MEDICAID POLICY INFORMATION SHEET

Policy Analyst: Dana Moore

Phone Number:

Initial ☐ Public Comment ☒ Final ☐

Brief description of policy:

The purpose of this bulletin is to revise the Habilitation Supports Waiver for Persons with Developmental Disabilities section of the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter within the Medicaid Provider Manual. Revisions bring state policy into alignment with 2019 Federal application updates. Updates include additional information on maximum bed size for HSW settings, clarity on the need for an OBRA assessment for disenrollment due to nursing home placement, and PIHP reporting requirements for inactive status for HSW beneficiaries, and general language updates for clarity.

Reason for policy (problem being addressed):

To align state policy with 2019 federal application updates.

Budget implication:

☒ budget neutral
☐ will cost MDHHS $, and (select one) budgeted in current appropriation
☐ will save MDHHS $

Is this policy change mandated per federal requirements?

Yes

Does policy have operational implications on other parts of MDHHS?

No

Does policy have operational implications on other departments?

No

Summary of input:

☐ controversial
☒ acceptable to most/all groups
☐ limited public interest/comment

Supporting Documentation:

State Plan Amendment Required: ☐ Yes ☒ No If Yes, please provide status: ☐ Approved ☐ Pending Approval ☐ Denied Date: Date:	Public Notice Required: ☒ Yes ☐ No If yes, Submission Date:

DRAFT FOR PUBLIC COMMENT Michigan Department of Health and Human Services		
	Project Number: 2256-BH	**Date:** July 6, 2023

Comments Due: August 10, 2023
Proposed Effective Date: October 1, 2023
Direct Comments To: Dana Moore
Address:
E-Mail Address: Moored61@michigan.gov
Phone: 517-256-7522 **Fax:**

Policy Subject: Policy Updates to the Habilitation Supports Waiver

Affected Programs: Habilitation Supports Waiver

Distribution: Prepaid Inpatient Health Plans (PIHPs), Community Mental Health Services Programs (CMHSPs)

Summary: The purpose of this bulletin is to revise the Habilitation Supports Waiver for Persons with Developmental Disabilities section of the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter within the Medicaid Provider Manual. Revisions bring state policy into alignment with 2019 Federal application updates. Updates include additional information on maximum bed size for HSW settings, clarity on the need for an OBRA assessment for disenrollment due to nursing home placement, and PIHP reporting requirements for inactive status for HSW beneficiaries, and general language updates for clarity.

Purpose: To align state policy with 2019 federal application updates.

Cost Implications: None

Potential Hearings & Appeal Issues: None

State Plan Amendment Required: Yes ☐ No ☒ **If yes, date submitted:**	**Public Notice Required: Yes ☒ No ☐** **Submitted date:**
Tribal Notification: Yes ☒ No ☐ - Date:	

THIS SECTION COMPLETED BY RECEIVER

☐ **Approved**	☐ **No Comments**
	☐ **See Comments Below**
☐ **Disapproved**	☐ **See Comments in Text**

Signature:	**Phone Number**

Signature Printed:	
Bureau/Administration *(please print)*	**Date**

Comment001 **Revised 6/16**

Proposed Policy Draft

Michigan Department of Health and Human Services
Behavioral & Physical Health and Aging Services Administration

Distribution: Prepaid Inpatient Health Plans (PIHPs), Community Mental Health Services Programs (CMHSPs)

Issued: September 1, 2023 (Proposed)

Subject: Policy Updates to the Habilitation Supports Waiver

Effective: October 1, 2023 (Proposed)

Programs Affected: Habilitation Supports Waiver

The purpose of this bulletin is to revise the Habilitation Supports Waiver for Persons with Developmental Disabilities section of the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter within the Michigan Department of Health and Human Services (MDHHS) Medicaid Provider Manual. Revisions bring state policy into alignment with 2019 Federal application updates. Updates include additional information on maximum bed size for Habilitation Supports Waiver (HSW) settings, clarity on the need for an Omnibus Budget Reconciliation Act (OBRA) assessment for disenrollment due to nursing home placement, Prepaid Inpatient Health Plan (PIHP) reporting requirements for inactive status for HSW beneficiaries, and general language updates for clarity. Individual waiver services have also been updated:

