**Lessons Learned Navigating the**

**MI Choice Waiver Program**

**2014 Update**

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# **Why is MI Choice a Waiver?**

Under Federal Medicaid law all states must provide nursing facilities for Medicaid beneficiaries who require nursing home level of care. Nursing facilities are mandatory services. States that wish to provide nursing home level services outside of a nursing home, must apply for and be granted a “waiver” by the Centers for Medicare and Medicaid Services (CMS). One of Michigan’s Home and Community Based Services Waiver is commonly referred to as MI Choice. Michigan filed its renewal application for the Waiver in July 2009. A copy of the renewal application can be found on the State of Michigan website at <http://www.michigan.gov/documents/mdch/1915-c_HCBS_Waiver-6-2007_205659_7.pdf>.

There is now also a 1915(b) waiver:

<http://www.michigan.gov/documents/mdch/Draft_MI_Choice_Waiver_Section_1915b_Application_08-2012_394335_7.pdf>

# **The Objectives of the Waiver Program**

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver’s target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

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## The Basics

The MI Choice Waiver is overseen by the Michigan Department of Community Health. The program director is Elizabeth Gallagher who can be contacted via e-mail at gallagher@michigan.gov. The program is administered statewide by Waiver Agents contracted with MDCH. In most areas of the State the Waiver Agents are the Area Agency on Aging (http://www.michigan.gov/mdch/0,4612,7-132-2943\_4857\_5045-16263--,00.html#list). To access the MI Choice Waiver Program an applicant calls a Waiver Agent to begin the process (discussed more thoroughly below). The overall guidelines of the MI Choice Waiver Program can be found in Michigan Medicaid Providers Manual (<http://www.pekdadvocacy.com/mi-choice-wavier/>).

# **Changes to the Waiver Renewal**

Describe any significant changes to the approved waiver that are being made in this renewal application: With this renewal, the Michigan Department of Community Health (MDCH) proposes to add Supports Coordination and Nursing Services to the waiver as new services, change the name of Nursing Facility Transition services to Community Transition Services, and eliminate Homemaker, Personal Care and Residential Services as outlined in Appendix C of this renewal application. MDCH proposes to add specifications for the entity that has responsibility for medication management. MDCH has also submitted an application for a §1915(b)(1) waiver to change from a Fee-For-Service (FFS) program to a managed care program, and a §1915(b)(4) waiver to implement selective contracting, which limits the number of providers for MI Choice. The §1915(b)(1)/(b)(4) waiver will run concurrently with this §1915(c) waiver.

**Services Provided**

Each participant can receive the basic services Michigan Medicaid covers, and one or more of the following services unique to the waiver:

* Community transition services
* Community living supports
* Nursing services (preventative nursing)
* Respite services
* Adult day health (adult day care)
* Environmental modifications
* Non-medical transportation
* Medical supplies and equipment not covered under the Medicaid State Plan
* Chore services
* Personal emergency response systems
* Private duty nursing
* Counseling
* Home delivered meals
* Training in a variety of independent living skills
* Supports coordination
* Fiscal intermediary
* Goods and services

\*List does not reflect current changes.

# **Wait List Priority Categories - 4 priority categories**

Michigan DCH created four distinct priority categories (located on Page 5 of the Eligibility and Admissions Process Policy - See Exhibit B), in order to determine when an assessment should be done and how long of a wait an individual has for the Waiver.

Per the Medical Waiver Manual (7/1/2014)

Whenever the number of participants receiving services through MI Choice exceeds the existing program capacity, any screened applicant must be placed on the waiver agency’s waiting list. Waiting lists must be actively maintained and managed by each MI Choice waiver agency. The enrollment process for the MI Choice program is not ever actually or constructively closed. The applicant’s place on the waiting list is determined by priority category in the order described below. Within each category, an applicant is placed on the list in chronological order based on the date of their request for services. This is the only approved method of accessing waiver services when the waiver program is at capacity.

These priority categories are:

3.4.A.1. CHILDREN’S SPECIAL HEALTH CARE SERVICES (CSHCS) AGE

EXPIRATIONS

This category includes only those persons who continue to require Private Duty Nursing

services at the time such coverage ends due to age restrictions under CSHCS.

