MI Choice Waiver Provider Manual

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Table of Contents

Introduction (Page 3)

Required Program Components (Page 4)

Person Centered Planning (Page 6)

Provision of Waiver Services (Page 7)

Compliance With Rules and Laws (Page 9)

HCBS Requirements (Page 14)

Home-Based Services (Page 16)

Community Based Services (Page 21)

Communication with Agency Expectations (Page 26)

Expectations of Professional Conduct (Page 27)

Provider Billing (Page 28)

WellWise Services Contacts (Page 30)

This manual is designed as a resource to support understanding of specific procedures or guidelines. However, it is intended solely as a guide and does not replace or override any terms of the official contract. For any clarification, the terms of the contract take precedence.

Introduction

WellWise Services AAA is a private non-profit established in 1974 to administer Older American Act funding. Eligible adults who meet Nursing Facility Level of Care (NFLOC), income, and asset criteria to receive Medicaid-covered services like those provided by nursing homes can stay in their own home or another residential setting. The waiver program became available in all Michigan counties October 1,1998. Each participant can receive the basic services Michigan Medicaid covers, and one or more of the following services unique to the waiver:

Adult Day Health	Chore Services
Community Health Worker	Community Living Supports
Community Transportation	Counseling
Environmental Accessibility Adaptations	Fiscal Intermediary
Goods and Services	Home Delivered Meals
Nursing Services	Personal Emergency Response System
Private Duty Nursing/ Respiratory Care	Respite
Specialized Medical Equipment	Supports Coordination
Training	Residential Services
Assistive Technology	

Required Program Components

The provider application process includes:

- Provider Enrollment Agreement
- Purchase of Service Agreement (Addendum A)
- Vendor Billing Provider Certification (Addendum B)
- Assurance of Compliance with Health and HHS Regulations (Addendum C)
- Business Associate Agreement
- Criminal History/Sex Offender Registries Check Certification
- Michigan Medicaid Sanctioned Provider Attestation
- Vendor View Enrollment
- Form IRS W-9 Form
- Provider Capacity Estimates Form

All potential providers must include a copy of the following with their application:

All Licenses as required for your field (i.e. counselor, general contractor, etc.) by state law and the Specific Operating Standards for the activities you will perform (Attachment H).

Proof of insurance coverage as required by state law and the General Operating Standards (Attachment H). You must contact your insurance company and add WellWise Services Area Agency on Aging as a certificate holder if accepted as a vendor.

By becoming an approved Medicaid Waiver provider, your company will be placed in a "service pool." When your organization's services are needed, supports coordinators will notify you and request the service.

Contractual Agreement

MI Choice waiver agencies may only administer the MI Choice waiver program through a formal contractual agreement between the waiver agency and MDHHS. Service providers may only deliver MI Choice Waiver services through a formal subcontract agreement between the waiver agency and the service provider agency. Each subcontract must contain all applicable contract components required by MDHHS.

Compliance with Service Definitions

State and Federal funds awarded by MDHHS may only pay for those services that MDHHS has included and defined in the Centers for Medicare and Medicaid Services (CMS) approved waiver application, and for which MDHHS has defined minimum standards. Each waiver agency and direct service provider must adhere to the definition and minimum standards to be eligible to receive reimbursement of allowable expenses.

MCE (Managed Care Entity) must require all its Network Providers are enrolled in the Michigan Medicaid Program via the State's Medicaid Management Information System. (MCE must verify and monitor its Network Providers' Medicaid enrollment.)

Required Insurance Coverage

Each waiver agency and direct service provider must have sufficient insurance to indemnify loss of federal, state, and local resources, due to casualty or fraud. Insurance coverage sufficient to reimburse MDHHS or the waiver agency for the fair market value of the asset at the time of loss must cover all buildings, equipment, supplies, and other property purchased in whole or in part with funds awarded by MDHHS. The following insurances are required for each waiver agency or direct service provider:

- Worker's compensation
- Unemployment
- Property and theft coverage
- Fidelity bonding (for persons handling cash)
- No-fault vehicle insurance (for agency owned vehicles)
- General liability and hazard insurance (including facilities coverage)

MDHHS recommends the following insurances for additional agency protection:

- Insurance to protect the waiver agency or direct service provider from claims against waiver agency or direct service provider drivers and/or passengers.
- Professional liability (both individual and corporate)
- Umbrella liability.
- Errors and Omission Insurance for Board members and officers
- Special multi-peril
- Reinsurance/Stop-loss insurance

Person-Centered Planning

Waiver agencies and direct service providers must utilize a person-centered planning process and knowledge of person-centered planning must be evident throughout the delivery of services. This includes assessing the needs and desires of participants, developing service/support plans, and continuously updating and revising those plans, as the participant's needs and preferences change.