- For Enhanced Pharmacy, Family Training and Private Duty Nursing, clarified that services are limited to additional services not otherwise covered under the Medicaid State Plan, including Early and Periodic Screening, Diagnosis and Treatment (EPSDT).
- For Private Duty Nursing, clarified the requirement for habilitative service.
- For Environmental Modifications, added general language updates for clarity and specified that in the event that the contract is terminated prior to the completion of the work, HSW funds may not be used to pay for any additional costs resulting from the termination of the contract.
- Added Fiscal Intermediary, Non-Family Training, and Overnight Health and Safety Supports as covered services.
- For Prevocational Services, updated terminology throughout and added detail on wage expectations.
- Eliminated Supports Coordination as a waiver service. Waiver enrollees will continue to receive this service through the Medicaid State Plan.
- For Supported Employment, replaced the former service description with an entirely new description that focuses on the tenets of competitive integrated employment (CIE).
- Eliminated certain limits for Out-of-Home Non-Vocational Habilitation.

I. Habilitation Supports Waiver for Persons with Developmental Disabilities

Beneficiaries with developmental disabilities may be enrolled in Michigan's Habilitation Supports Waiver (HSW) and receive the supports and services as defined in this section. HSW beneficiaries may also receive other Medicaid State Plan covered services. A HSW beneficiary must receive at least one HSW habilitative service per month in order to retain eligibility. Medical necessity criteria should be used in determining the amount, duration, and scope of services and supports to be used. The beneficiary's services and supports that are to be provided under the auspices of the PIHP must be specified in their individual plan of services (IPOS) developed through the person-centered planning process.

HSW beneficiaries must be enrolled through the MDHHS enrollment process completed by the PIHP. The enrollment process must include annual verification that the beneficiary:

- Has a developmental disability (as defined by Michigan law);
- Is Medicaid-eligible;
- Is residing in a community setting;
- If not for HSW services, would require Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) level of care services; and
- Chooses to participate in the HSW in lieu of ICF/IID services.

The PIHP's enrollment process responsibilities also include confirmation of changes in the beneficiary's enrollment status, including termination from the waiver, changes of residence requiring transfer of the waiver to another PIHP, and death. MDHHS continues to review bed size as part of the waiver enrollment which includes a limit of no more than 12 beds. Termination from the HSW may occur when the beneficiary no longer meets one or more of the eligibility criteria specified above as determined by the PIHP, does not receive at least one HSW habilitative service per month, moves out of the state, withdraws from the program voluntarily, or dies. An OBRA assessment must be provided for disenrollment due to nursing facility placement. Instructions for beneficiary enrollments and annual re-certification may be obtained from the MDHHS Bureau of Specialty Behavioral Health Services (Refer to the Directory Appendix the MDHHS Medicaid Provider Manual for contact information.)

PIHPs must report inactive status on HSW beneficiaries not living in community settings (e.g., hospital, nursing facility Child Caring Institution [CCI], jail, prisons or juvenile detention facilities). HSW beneficiaries can be on inactive status for 90 days. After the 90-day period, the PIHP shall start the disenrollment process if there is no transition planning back to the community.

The PIHP shall use value purchasing for HSW services and supports. The PIHP shall assist beneficiaries to examine their first- and third-party resources to pursue all reimbursements to which they may be entitled, and to make use of other community resources for non-PIHP covered activities, supports or services.

Reimbursement for services rendered under the HSW is included in the PIHP capitation rate.

Beneficiaries enrolled in the HSW may not be enrolled simultaneously in any other §1915(c) waiver.

Habilitation services under the HSW are not otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973.

