications, per service	5008 Outside Railings	
S5165		Home modifications, per service	5009 Telephone Conversion for PERS Unit	
S5165		Home modifications, per service	5010 Stair Lift	
S5165		Home modifications, per service	5011 Ramp Installation	
S5165		Home modifications, per service	5012 Ramp Repair	
S5165		Home modifications, per service	5013 Portable Ramp	
S5165		Home modifications, per service	5014 Safety Railings	
S5165		Home modifications, per service	5015 Wireless Door Alarm	
S5165		Home modifications, per service	5016 Specialized Electrical System Installation	
S5165		Home modifications, per service	5017 Specialized Plumbing System Installation	
S5165		Home modifications, per	5018 Other Repair	

HCPCS/ CPT Code	HCPCS/ CPT Modifier	HCPCS/ CPT Code Description	Standardized Remark	Comment
		service		
S5165		Home modifications, per service	5019 Weatherization	
S5165		Home modifications, per service	5020 Injury Prevention	
S5170		Home delivered meals, including preparation, per meal	8001 Hot/Frozen	
S5170		Home delivered meals, including preparation, per meal	8002 Cold	
S5170		Home delivered meals, including preparation, per meal	8003 Liquid	
S5170		Home delivered meals, including preparation, per meal	8008 Emergency	
S5170		Home delivered meals, including preparation, per meal	8009 Breakfast	
S5199		Personal care item, NOS, each	0100 Reacher	
S5199		Personal care item, NOS, each	0101 Shower Attachment	
S5199		Personal care item, NOS, each	0102 Back scrubber	
S5199		Personal care item, NOS, each	0103 Beverage Bud	
S5199		Personal care item, NOS, each	0104 Adaptive Clothing	
S5199		Personal care item, NOS, each	0105 Assistive dressing device	
S5199		Personal care item, NOS, each	0106 Specialized bedding	
S5199		Personal care item, NOS, each	0107 Hospital gown	
S5199		Personal care item, NOS, each	0108 Key holder	
S5199		Personal care item, NOS, each	0109 Nail clippers	
S5199		Personal care item, NOS, each	0110 Specialized Shampoo tray	
S5199		Personal care item, NOS, each	0111 Specialized basin	

HCPCS/ CPT Code	HCPCS/ CPT Modifier	HCPCS/ CPT Code Description	Standardized Remark	Comment
S5199		Personal care item, NOS, each	0112 Specialized bib unit	
S5199		Personal care item, NOS, each	0113 Assistive device for performing personal care	
S5199		Personal care item, NOS, each	0114 In-bed Vacuumed Bath Unit	
T1000	TD	Private duty/independent nursing service(s); Licensed, up to 15 minutes		TD indicates RN
T1000	TE	Private duty/independent nursing service(s); Licensed, up to 15 minutes		TE indicates LPN
T1002		RN Services, up to 15 minutes		
T1003		LPN/LVN services, up to 15 minutes		
T1028		Assessment of home, physical and family environment, to determine suitability to meet patient's medical needs		Use for assessment of possible domiciles for NF transition
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0200 Specialized turner or pointer, adaptive equipment	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0201 Mouth stick for TDD	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0202 Foot massaging unit	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0203 Talking timepiece	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0204 Adaptive or specialized communication device, retail purchase	

HCPCS/ CPT Code	HCPCS/ CPT Modifier	HCPCS/ CPT Code Description	Standardized Remark	Comment
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0205 Adaptive eating or drinking devices	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0206 Assistive dialing device	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0207 Book holder	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0208 Adaptive door opener	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0209 Specialized alarm or intercom	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0210 Medical alert bracelet	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0211 Adapted mirror	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0212 Automatic light	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0213 Smokeless ashtray	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0214 No slip stabilizing device	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0215 Assistive writing device	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0216 Weighted blanket	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0217 Back knobber	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0218 Other adaptive or assistive devices	
T2003		Non-Emergency Transportation; per encounter/trip	7001 Public Transportation	