3.4.A.2. NURSING FACILITY TRANSITION PARTICIPANTS

Nursing facility residents who desire to transition to the community and will otherwise

meet enrollment requirements for MI Choice qualify for this priority status and are

eligible to receive assistance with supports coordination, transition activities, and

transition costs. Priority status is not given to applicants whose service and support

needs can be fully met by existing State Plan services.

3.4.A.3. CURRENT ADULT PROTECTIVE SERVICES (APS) AND DIVERSION

APPLICANTS

An applicant with an active Adult Protective Services (APS) case is given priority when

critical needs can be addressed by MI Choice services. It is not expected that MI Choice

waiver agencies solicit APS cases, but priority is given when necessary.

An applicant is eligible for diversion priority if they are living in the community or are

being released from an acute care setting and are found to be at imminent risk of

nursing facility admission. Imminent risk of placement in a nursing facility is determined

using the Imminent Risk Assessment (IRA), an evaluation developed by MDCH. Use of

the IRA is essential in providing an objective differentiation between those applicants at

risk of a nursing facility placement and those at imminent risk of such a placement. Only

applicants found to meet the standard of imminent risk are given priority status on the

waiting list. Applicants may request that a subsequent IRA be performed upon a change

of condition or circumstance.

Supports coordinators must administer the IRA in person. The design of the tool makes

telephone contact insufficient to make a valid determination. Waiver agencies must

submit a request for diversion status for an applicant to MDCH. A final approval of a

diversion request is made by MDCH.

3.4.A.4. CHRONOLOGICAL ORDER BY SERVICE REQUEST DATE

This category includes applicants who do not meet any of the above priority categories or

for whom prioritizing information is not known. As stated, applicants will be placed on

the waiting list in the chronological order that they requested services as documented by

the date of TIG completion or initial nursing facility interview.

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| --- | --- | --- |
| Data Collection | Period | Due Date |
| First Quarter | October 1 – December 31 | January 15 |
| Second Quarter | January 1 – March 31 | April 15 |
| Third Quarter | April 1 – June 30 | July 15 |
| Fourth Quarter | July 1 – September 30 | October 15 |

# **New MI Choice Waiver Application Process**

The Eligibility and Admissions Process Policy (See exhibit A) per MSA 14-27 issued July 1, 2014 effective August 1, 2014 sets out the official policy in determining MI Choice Waiver Eligibility.

The Michigan Department of Community Health (MDCH) specifically formulated a more accurate telephonic evaluation for MI Choice applicants to determine potential program eligibility and waiting list placement. The new telephonic evaluation, named the MI Choice Intake Guidelines, is for use by the MI Choice program only. The MI Choice Intake Guidelines document does not, in itself, establish program eligibility. It is not intended to be used for any other purpose within the MI Choice program, nor for any other Medicaid program. A properly completed MI Choice Intake Guidelines document is required prior to placement on the MI Choice waiting list.

MI Choice waiver agencies must collect MI Choice Intake Guidelines data electronically using COMPASS, which is an online program developed by the Center for Information Management. Additional questions not included in the MI Choice Intake Guidelines may be asked for clarification. The online MI Choice Intake Guidelines is the only approved format and is only accessible to MI Choice waiver agencies. The LOCD TIG is no longer acceptable for use by the MI Choice program in determining potential program eligibility or waiting list placement. Any hard copy LOCD TIG performed before the effective date of this bulletin must be retained for the minimum

period of six years.

The premise for completing the MI Choice Intake Guidelines online is that it is scored using a complex algorithm that is most efficiently applied with the COMPASS program. Individuals who score as Level C, Level D, Level D1 or Level E are those applicants determined potentially eligible for program enrollment and will be placed on the MI Choice waiting list.

Beginning August 1, 2014, the MI Choice Intake Guidelines will be available for download at

www.michigan.gov/providers >> Providers >> Other Health Care Programs >> MI Choice. The LOCD TIG remains available for use by nursing facilities, PACE and hospitals and continues to be available for download at www.michigan.gov/MedicaidProviders >> Prior Authorization >> The Medicaid Nursing Facility Level of Care Determination.

However, the practical experience of filing for Waiver benefits is vastly different from actual policy. In my experience, the following steps are necessary to qualify a client for Waiver benefits.

*Step 1* – *Call Waiver Agent to be interviewed ­­– Telephone Intake Guidelines (TIG)*

*Recommendations:*

* Assist client with the telephone interview.
* Prepare by reviewing the New Intake Guidelines (Exhibit B).
* When appropriate, make sure Agent does the pre-assessment of the applicant’s Imminent Risk / Diversion score.
* Prepare by reviewing the New Indicators (Exhibit C).
* Remind client that getting on wait list does not equal getting funding or services.