A. Waiver Supports and Services

Community Living Supports (CLS) (This is a habilitative service.)	Community Living Supports (CLS) facilitate an individual's independence, productivity, and promote inclusion and participation. The supports can be provided in the beneficiary's residence (licensed facility, family home, own home or apartment) and in community settings (including, but not limited to, libraries, city pools, camps, etc.), and may not supplant other waiver or state plan covered services (e.g., out-of-home non-vocational habilitation, Home Help Program, personal care in specialized residential, respite). The supports are: ▪ Assisting (that exceeds the Medicaid State Plan for adults), prompting, reminding, cueing, observing, guiding and/or training the beneficiary with: ➢ Meal preparation; ➢ Laundry; ➢ Routine, seasonal, and heavy household care and maintenance (where no other party, such as a landlord or licensee, has responsibility for provision of these services); ➢ Activities of daily living, such as bathing, eating, dressing, personal hygiene; and ➢ Shopping for food and other necessities of daily living. ▪ Assisting, supporting and/or training the beneficiary with: ➢ Money management; ➢ Non-medical care (not requiring nurse or physician intervention); ➢ Socialization and relationship building;

	➢ Transportation (excluding to and from medical appointments that are the responsibility of Medicaid through Medicaid Fee-for-Service [FFS] or the Medicaid Health Plan [MHP]) from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence); ➢ Leisure choice and participation in regular community activities; ➢ Attendance at medical appointments; and ➢ Acquiring goods and/or services other than those listed under shopping and non-medical services. ▪ Reminding, observing, and/or monitoring of medication administration. CLS does not include costs associated with room and board. Payments for CLS may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian. For beneficiaries living in unlicensed homes, CLS assistance with meal preparation, laundry, routine household care and maintenance, activities of daily living (ADL), and/or shopping may be used to complement Home Help services when the beneficiary's needs for this assistance have been officially determined to exceed MDHHS allowable parameters. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help. CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, State Plan coverage of Personal Care in Specialized Residential Settings. If beneficiaries living in unlicensed homes need assistance with meal preparation, laundry, routine household care and maintenance, ADL, and/or shopping, the beneficiary must request Home Help from MDHHS. CLS may be used for those activities while the beneficiary awaits determination by MDHHS of the amount, scope and duration of Home Help. If the beneficiary requests it, the PIHP must assist with applying for Home Help or submitting a request for a Fair Hearing when the beneficiary believes that the MDHHS authorization of amount, scope and duration of Home Help does not accurately reflect their needs. CLS may also be used for those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a MDHHS decision. CLS provides support to a beneficiary younger than 18, and the family in the care of their child, while facilitating the child's independence and integration into the community. This service provides skill development related to ADL, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; and skill development to achieve or maintain mobility, sensory-motor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings. For children and adults up to age 26 who are enrolled in school, CLS services are not intended to supplant services provided in school or other settings or to be provided during the times when

	the child or adult would typically be in school but for the parent's choice to home-school.
Enhanced Medical Equipment and Supplies	Enhanced medical equipment and supplies includes devices, supplies, controls, or appliances that are not available under regular Medicaid coverage or through other insurances. (Refer to the Medical Supplier Chapter of this manual for more information about Medicaid-covered equipment and supplies.) All enhanced medical equipment and supplies must be specified in the IPOS and must enable the beneficiary to increase their abilities to perform ADL; or to perceive, control, or communicate with the environment. Items that are not of direct medical or remedial benefit, or that are considered to be experimental to the beneficiary, are excluded from coverage. ▪ "Direct medical or remedial" benefit is a prescribed specialized treatment and its associated equipment or environmental accessibility adaptation that are essential to the implementation of the IPOS. ▪ "Experimental" means that the validity of the use of the item has not been supported in one or more studies in a refereed professional journal. The plan must document that, as a result of the treatment and its associated equipment or adaptation, institutionalization of the beneficiary will be prevented. There must be documented evidence that the item is the most cost-effective alternative to meet the beneficiary's need. All items must be ordered on a prescription as defined in the General Information section of this chapter. An order is valid one year from the date it was signed. This coverage includes: ▪ Adaptations to vehicles; ▪ Items necessary for life support; ▪ Ancillary supplies and equipment necessary for proper functioning of such items; and ▪ Durable and non-durable medical equipment not available under the Medicaid State Plan. Generators may be covered for beneficiary who is ventilator dependent or requires daily use of an oxygen concentrator. The size of a generator will be limited to the wattage required to provide power to essential life-sustaining equipment. Assessments and specialized training needed in conjunction with the use of such equipment, as well as warranted upkeep and repair, shall be considered as part of the cost of the services. Furnishings (e.g., furniture, appliances, bedding) and other non-custom items (e.g., wall and floor coverings, decorative items) that are routinely found in a home are not included.