Waiver agencies and direct service providers must implement person-centered planning in accordance with the MDHHS Person-Centered Planning Guideline.

Person Centered Service Plan Minimum Requirements (PCSP)

- The individual chose the setting in which he/she resides
- The services and supports that are important to the individual to meet the needs identified during the individual's assessment
- The individual's strengths and preferences
- The clinical and support needs identified by a functional assessment
- The amount of service authorized
- The frequency and duration of each service, and the individual's preference for receiving those services and supports
- Units of each service per visit and per week
- Cost per unit
- Total cost of service plan
- Start and stop dates for each service
- The type of provider to furnish each service
- Participant-focused goals and outcomes
- For participants receiving home-delivered meals, notations regarding the number of meals served per day, the days of service, and special diet orders or requests
- Risk factors and measures identified to mitigate them
- Individuals responsible for monitoring the plan
- The informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation

Provision of Waiver Services

Contributions

Neither the waiver agency nor any service provider under contract with the waiver agency may require monetary donations from participants of the MI Choice waiver program as a condition of participation in the MI Choice waiver.

The waiver agency and each direct service provider must accept MI Choice payments for services as payment in full for such services.

No paid or volunteer staff person of a direct service provider may solicit contributions from program participants, offer for sale any type of merchandise or service, or seek to encourage the acceptance of any particular belief or philosophy by any program participant.

Confidentiality

Each waiver agency and direct service provider must have procedures to protect the confidentiality of information about participants or persons seeking services collected in the conduct of its responsibilities.

The procedures must ensure that no information about a participant or person seeking services or obtained from a participant or person seeking services by a service provider, is disclosed in a form that identifies the person without the informed consent of that person or of his or her legal representative.

However, disclosure may be allowed by court order, or for program monitoring by authorized federal, state, or local agencies (which are also bound to protect the confidentiality of the client information) so long as access is in conformity with the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Waiver agencies and direct service providers must maintain all client information in controlled access files. This requirement applies to all protected information whether written, electronic, or oral.

Record Retention

Each waiver agency and direct service provider must keep all records related to or generated from the provision of services to waiver participants for not less than ten years.

Providers, subcontractors and other entities receiving monies originating by or through Michigan Medicaid must maintain books, records, documents and other evidence pertaining to services rendered, equipment, staff, financial records, medical records and the administrative costs and expenses incurred pursuant to this Contract as well as medical information relating to the individual Enrollees as required for the purposes of audit, or administrative, civil and/or criminal

investigations and/or prosecution or for the purposes of complying with the requirements set forth within the MCE contract.

Providers, subcontractors or any person or entity receiving monies directly or indirectly by or through Michigan Medicaid, that MDHHS representatives and authorized federal and State personnel, including, but not limited to MDHHS-OIG, the Michigan Department of Attorney General, the US Department of Health and Human Services, US Office of Inspector General (DHHS OIG) and the Department of Justice (DOJ), and any other duly authorized State or federal agency must have immediate and complete access to all records pertaining to services provided to Michigan Medicaid Enrollees, without first obtaining authorization from the Enrollee to disclose such information (42 CFR § 455. 21 and 42 CFR § 431. 107).

Subcontractors and any providers of service, including, but not limited to providers or any person or entity receiving monies directly or indirectly by or through Michigan Medicaid must retain and make all records (including, but not limited to, financial, medical and enrollee grievance and appeal records, base data in 42 CFR 438. 5(c), Medical Loss Ratio (MLR) reports in 42 CFR 438. 8(k), and the data, information, and documentation specified in 42 CFR 438. 604, 438. 606, 438. 608, and 438. 610) available at the MCE's, provider's, and/or the subcontractor's expense for administrative, civil and/or criminal review, audit, or evaluation, inspection, investigation and/or prosecution by authorized federal and state personnel, including representatives from the MDHHS-OIG, the Michigan Department of Attorney General, DHHS OIG and the DOJ, or any duly authorized State or federal agency for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

Compliance with Rules and Laws

Cultural Considerations

The Grantee shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all participants, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities and regardless of gender, sexual orientation, gender identity or expression.

Civil Rights Compliance and Nondiscrimination

Each waiver agency or direct service provider must not discriminate against any employee or applicant for employment, or against any MI Choice applicant or participant, pursuant to the Federal Civil Rights Act of 1964, the Elliot-Larsen Civil Rights Act (P.A. 453 of 1976), and Section 504 of the Federal Rehabilitation Acts of 1973. Each waiver agency or direct service provider must complete an appropriate Federal Department of Health and Human Services form assuring compliance with the Civil Rights Act of 1964. Each waiver agency or direct service provider must clearly post signs at agency offices and public locations where services are provided in English and other languages as appropriate, indicating non-discrimination in hiring, employment practices, and provision of services.