*Step 2* – *Advocate to change priority category if and when appropriate*

*Step 3* *– In-person Assessment*

* Completed by a nurse and a social worker employed by the Waiver Agent.
* You may need to request reasonable accommodation.

*Step 4* – *Services / Funding Determination is Made*

* Decide if further advocacy is needed to request additional services.
* You may want independent evaluations.
* Decide how benefits will be received (ie Waiver Agent arrange for care provider; beneficiary has (Medicaid certified) provider and wants provider paid by Waiver Agent for services; self-determination - beneficiary wants non-Medicaid certified provider paid for care services).
* Self-determination budget once determined eligible - money to fiscal intermediary (GT Financial) allows beneficiary to employ caregiver(s) of choice but at hourly rates determined by agency (approx. $15 / hr).

### Step 5 – Appeals

* File Request for Hearing (see pages 34-35 for more information <http://www.michigan.gov/documents/FIA-Pub18_14356_7.pdf>).
* File Brief in Support (see Exhibit D).
* Appeal regarding Waiver Agent's misrepresentation of program policy blocking access to the program.
* Appeal Waiver Agent’s improper placement of applicant in wrong priority category.
* Appeal untimely in-person assessment. \*
* Appeal Waiver Agent’s determination for amount, duration and scope of services.\*

*Form used to file an appeal*: <http://www.michigan.gov/documents/FIA-Pub18_14356_7.pdf>

New Policy manual on appeals July 1, 2014: <http://www.mfia.state.mi.us/olmweb/ex/BP/Public/BAM/600.pdf>

**Financial Eligibility Requirements**

* Same financial eligibility resource requirements as for nursing home Medicaid.
  + Monthly gross income limit $2163 (300% SSI Federal Benefit Rate).
  + New Jersey’s response to over income issues. (See Exhibit E)
  + Patricia E. Kefalas Dudek makes it a reasonable accommodation.
* Medicaid application filed:
  + if the individual is in the community, use DHS 1171 application; and
  + if the individual is in a nursing home, use DHS 4754 application.
* **Note**: Applicant does NOT have to be:
  + Presently on Medicaid; or
  + Have an application pending; or
  + Be otherwise financially eligible prior to being placed on wait list.
  + APPEARS NO LONGER TRUE – Can anyone confirm? (See page 5 of New Guidelines Exhibit B)

**When to File Medicaid Application if seeking Waiver**

Application does NOT have to filed prior to:

* Making call to get on wait list –
  + Although, TIG questions screen for current eligibility.
  + Typically, during the TIG, the intake worker will try to confirm that the individual will be income and asset eligible by the assessment.

Application SHOULD be filed prior to:

* In-person assessment - agents want to protect themselves and will usually push for proof of at least a pending application.

Application MUST be filed and applicant must be qualified for Medicaid:

* In order to receive MI Choice benefits.

# **Perennial Problems**

* Insufficient budget to meet demand.
* Not enough Waiver slots available.
* Long waiting list.
* Lack of uniformity of program administered by Waiver Agents located throughout the state.
* Transportation (See Exhibit F)

# **Specific Problems**

* In-person assessment:
  + It is the watershed event that must occur in order to receive funding for needed services.
  + It is the major consideration that verifies and quantifies the amount, duration, and scope of services needed.
  + Scope of services is typically less than required but difficult to advocate for once in-person assessment is complete.
* Funding or staffing:
  + Both are insufficient to allow for timely in-person assessments for all priority groups.
  + Administered via a capitated contract which forces agents to work in “managed care” mindset.
  + Assessors assume less hours of services than are actually needed – **Direct client to request copy of assessment.**
* Waiver agents:
  + Utilize no definitive basis or objective criteria for determining amount, duration and scope of services.
  + Agents are directed to assume that family members will continue to provide services gratis.
  + Appeal of agent’s determination of scope of services is time consuming and expensive for relatively small gain.
  + Ignoring short stay policy application. 🡪 Sandy to address
* Waiver policy:
  + Difficult and significantly less flexible than Adult Home Help (AHH) Program.