	Items that are considered family recreational choices are not covered (e.g., outdoor play equipment, swimming pools, pool decks and hot tubs). The purchase or lease of a vehicle, as well as any repairs or routine maintenance to the vehicle, is not covered. Educational equipment and supplies are expected to be provided by the school as specified in the Individualized Education Plan (IEP) and are not covered. Eyeglasses, hearing aids, and dentures are not covered. Covered items must meet applicable standards of manufacture, design, and installation. There must be documentation that the best value in warranty coverage was obtained for the item at the time of purchase. The PIHP should have a process in place that gives notice to a medical equipment supplier that purchase of the equipment or supply has been authorized. Repairs to enhanced medical equipment that are not covered benefits through other insurances may be covered. There must be documentation in the IPOS that the enhanced medical equipment continues to be of direct medical or remedial benefit. All applicable warranty and insurance coverage must be sought and denied before paying for repairs. The PIHP must document the repair is the most cost-effective solution when compared with replacement or purchase of a new item. If the equipment requires repairs due to misuse or abuse, the PIHP must provide evidence of training in the use of the equipment to prevent future incidents. The PIHP must assure that all applicable private insurance, Medicare and/or Medicaid requirements for the procurement of durable medical equipment and supplies have been met. The PIHP may not use the waiver service to purchase equipment or supplies that would have been covered by another program if the program's rules were followed, including using providers who participate with that program.
Enhanced Pharmacy	Physician-ordered, nonprescription "medicine chest" items as specified in the beneficiary's IPOS. Items that are not of direct medical or remedial benefit to the beneficiary are not allowed. Only the following items are allowable: ▪ Cough, cold, pain, headache, allergy, and/or gastrointestinal distress remedies; ▪ Vitamins and minerals; ▪ Special dietary juices and foods that augment, but do not replace, a regular diet; ▪ Thickening agents for safe swallowing when the beneficiary has a diagnosis of dysphagia and either: ➢ A history of aspiration pneumonia, or ➢ Documentation that the beneficiary is at risk of insertion of a feeding tube without thickening agents for safe swallowing;

	▪ First aid supplies (e.g., band-aids, iodine, rubbing alcohol, cotton swabs, gauze, antiseptic cleansing pads); ▪ Special oral care products to treat specific oral conditions beyond routine mouth care (e.g., special toothpaste, toothbrushes, anti-plaque rinses, antiseptic mouthwashes); and ▪ Special items (i.e., accommodating common disabilities -- longer, wider handles), tweezers and nail clippers. Routine cosmetic products (e.g., make-up base, aftershave, mascara, and similar products) are not included. However, products necessary to ameliorate negative visual impact of serious facial disfigurements (e.g., massive scarring) and/or skin conditions (including exposed area eczema, psoriasis, and/or acne) will be covered. Refer to the Pharmacy Chapter in this manual for information about Medicaid-covered prescriptions. HSW funds cannot be used to pay for copays for other prescription plans the beneficiary may have. ▪ The services under Enhanced Pharmacy are limited to additional services not otherwise covered under the state plan, including EPSDT.
Environmental Modifications	Physical adaptations to the home and/or workplace required by the beneficiary's assessed need and in the IPOS that are necessary to ensure the health, safety, and welfare of the beneficiary, or enable them to function with greater independence within the environment(s) and without which the beneficiary would require institutionalization. Adaptations may include: ▪ The installation of ramps and grab bars; ▪ Widening of doorways; ▪ Modification of bathroom facilities; ▪ Installation of specialized electrical and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the beneficiary; and ▪ Environmental control devices that replace the need for paid staff and increase the beneficiary's ability to live independently, such as automatic door openers. Excluded are those adaptations or improvements to the home that are of general utility, are considered to be standard housing obligations of the beneficiary and are not of direct medical or remedial benefit. Examples of exclusions include, but are not limited to, carpeting, roof repair, sidewalks, driveways, heating, central air conditioning (except under exceptions noted in the service definition), garages, raised garage doors, storage and organizers, hot tubs, whirlpool tubs, swimming pools, landscaping and general home repairs. The HSW does not cover construction costs in a new home or additions to a home purchased after the beneficiary is enrolled in the waiver.