Nondiscrimination (Section 1557 of the Patient Protection and Affordable Care Act)

Section 1557 of the Patient Protection and Affordable Care Act (ACA) applies to the MI Choice program and provides that, except as provided in Title I of the ACA, an individual shall not, on the grounds prohibited under Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, or Section 504 of the Rehabilitation Act of 1973, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under Title I of the ACA. This part applies to health programs or activities administered by recipients of Federal financial assistance from the Department, Title I entities that administer health programs or activities, and Department-administered health programs or activities.

Equal Employment

Each waiver agency and direct service provider must comply with equal employment opportunity principles in keeping with Executive Order 1979-4 and Civil Rights Compliance in state and federal contracts.

Standard Precautions

Each waiver agency and direct service provider must evaluate the occupational exposure of employees to blood or other potentially infectious materials that may result from the employee's performance of duties. Each waiver agency and direct service provider must establish

appropriate standard precautions based upon the potential exposure to blood or infectious materials. Each waiver agency and direct service provider with employees who may experience occupational exposure must also develop an exposure control plan that complies with the Federal regulations implementing the Occupational Safety and Health Act.

Drug Free Workplace

MDHHS prohibits the unlawful manufacture, distribution, dispensing, possession, or use of controlled substances in all waiver agency and direct service provider workplaces. Each waiver agency and direct service provider must operate in compliance with the Drug-Free Workplace Act of 1988.

Americans with Disabilities Act (ADA)

Each program must operate in compliance with the Americans with Disabilities Act (PL 101-336).

This Act guarantees that people with disabilities shall have equal access to employment, public services and accommodations, transportation and telecommunications services.

The network providers must provide physical access, reasonable accommodation, and accessible equipment for Medicaid enrollees with physical or mental disabilities.

Fraud, Waste, and Abuse

WellWise Services Area Agency on Aging's Compliance Program began in 2018 as a requirement by Centers for Medicaid/Medicare and the Michigan Department of Health and Human Services for the MI Choice Waiver Program.

- It is meant to demonstrate to staff and community our commitment to good corporate conduct.
- Identify and prevent criminal and unethical conduct
- Improve the quality of participant care
- Create a centralized source of information on health care regulations
- Develop a mechanism for reporting
- Develop procedures that allow the prompt, thorough investigation of alleged misconduct
- Initiate immediate and appropriate corrective action
- Reduce WellWise Services Area Agency on Aging's exposure to civil damages and penalties, criminal sanctions, and administrative remedies such as program exclusion.
- In essence the program is to work to identify fraud, waste, and abuse and develop a way for staff, providers, participants to report

The False Claims Act

Prohibits any person from knowingly presenting or causing to be presented a false or fraudulent claim to the United States government for payment.

This act imposes civil liability on any person who:

- Knowingly presents a false or fraudulent claim for payment or approval.
- Knowingly makes or uses a false record or statement to get a false or fraudulent claim paid or approved.
- Conspires with another to get a false or fraudulent claim paid or allowed.
- Knowingly makes or uses a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property.
- Commits other fraudulent acts enumerated in the statute.

Medicaid False Claims Act

This is a companion law to the Federal False Claims Act. This act imposes prison terms of up to 4 years and fines up to $50,000 for:

- Knowingly making a false statement or false representation of a material fact in any application for Medicaid benefits or for use in determining rights to a Medicaid benefit
- Soliciting, offering, or receiving kickbacks or bribes for referrals to another for Medicaid-funded services
- Entering an agreement with another to defraud Medicaid through a false claim
- Making or presenting to the state of Michigan a False Claim for Payment.

Whistleblower Protection Law

In addition to WellWise Services Area Agency on Aging's Whistleblowing provision within this policy, both the federal and state laws protect individuals who investigate or report possible False Claims made by their employer against discharge or discrimination in employment because of such investigation. Employees who are discriminated against based on whistleblower activities may sue in court for damages. Under either the federal or state law, any employer who violates the whistleblower protection law is liable to the employee for (1) reinstatement of the employee's position without loss of seniority, (2) two times the amount of lost back pay, (3) interest and compensation for any special damages, and such other relief necessary to make the employee whole.

Qui Tam Relater

Any person may bring a civil action on behalf of the state of Michigan to recover losses that the state suffered from someone violating the Michigan Medicaid False Claims Act and the Michigan Attorney General is to be notified and has the opportunity to appear and intervene in the action brought on behalf of the state of Michigan. The person bringing forth the violation may receive his/her expenses, costs, and reasonable attorney fees paid for, in addition to potentially receiving a portion of the monetary proceeds resulting from the action or settlement.

Fraud

Fraud involves the false representation of facts, whether by intentionally withholding important information or providing false statements to another party for the specific purpose of gaining something that may not have been provided without deception.