# **Advocacy Recommendations**

* Advocate for the in-person assessment to be completed as soon as possible.
  + This is critical because the In-person assessment will determine amount, duration and scope of services that will be covered by MI Choice (usually broken down in terms of units of service and then converted to numbers of hours of care at an hourly benefit rate).
* Prepare strong evidence to provide to the Waiver Assessment Team (often a nurse and social worker) demonstrating need for *comprehensive* services (doctors letters, geriatric care assessment, etc...).
* Request copy of the in-person assessment, once completed, to assure accuracy and to determine if facts or assumptions need to be corrected.
* Advise clients to enter the wait list at the earliest possible date to be registered and in the Waiver queue.
  + In certain circumstances applying for AHH may be beneficial while waiting for Waiver acceptance.
* Work the Wait List.

**Other Issues**

1. **Exceptional Care Needs – Huge Problem!!**

MDCH recognizes that the care needs of some participants are exceptional in comparison with the general MI Choice population. Rather than omit such participants from the program, MDCH provides waiver agencies extra consideration in allowing the waiver agencies to authorize the necessary services and support for such individuals.

A Memorandum of Understanding (MOU) for participants with extensive service and support needs may be requested for participants whose average daily service costs meet or exceed $120.00 for a seven-day service week, regardless of how many days the participant actually received services. MDCH will not approve an MOU request to cover short-term increases in service costs due to temporary increases in MI Choice services. MDCH defines short-term as less than 30 days.

MDCH will authorize a Special Memorandum of Understanding (SMOU) for participants with complex medical acuity who require extensive MI Choice services. MDCH will consider an SMOU for participants meeting at least one of the following:

* Participant is aging out of the Children’s Special Health Care Services program or transferring from the Habilitation Supports Waiver program who requires continuing private duty nursing services.
* Participant is ventilator dependent.
* Participant has a tracheotomy that requires extensive suctioning, tracheotomy care, or nebulizer treatments.
* Participant has multiple wounds at stages 2, 3, or 4 that require frequent dressing changes and treatment.
* Participant has a medical condition with a high acuity and the attendant required care is complex (i.e., a combination of tube feedings, dressing changes, intravenous medications, oxygen therapy, colostomy/ileostomy, etc.).

MDCH will not approve an SMOU for participants for the following:

* Participant requires a temporary increase in services to either provide relief for, or substitute for, informal support.
* Participant requires a temporary increase in services to cover night, weekend, or holiday premiums for staff.

The waiver agency may apply for an SMOU through procedures stipulated in Appendix C

of the waiver agency contract. MDCH approves SMOU requests for up to one year.

Waiver agencies must receive MDCH approval for these enhanced service.

1. **Family Members as Providers**

Waiver agencies may pay relatives of MI Choice participants to furnish services. This authorization

excludes legally responsible individuals and legal guardians. The MI Choice participant must specify

his/her preference for a relative to render services. The relative must meet the same provider standards as established for non-related caregivers. All waiver services furnished shall be included in the plan of service and authorized by the supports coordinator. The supports coordinator must periodically evaluate the effectiveness of the relative in rendering the needed service. If the supports coordinator finds that the relative fails to meet established goals and outcomes or fails to render services as specified in the plan of service, the supports coordinator must rescind the authorization of that relative to provide waiver services to the participant. When the supports coordinator finds the relative has failed to render services, payments must not be authorized.

1. **Background Checks** (See Exhibit G)

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

Both waiver agencies and MDCH conduct administrative monitoring reviews of providers annually to verify that mandatory criminal background checks have been conducted in compliance with operating standards.

1. **FLSA Final Rule on Minimum Wage and Overtime** (See exhibit H)

The FLSA rule on minimum wage and overtime changed on October 1, 2013 and goes into effect on January 1, 2015.

The Final Rule extends FLSA minimum wage, overtime and record keeping requirements to most home care workers (Michigan law already requires minimum wage and overtime for most home care workers).

* FLSA requires that an employee paid at least minimum wage ($8.15 starting 9/1/14) for all hours worked.
* FLSA requires that each employee receive one and a half times the hourly rate for each hour worked over 40 in a workweek.
* FLSA requires that employers keep records regarding their employees and hours worked.

1. **Coming Soon.. TBI Waiver (See Exhibit I)**

Additional resources: http://www.michigan.gov/mdch/0,1607,7-132-2945\_42542\_42543\_42549\_42592-151693--,00.html