	"Direct medical or remedial" benefit is a prescribed specialized treatment and its associated equipment or environmental accessibility adaptation that are essential to the implementation of the IPOS. The plan must document that, as a result of the treatment and its associated equipment or adaptation, institutionalization of the beneficiary will be prevented. There must be documented evidence that the item is the most cost-effective alternative to meet the beneficiary'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. Assessments and specialized training needed in conjunction with the use of such environmental modifications are included as a part of the cost of the service. All items must be ordered on a prescription as defined in the General Information section of this chapter. An order is valid for one year from the date it was signed. Central air-conditioning is included only when prescribed by a physician and specified with extensive documentation in IPOS as to how it is essential in the treatment of the beneficiary's illness or condition. This supporting documentation must demonstrate the cost-effectiveness of central air compared to the cost of window units in all rooms that the beneficiary must use. Environmental modifications that are required to support proper functioning of medical equipment, such as electrical upgrades, are limited to the requirements for safe operation of the specified equipment and are not intended to correct existing code violations in a beneficiary's home. The PIHP must assure there is a signed contract or bid proposal with the builder prior to the start of an environmental modification. It is the responsibility of the PIHP to work with the beneficiary and builder to ensure that the work is completed as outlined in the contract or bid proposal. If the contract is terminated prior to the completion of the work, HSW funds may not be used to pay for any additional costs resulting from the termination of the contract. Adaptations may be made to rental properties when the landowner agrees to the adaptation in writing. A written agreement between the landowner, the beneficiary, and the PIHP must specify any requirements for restoration of the property to its original condition if the beneficiary's moves. If a beneficiary or their family purchases or builds a home while receiving waiver services, it is the beneficiary's or family's responsibility to ensure that the home will meet basic needs, such as having a ground floor bath/bedroom if the beneficiary has mobility limitations. HSW funds may be authorized to assist with the adaptations noted above (e.g., ramps, grab bars, widening doorways, etc.) for a home recently purchased. If modifications are needed to a home under construction that require special adaptation to IPOS (e.g., roll-in shower), the HSW may be used to fund the difference between the standard fixture and the modification required to accommodate the beneficiary's need. Environmental modifications for **licensed settings** include only the remaining balance of previous environmental modification costs that

	accommodate the specific needs of current waiver beneficiaries and will be limited to the documented portion being amortized in the mortgage or the lease cost per bed. Environmental modifications exclude the cost of modifications required for basic foster care licensure or to meet local building codes. The existing structure must have the capability to accept and support the proposed changes. The infrastructure of the home involved in the funded modifications (e.g., electrical system, plumbing, well/septic, foundation, heating/cooling, smoke detector systems, roof) must be in compliance with any applicable local codes. Environmental modifications shall exclude costs for improvements exclusively required to meet local building codes. The environmental modification must incorporate reasonable and necessary construction standards, excluding cosmetic improvements. The adaptation cannot result in valuation of the structure significantly above comparable neighborhood real estate values. The beneficiary, with the direct assistance by the PIHP supports 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, for assistance. A record of efforts to apply for alternative funding sources must be documented in the beneficiary's records, as well as acceptances or denials by these funding sources. The HSW is a funding source of last resort. Adaptations to the **work environment** are limited to those necessary to accommodate beneficiary's individualized needs and cannot be used to supplant the requirements of Section 504 of the Rehabilitation Act, the Americans with Disabilities Act (ADA), or covered by Michigan Rehabilitation Services (MRS) or the Bureau of Services for Blind Persons (BSBP). All services must be provided in accordance with applicable state or local building codes.
Family Training	Family training includes training and counseling services for the families of beneficiaries served on the waiver. For purposes of this service, "family" is defined as the family members who live with or provide care to the beneficiary in the HSW, and may include parent, spouse, children, relatives, foster family, unpaid caregivers, or in-laws. Training includes instructions about treatment regimens and use of equipment specified in the individual plan of services, and includes updates as needed to safely maintain the beneficiary at home. Family training goals, and the content, frequency, and duration of the training and/or counseling, should be identified in the beneficiary's individual plan of services. Not included are individuals who are employed to provide waiver services for the beneficiary.