Examples:

- ➢ Billing for goods or services that were not delivered or rendered.
- ➢ Submitting false service records such as time sheets when work was not completed.
- ➢ Having someone else do the work for you but submitting the timesheet like you had done it.
- ➢ Billing for work that was not performed.
- ➢ Forging participant signatures or signing for participants on timecards.
- ➢ Submitting false service records to show better than actual performance.

Process for investigation

- Fraud allegation/complaint is logged.
- Compliance Officer and staff assist in the investigation
- WellWise Services Area Agency on Aging will request documents from providers for review. This could be timecards, payroll documents, service logs.
- WellWise Services Area Agency on Aging will speak to participant and providers if warranted.
- WellWise Services Area Agency on Aging will speak with the Office of Inspector General (OIG) and/or Michigan Department of Health and Human Services (MDHHS) regarding any complaints if warranted.
- If the fraud is determined to be committed knowingly and is over $5000, WellWise Services Area Agency on Aging is required to submit to OIG. They will investigate and make a determination to prosecute or not with court guidance.
- WellWise Services Area Agency on Aging will be required to recoup any overpayments relevant to the fraud.
- If OIG determines to sanction the person involved in the fraud (provider agency or staff), WellWise Services Area Agency on Aging will no longer be able to use that provider or staff.
- WellWise Services Area Agency on Aging and all providers are required to do monthly sanction checks to make sure that there are no staff or providers listed. If so, they must be removed immediately.

WellWise Services Area Agency on Aging combats Medicaid fraud, waste, and abuse by investigation:

- Investigating tips/grievances reported through Compliance Hotline and email box.
- Auditing service providers for billing irregularities or over payments
- Data Mining agency billing claims data,

- Educating staff, service providers, and participants on compliance with state and federal laws.

How to Report Fraud

Reports may be submitted anonymously or by leaving a name and contact information through one of the following options:

- The WellWise Services Area Agency on Aging Compliance Hotline (517-592-1659).
- The WellWise Services Area Agency on Aging Hotline Mailbox (Compliance.Hotline@wellwiseservices.org)
- The Michigan Department of Health and Human Services, Office of Inspector General (MDHHS OIG) by calling 855-MI-FRAUD (643-7283) or sending a memo or letter to:

  MDHHS Office of Inspector General

  P.O. Box 30062

  Lansing, MI 48909

- Reports of suspicions of fraud can also be made online at www.michigan.gov/fraud

Home and Community Based Service Setting (HCBS) Requirements

Each waiver agency and direct service provider must comply with the Federal Home and Community Based Services Settings Requirements as specified in 42 CFR §441.301(c)(4) as well as in the Home and Community-Based Services Chapter of this Manual. Direct service providers with subcontracts secured prior to March 17, 2019, must be fully compliant with this regulation by March 17, 2019, unless they are included in the heightened scrutiny process. All direct service providers added to the waiver agency's provider network after March 17, 2019, must be compliant with this ruling before the direct service provider may furnish services to a waiver participant.

MDHHS will use the following process to ensure compliance to this requirement:

- Each waiver agency will assess all applicable providers annually using a MDHHS-approved survey. In some situations, described below within this section, the results of the surveys will be submitted electronically to MDHHS for a determination of compliance to the requirements.
- MDHHS will notify both the provider and the MI Choice waiver agency regarding the provider's compliance based upon the completed survey tool that was submitted to MDHHS.
- For providers who are non-compliant, the provider will have one to two weeks to correct all issues that cause non-compliance.
- Once the issues are corrected, the provider will notify the waiver agency and schedule another on-site survey.
- The waiver agency will have one to two weeks to complete another on-site survey and submit the survey to MDHHS for review within 10 days of the visit.
- If a provider does not contact the waiver agency within one to two weeks, the waiver agency will contact the provider to determine progress on the corrective action and schedule another on-site visit accordingly.
- If the provider has not satisfactorily resolved the compliance issues, the waiver agency will suspend the provider from receiving new MI Choice participants until such time as the provider comes into compliance.

Some providers may require Heightened Scrutiny to determine compliance. These providers will follow the Heightened Scrutiny Process defined by MDHHS to ensure compliance and to continue participation with the MI Choice program.

Regardless of the original notification date, all providers in all MI Choice provider networks will be compliant with the ruling no later than March 17, 2019, or the date approved in the State Transition Plan, whichever is sooner.

Waiver agencies must have completed person-centered transition plans with individuals served by non-compliant providers before March 17, 2019.

By March 17, 2019, no MI Choice participants will be served by non-compliant providers, and all non-compliant providers will be removed from the MI Choice provider network.

For MI Choice participants residing in a provider-owned and controlled setting, the waiver agency must keep a copy of the lease agreement and resident care agreement on file.

Home-Based Services

MI Choice waiver home-based services include community living supports, respite services provided in the home, chore services, personal emergency response systems, private duty nursing/respiratory care, nursing services, counseling, home delivered meals, training services, assistive technology, and community health workers.