HCPCS/ CPT Code	HCPCS/ CPT Modifier	HCPCS/ CPT Code Description	Standardized Remark	Comment
T2003		Non-Emergency Transportation; per encounter/trip	7002 Private Transportation	
T2003		Non-Emergency Transportation; per encounter/trip	7003 Volunteer Transportation	
T2004		Non-emergency Transportation, commercial carrier, multi-pass	7001 Public Transportation	
T2004		Non-emergency Transportation, commercial carrier, multi-pass	7002 Private Transportation	
T2004		Non-emergency Transportation, commercial carrier, multi-pass	7003 Volunteer Transportation	
T2025		Waiver Services, NOS	8500 Fiscal Intermediary Services, per month	
T2025		Waiver Services, NOS	8501 Self- determination workman's compensation insurance fee	For use only with SD enrollment for WCI fees.
T2028		Specialized supply, NOS	0301 Specialized Cabinet	
T2028		Specialized supply, NOS	0302 Non-Orthotic Elbow pad	
T2028		Specialized supply, NOS	0303 Non-Orthotic Knee pad	
T2028		Specialized supply, NOS	0304 Lap Tray not for wheelchair	
T2028		Specialized supply, NOS	0305 Tennis balls for use with walkers	
T2028		Specialized supply, NOS	0306 Water shield for cast	
T2028		Specialized supply, NOS	0307 Battery charger for specialized equipment	
T2028		Specialized supply, NOS	0308 Disinfectant	

HCPCS/ CPT Code	HCPCS/ CPT Modifier	HCPCS/ CPT Code Description	Standardized Remark	Comment
T2028		Specialized supply, NOS	0309 Non-medical air filtering facial mask	
T2028		Specialized supply, NOS	0310 GT Feeding Plugs, not part of feeding system	
T2028		Specialized supply, NOS	0311 Specialized holders or cuffs for limbs	
T2028		Specialized supply, NOS	0312 Medication planner	
T2028		Specialized supply, NOS	0313 Pill crusher	
T2028		Specialized supply, NOS	0314 Non-slip mat or strip for bathtub	
T2028		Specialized supply, NOS	0315 Sharps container	
T2028		Specialized supply, NOS	0316 Electrostatic Air Filter	
T2028		Specialized supply, NOS	0317 Quantity above SP PA denial on file	
T2028		Specialized supply, NOS	0318 Stethoscope	
T2028		Specialized supply, NOS	0319 Non-Orthotic back support	
T2028		Specialized supply, NOS	0320 Electrodes for neuromuscular stimulator	To be used in conjunction with E0745
T2029		Specialized medical equipment, NOS	0400 Bumper pad	
T2029		Specialized medical equipment, NOS	0401 Air cushion ring	
T2029		Specialized medical equipment, NOS	0402 Electric cart	
T2029		Specialized medical equipment, NOS	0403 Geri Chair	
T2029		Specialized medical equipment, NOS	0404 Shower Stool with Back	
T2029		Specialized medical equipment, NOS	0405 Portable easy up	

HCPCS/ CPT Code	HCPCS/ CPT Modifier	HCPCS/ CPT Code Description	Standardized Remark	Comment
T2029		Specialized medical equipment, NOS	0406 Safety frame for toilet	
T2029		Specialized medical equipment, NOS	0407 Walker Accessories; tray, basket, apron	
T2029		Specialized medical equipment, NOS	0408 Air Filtering Machine	
T2029		Specialized medical equipment, NOS	0409 Pressure relieving boot for decubitus care	
T2029		Specialized medical equipment, NOS	0410 Electronic Pill Dispenser	
T2029		Specialized medical equipment, NOS	0411 Humidifier not used with oxygen equipment	
T2029		Specialized medical equipment, NOS	0412 Dehumidifier not used with oxygen equipment	
T2029		Specialized medical equipment, NOS	0413 Specialized holder for insulin syringes	
T2029		Specialized medical equipment, NOS	0414 Palm cone	
T2029		Specialized medical equipment, NOS	0415 Air Conditioner	
T2029		Specialized medical equipment, NOS	0416 Air Purifier	
T2029		Specialized medical equipment, NOS	0417 Lift Chair Repair	
T2029		Specialized medical equipment, NOS	0418 Wheelchair stabilizer in vehicle	
T2029		Specialized medical equipment, NOS	0419 Installation of Elec Pill Dispenser	
T2029		Specialized medical equipment, NOS	0420 SP PA denied copy of denial on file	
T2029		Specialized medical equipment, NOS	0421 Specialized patient lift	