Supervision of Direct Care Workers

Home-based service providers must always have a supervisor available to direct care workers while the worker is furnishing services to MI Choice participants.

The provider may offer supervisor availability by telephone.

Home-based service providers must conduct in-home supervision of their staff at least twice each fiscal year. A qualified professional must conduct the supervisory visit.

Participant Assessments

Each waiver agency must complete the state-approved assessment instrument for each participant according to established standards before initiating service. Direct providers of home-based services must avoid duplicating assessments of individual participants to the maximum extent possible. Home-based service providers must accept assessments conducted by waiver agencies and initiate home-based services without having to conduct a separate assessment. Waiver agencies must make every attempt to supply direct providers of home-based services with enough information about each participant served by that organization to provide needed services properly.

Service Need Level

Waiver agencies must classify each MI Choice participant into a service need level based upon the participant's immediacy of need for the provision of services and the availability of informal support. Waiver agencies must establish and utilize written procedures consistent with the service need levels specified below to assure each participant's needs are met in the event of an emergency. Waiver agencies must make direct service providers aware of the service need levels and the classification of each participant served by that provider so that the service provider can target services to the highest priority participants in emergencies.

Immediacy of need for the provision of services:

Immediate – the participant cannot be left alone.

Urgent – the participant can be left alone for a short time (less than 12 hours)

Routine – the participant can be left alone for a day or two.

Availability of Informal Supports

No informal supports are available for the participant

Informal supports are available for the participant

The participant resides in a supervised residential setting

Immediacy	Informal Supports	Service Need Level	Service Need Level Description
Immediate	None	1A	This means the participant cannot be left alone. If services are not delivered as planned, the backup plan needs to start immediately.
Immediate	Available	1B	This means the participant cannot be left alone. If services are not delivered as planned, family or friends need to be contacted immediately.
Immediate	SRS	1C	This means the participant cannot be left alone. Staff at the place of residence must be available as planned or follow established emergency procedures.
Urgent	None	2A	This means the participant can be left alone for a short time. If services are not delivered as planned, the backup plan needs to start within 12 hours.
Urgent	Available	2B	This means the participant can be left alone for a short time. If services are not delivered as planned, family or friends need to be contacted within 12 hours.
Urgent	SRS	2C	This means the participant can be left alone for a short time. Staff at the place of residence must check on the participant periodically each day. Follow established emergency procedures if no staff is present in the home.
Routine	None	3A	This means the participant can be left alone for a day or two. If services are not delivered as planned, the backup plan needs to start within a couple of days.
Routine	Available	3B	This means the participant can be left alone for a day or two. If services are not delivered as planned, family or friends need to be contacted within a couple of days.
Routine	SRS	N/A	There is not a 3C service need level because participants in supervised residential settings typically require 24-hour supervision and cannot be left alone for long periods.

Record Keeping Requirements

- Service work orders or authorizations.
- Assessment, parts, or the entire assessment provided by the waiver agency. Types of services provided to each participant, i.e., a description of tasks completed by date of service, worker notes describing the tasks completed for each shift, and in-home service logs. Worker time sheets without tasks performed do not meet these criteria. Ranges of time that each service is provided (i.e., 10:00 a.m. – 12:00 p.m.); times are subject to change according to participant preferences and waiver agency authorization.
- Date of service delivery.
- Progress notes and supervisory notes.
- Identification of the worker providing each service and that worker's signature.
- Additionally, providers are required to maintain the following:
- A worker service record (in-home log) is a daily account of services furnished. The worker providing the service documents tasks accomplished each day. This log may be electronic as long as one is able to indicate all of the tasks performed during a shift. (Telephonic systems that record this information are considered electronic.)
- Service workers maintain a record of services furnished by date of service, description of service provided on each date, and time of service provision each day.
- Service provider agencies may not use worker time sheets as worker service records. Worker time sheets that do not include the tasks performed do not meet the requirement of worker service documentation.
- Absence of a worker service record at a review for any date of service for which the provider makes a claim is equivalent to having no record that the service was rendered and could be subject to Medicaid recovery.
- Service workers must sign each service entry. Electronic systems must include a method to identify the worker providing the information and rendering the service.
- Counseling Records: Providers furnishing MI Choice counseling services maintain ongoing case records for each participant, recording assessed needs, treatment plan, and progress achieved at each counseling session.

Notifying Participant of Rights

Each waiver agency or direct provider of home-based services must notify each participant, in writing, at the initiation of service of his or her right to comment about service provision or appeal the denial, reduction, suspension, or termination of services. Such notice must also advise the participant that they may file complaints of discrimination with the respective waiver agency, the Department of Health and Human Services Office of Civil Rights, or the Michigan Department of Civil Rights. The MI Choice Participant Handbook meets this requirement.

In-Service Training

Staff of waiver agencies and direct providers of home-based services must receive in-service training at least twice each fiscal year.

Waiver agencies and providers must design the training so that it increases staff knowledge and understanding of the program and its participants and improves staff skills at tasks performed in the provision of service.

Waiver agencies and direct providers of home-based services must maintain comprehensive records identifying dates of training and topics covered in an agency training log or in each employee's personnel file.

The employer must develop an individualized in-service training plan for each employee when performance evaluations indicate a need.

Reference, Criminal History Screenings, and Sanctions Checks

Each waiver agency and direct provider of home-based services must require and thoroughly check references of paid staff that will enter participant homes. In addition, each waiver agency and direct provider of home-based services must conduct a criminal history screening through the Michigan State Police for each paid and volunteer staff person who will be entering participant homes. The waiver agency and direct provider must conduct reference and criminal history screening checks before authorizing the employee to furnish services in a participant's home. Provider must have a written policy regarding the removal of employee from direct responsibility for, or involvement with the Medicaid program who is found ineligible to work.

Sanctions Checks

All enrolled service providers must conduct, or initiate, through a third party, monthly sanctions screenings on staff and Board members.

> Federal: https://exclusions.oig.hhs.gov/?_gl=1*10ga9x5*_ga*ODM0NDE5NzE5LjE3MDYwMzcyNTA.*_ga_W5DCJS81Y5*MTcyMTg0MDYxMC4xLjAuMTcyMTg0MDYxMC4wLjAuMA..
>
> Michigan: https://www.michigan.gov/mdhhs/doing-business/providers/providers/billingreimbursement/list-of-sanctioned-providers

Criminal Background Checks

Conduct or cause to be conducted a search that reveals information similar or substantially similar to information found on an Internet Criminal History Access Tool (ICHAT) check and a national and state sex offender registry check for each new employee, employee, subcontractor,

subcontractor employee, or volunteer who, under this Agreement works directly with clients or has access to client information.

Require each new employee, employee, subcontractor, subcontractor employee or volunteer who, under this Agreement, works directly with clients or who has access to client information to notify WellWise Services in writing of criminal convictions (felony or misdemeanor), pending felony charges, at hire or within 10 days of the event after hiring.

Determine whether to prohibit any employee, subcontractor, subcontractor employee, or volunteer from performing work directly with clients or accessing client information related to clients under this Agreement, based on the results of a positive ICHAT response or reported criminal felony conviction or perpetrator identification.

Require any employee, subcontractor, subcontractor employee or volunteer who may have access to any databases of information maintained by the federal government that contains confidential or personal information, including, but not limited to, federal tax information, to have a fingerprint background check performed by the Michigan State Police.

Procedures While in the Home

Each waiver agency and direct provider of home-based services will assure MDHHS that employees or volunteers who enter and work within participant homes abide by the following additional conditions and qualifications:

Service providers must have procedures in place for obtaining participant signatures on the time sheets (or similar document) of direct care workers to verify the direct service worker provided the work ordered by the waiver agency. Electronic Visit Verification (EVV) systems may take the place of this requirement as long as the verification is available to the waiver agency. If providers are utilizing EVV systems, paper time sheets are not needed.

Direct service workers are prohibited from smoking in participant's homes.

Direct service workers must demonstrate the ability to communicate adequately and appropriately, both orally and in writing, with their employers and the MI Choice participants they serve. This includes the ability to follow product instructions properly in carrying out direct service responsibilities (i.e., read grocery lists, identify items on grocery lists, and safely use cleaning and cooking products).

Direct service workers must not use their cell phones for personal use while in a participant's home. Exceptions may be made in cases of emergency. Direct service workers should engage with the participants while furnishing the services specified on the person-centered service plan.

Direct service workers must not threaten or coerce participants in any way. Failure to meet this standard is grounds for immediate discharge.

Waiver agencies will inform service contractors and direct service workers promptly of new service standards or any changes to current services standards.

Community Based Services

Self-Determined Providers

Participants choosing the self-determination option may directly manage service providers for the following home and community-based MI Choice waiver services; chore, community health worker, community living supports, environmental accessibility adaptations, fiscal intermediary, goods and services, transportation, private duty nursing/respiratory care, respite services provided inside the participant's home, and respite services provided in the home of another.

Supervision of Direct-Care Workers

The MI Choice participant, or designated representative, acts as the employer and provides direct supervision of the chosen workers for self-determined services in the participant's PCSP. The participant, or designated representative, directly recruits, hires, and manages employees.

Use of a Fiscal Intermediary

MI Choice participants choosing the self-determination option must use an approved fiscal intermediary agency. The fiscal intermediary agency will help the individual manage and distribute funds contained in the participant's budget. The participant uses the funds in the budget to purchase waiver goods, support, and services authorized in the participant's PCSP. Refer to the Fiscal Intermediary service standard for more information about this MI Choice service.