HCPCS/ CPT Code	HCPCS/ CPT Modifier	HCPCS/ CPT Code Description	Standardized Remark	Comment
T2029		Specialized medical equipment, NOS	0422 Pivot Disk	
T2029		Specialized medical equipment, NOS	0423 Over-tub sliding bath system	
T2029		Specialized medical equipment, NOS	0424 Bath system accessory	
T2029		Specialized medical equipment, NOS	0425 Incentive Spirometer	
T2029		Specialized medical equipment, NOS	0426 Personal locator unit	
T2039		Vehicle Modifications, waiver, per service	9001 Water Heater	
T5999		Individual Directed Goods and Services	9002 Equipment Repair	
T5999		Individual Directed Goods and Services	9003 Hand Control Unit for Hospital Bed	
T5999		Individual Directed Goods and Services	9004 Power Converter Pack	
T5999		Individual Directed Goods and Services	9005 Wheelchair Accessories	If medically necessary
T5999	RR	Individual Directed Goods and Services	9005 Wheelchair Accessories	RR=Rental
T5999		Individual Directed Goods and Services	9006 Appliance	
T5999		Individual Directed Goods and Services	9007 Personal Hygiene Item	
T5999		Individual Directed Goods and Services	9008 Masseur	Per 15 minutes
T5999		Individual Directed Goods and Services	9009 Household Supplies	
T5999		Individual Directed Goods and Services	9010 Moving Expenses	
T5999		Individual Directed Goods and Services	9011 Repair Service	
T5999		Individual Directed Goods and Services	9012 Water Therapy	
T5999		Individual Directed Goods and Services	9013 Utility Services	

HCPCS/ CPT Code	HCPCS/ CPT Modifier	HCPCS/ CPT Code Description	Standardized Remark	Comment
T5999		Individual Directed Goods and Services	9014 Furniture	
T5999	RR	Individual Directed Goods and Services	9014 Furniture	RR= Rental
T5999		Individual Directed Goods and Services	9015 Groceries	In emergencies only
T5999		Individual Directed Goods and Services	9016 Roof Repair	If no other funding source
T5999		Individual Directed Goods and Services	9017 Safety Gate	
T5999		Individual Directed Goods and Services	9018 Smoke Alarm	
T5999		Individual Directed Goods and Services	9019 Electric Fan	
T5999		Individual Directed Goods and Services	9020 Financial Management	Per 15 minutes
T5999		Individual Directed Goods and Services	9021 Clothing	
T5999		Individual Directed Goods and Services	9023 Emergency Meal	
T5999		Individual Directed Goods and Services	9024 Protective Apron	
T5999		Individual Directed Goods and Services	9025 Step Stool	
T5999		Individual Directed Goods and Services	9026 Fire Extinguisher	
T5999		Individual Directed Goods and Services	9028 Magnifier	
T5999		Individual Directed Goods and Services	9029 Court Fees for Conservator/Guardian	
T5999		Individual Directed Goods and Services	9030 Carbon monoxide detector	
T5999		Individual Directed Goods and Services	9031 Specialty Camp	
T5999		Individual Directed Goods and Services	9033 SD advertisement for workers	

HCPCS/ CPT Code	HCPCS/ CPT Modifier	HCPCS/ CPT Code Description	Standardized Remark	Comment
T5999		Individual Directed Goods and Services	9034 SD one-time payment for workers	
T5999		Individual Directed Goods and Services	9035 Social Isolation Remedy	
V5268		Assistive listening device, telephone amplifier, any type		
V5270		Assistive listening device, television amplifier, any type		
V5270		Assistive listening device, television amplifier, any type		