Reference and Criminal History Screening Checks

Each MI Choice participant, or fiscal intermediary chosen by the participant, must conduct reference checks and a criminal history screening through the Michigan State Police for each paid staff person who will be entering the participant's home. The MI Choice participant or fiscal intermediary must conduct the criminal history screening before authorizing the employee to furnish services in the participant's home. Waiver agencies must also check the Michigan Medicaid sanctioned provider list to determine if the provider is on the list; these providers must be excluded from providing any MI Choice services.

Provider Qualifications

Providers of self-determined services must minimally:

- Be 18 years old.
- Be able to communicate effectively both orally and in writing and follow instructions.
- Be trained in universal precautions and blood-borne pathogens. The waiver agency must maintain a copy of the employees' training record in the participant's case file.
- Providers of self-determined services cannot also be the participant's spouse.

Specific Operating Standards for MI Choice Waiver Service Providers

Please refer to Attachment H, pages 14 – 75, for specific operating standards for each waiver service. The standards apply only to the service being described within each section.

Standards from one service are not to be construed to apply to other MI Choice services. The standards apply to each provider interested in furnishing the specific service to MI Choice participants.

The waiver agency must authorize the provision of each service to waiver participants.

Waiver agencies will not use MI Choice funds to pay for services not specifically authorized in advance and included in the participant's PCSP.

Residential Facilities

All new settings (either newly established or new to the specific program) must be immediately compliant with the HCBS Final Rule. Determination of a new setting's compliance with the HCBS Final Rule must be determined after the setting is built and has been operational with residents or individuals receiving services in order for the evaluating entity to have a full understanding of the individual's experience while participating with the setting.

In order to comply with the federal HCBS Final Rule, new providers must:

- Ensure individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Enhance independence;
- Enhance independence in making life choices;
- Enable choice regarding services and who provides them; and
- Ensure that the setting is integrated in, and supports full access to, the greater community.

New residential providers must demonstrate that services are delivered within a setting affording the beneficiary sufficient opportunity and choice to engage with the broader community by ensuring that the:

- Setting is selected by the individual from among setting options;
- Individual has a lease or other legally enforceable agreement providing similar protection;
- Individual has privacy in their unit, including lockable doors;
- Individual has a choice of roommates (if applicable) and freedom to furnish or decorate the unit;
- Individual controls their own schedule, including access to food at any time;
- Individual can have visitors at any time; and

- Setting is physically accessible.

New non-residential providers must demonstrate that services are delivered within a setting affording the beneficiary sufficient opportunity and choice to engage with the broader community by ensuring that the setting:

- Does not isolate the individual from the broader community; and
- Is not institutional in nature or has the characteristics of an institution.

Waiver programs can only pay for services that have been assessed as being needed to keep someone out of the nursing home.

Waiver agencies cannot duplicate services – MI Choice (PACE, MI Health Link, etc.) cannot duplicate what you are REQUIRED to provide by law via licensure.

The better grasp you have on what your “Room and Board” costs include the better we can fill in the gaps with MI Choice services – and the better and easier it will be to build WORKING relationships.

If you are licensed, it is not an option to state that your “Room and Board” only includes rent and food. Licensure requires you to provide more.

Waiver agencies must develop a person-centered service plan for everyone that is designed to meet that individual’s assessed and expressed needs and goals.

Collaborate with the waiver agency in the development of the PCSP and your resident’s written assessment plan. These documents should include the same services.

AFC/HFA Definition of Supervision, Protection, Personal Care

1. Minimally, every licensed AFC/HFA shall provide supervision, protection, and personal care as defined in the act

2. Licensees must provide opportunities for:

    Developing positive social skills

    Contact with relatives and friends

    Community-based recreational activities

    Privacy and Leisure time

    Religious education and activities

3. Licensees must assure the availability of transportation services

AFC/HFA Definition of Supervision, Protection, Personal Care

Supervision means guidance of a resident in the activities of daily living, including all of the following:

> (a) Reminding a resident to maintain his or her medication schedule, as directed by the resident's physician.
>
> (b) Reminding a resident of important activities to be carried out.
>
> (c) Assisting a resident in keeping appointments.
>
> (d) Being aware of a resident's general whereabouts even though the resident may travel independently about the community.

Protection means the continual responsibility of the licensee to take reasonable action to ensure the health, safety, and well-being of a resident, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the licensee or an agent or employee of the licensee, or when the resident's assessment plan states that the resident needs continuous supervision

Personal care means personal assistance provided by a licensee or an agent or employee of a licensee to a resident who requires assistance with dressing, personal hygiene, grooming, maintenance of a medication schedule as directed and supervised by the resident's physician, or the development of those personal and social skills required to live in the least restrictive environment.

Defining Your Usual and Customary

- The law says you must afford the opportunity & instructions for daily bathing, shaving, dressing.
- The law also says you must provide opportunities for haircuts, grooming, and laundry.
- Given your fee schedule – think about what is included in that schedule
- Does this include hands-on assistance? Or just prompting and cuing?
- Does it include cutting up food?
- Does it include assistance with feeding?
- Does it include medication management and administration?
- Does it include housekeeping activities?
- Does it include doing laundry or just access to washer & dryer?

Room and Board

MI Choice (and similar programs – PACE, MI Health Link, Habilitation Supports Waiver, etc.) is strictly prohibited from paying for room and board.

> Room = rent
>
> Board = three meals per day

MI Choice participants can only have up to $2829 in GROSS income/month

Waiver agencies do not need to be involved in rent negotiations between ALF
and the participant.

Waiver agencies do need to know what the monthly rental amount is.

As a participant advocate, the waiver agency does need to advise participants if the rent amount is affordable to them given their income and expressed goals for home & community-based living.

Supports coordinators must provide education and information to participants.

*Waiver agencies are not responsible for (and are not legally able to) making up the difference between what is affordable rent and the ALF's going rate.

Communication with Agency Expectations

Compass Vendor View

Compass Vendor View was designed to automate some of the communications required between MI-Choice Waiver Agents and Vendors providing services to waiver participants. Many processes which authorize services, make service changes, stop services, and communications regarding service delivery and participant issues can be replaced with Vendor View functions.

Certain actions in COMPASS used by Waiver Agents will trigger notifications of service changes and other pertinent information for participating vendors in Vendor View. For example, a new care plan will trigger a new service notice for a particular vendor. In addition, new assessments, or changes to address and phone number will trigger notifications for vendors.

Another feature of Vendor View supports the exchange of messages about participants and services between agents and vendors. Because Vendor View is housed on a secure, limited access web server, the information exchanged in messages is not available for access by non-authorized users.

Providers are permitted an unlimited number of Vendor View users.

Requests to remove users must be submitted to WellWise Services AAA in writing

*__All Vendor View notices and messages must be read and archived daily.__

To ensure the confidentiality and security of Protected Health information (PHI), all correspondence must be sent via Compass Vendor View, encrypted email or by fax at (517) 592-1975.

Expectations of Professional Conduct

In accordance with our expectations of professional conduct, providers must not:

- Solicit or attempt to solicit any of our staff.
- Influence or attempt to influence any of our staff.
- Attempt to hire or discuss employment opportunities with any of our staff.
- Offer gifts or other incentives to any of our staff.
- These guidelines are in place to maintain the integrity and professionalism of our working relationships. Your cooperation in adhering to these standards is greatly appreciated.

Provider Billing

WellWise Services AAA Weekly Billing Process Period runs Sunday through Saturday.

Bills submitted that run in a different succession of the week appear as "overages" and will have the overage amount denied.

Billing for reoccurring services can be submitted on a bi-weekly basis or monthly only.

Providers must report any overpayments in writing, explaining the reason for the overpayment. These overpayments must be returned to WellWise Services AAA within 60 days of being identified.

WellWise Services AAA has the right to recover overpayments from providers after a post-payment audit.

Billing Methods

Compass Billing:

- ❖ Available to all Providers
- ❖ Each user must complete a Vendor View Enrollment Form to register.
- ❖ Compass Billing User Guide: https://www.ciminc.com/help/COMPASS/Compass_User_Guide_Billing_Agent.pdf
- ❖ Preferred method of billing

Billing Submission via USPS, Email, In-Person Drop Off or Fax:

- ❖ Mail to: 107 Chicago St. P.O. Box 189 Brooklyn, MI. 49230
- ❖ In-Person Drop Off: 107 Chicago St. P.O. Box 189 Brooklyn, MI. 49230
- ❖ Email: Accounting@wellwiseservices.org
- ❖ Fax: (517) 592-1975 ATTN: Accounting Department

Amended Billing

All billing regardless of submission type that requires a change to approved billing will need to be submitted using a paper invoice.

❖ Please report any billing errors/ adjustments needs as soon as possible as this affects Quality Indicator reports along with State and Federal reporting.

❖ Submit amended billing only for the additional units needing reimbursement.

❖ Providers must report all identified overpayments immediately upon finding the overpayment to WellWise Services AAA. This is to be communicated in writing by emailing WellWise Services accounting email (accounting@wellwiseservices.org) or by utilizing the Vendor View messaging module in COMPASS.
   - INFORMATION TO INCLUDE:
      - Participant Name
      - Service provided
      - Month and date of service(s)
      - Number of units and total cost
      - Reason for discrepancy

❖ The Provider is required to return the overpayment within 60 days of overpayment identification.

WellWise Services AAA Contacts

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