	The services under Family Training are limited to additional services not otherwise covered under the state plan, including EPSDT.
Fiscal Intermediary	Fiscal Intermediary services are defined as services that assist the beneficiary, or a representative identified in the beneficiary's IPOS, to meet the beneficiary's goals of community participation and integration, independence or productivity while controlling their individual budget, and choosing staff who will provide the services and supports identified in the IPOS and authorized by the PIHP. The fiscal intermediary helps the beneficiary manage and distribute funds contained in the individual budget. Fiscal intermediary services include, but are not limited to: ▪ Facilitation of the employment of service workers by the beneficiary, including federal, state and local tax withholding/payments, unemployment compensation fees, wage settlements, and fiscal accounting; ▪ Tracking and monitoring beneficiary-directed budget expenditures and identifying potential over- and under-expenditures; ▪ Ensuring adherence to federal and state laws and regulations; and ▪ Ensuring compliance with documentation requirements related to management of public funds. The fiscal intermediary may also perform other supportive functions that enable the beneficiary to self-direct needed services and supports. These functions may include selecting, contracting with or employing and directing providers of services, verification of provider qualifications (including reference and background checks), and assisting the beneficiary to understand billing and documentation requirements. Fiscal intermediary services are available only to beneficiaries choosing the self-determination option. Fiscal intermediary services may not be authorized for use by a beneficiary's representative where that representative is not conducting tasks in ways that fit the beneficiary's preferences, and/or do not promote achievement of the goals contained in the beneficiary's plan of service so as to promote independence and inclusive community living for the beneficiary, or when they are acting in a manner that is in conflict with the interests of the beneficiary.
Goods and Services	The purpose of Goods and Services is to promote individual control over, and flexible use of, the individual budget by the beneficiary using self-directed services and facilitate creative use of funds to accomplish the goals identified in the IPOS through achieving better value or an improved outcome. Goods and services must increase independence, facilitate productivity, or promote community inclusion and substitute for human assistance (such as personal care in the Medicaid State Plan and CLS and other one-to-one support as described in the HSW or covered State Plan definitions) to the extent that individual budget expenditures would otherwise be made for the human assistance.

	A Goods and Services item must be identified using a person-centered planning process, meet medical necessity criteria, and be documented in the IPOS. Purchase of a warranty may be included when it is available for the item and is financially reasonable. Goods and Services are available only to beneficiaries who self-direct their services and whose individual budget is lodged with a fiscal intermediary. This coverage may not be used to acquire goods or services that are prohibited by federal or state laws or regulations, e.g., purchase or lease or routine maintenance of a vehicle.
Non-Family Training	This service provides coaching, training, supervision and monitoring of CLS and respite staff by clinical professionals working within the scope of their practice. Professional staff work with CLS and respite staff to implement the beneficiary's IPOS, with focus on all behavioral health services designed to assist the beneficiary in acquiring, retaining and improving self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. The activities of the professional staff ensure the appropriateness of services delivered by CLS and respite staff and continuity of care. The service provider is selected on the basis of their competency in the aspect of the IPOS on which training is conducted. Services under Non-Family Training are limited to additional services not otherwise covered under the state plan, including EPSDT.
Out-of-Home Nonvocational Habilitation (This is a habilitative service.)	This service provides assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills; and the supports services, including transportation to and from, incidental to the provision of that assistance that takes place in a non-residential setting, separate from the home or facility in which the beneficiary resides. Examples of incidental support include: ▪ Aides helping the beneficiary with their mobility, transferring, and personal hygiene functions at the various sites where habilitation is provided in the community. ▪ When necessary, helping the beneficiary to engage in the habilitation activities (e.g., interpreting). Services must be furnished on a regularly scheduled basis for one or more days per week unless provided as an adjunct to other day activities included in the beneficiary's IPOS. These supports focus on enabling the beneficiary to attain or maintain their maximum functioning level, and should be coordinated with any physical, occupational, or speech therapies listed in the IPOS. Services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

Overnight Health and Safety Supports (OHHS)	NOTE: Overnight Health and Safety Supports (OHSS) is not available for beneficiaries residing in licensed non-community facilities or settings. Payment of OHSS may not be made directly or indirectly to responsible relatives (i.e., spouses or parents of minor children) or a legal guardian. The need for OHSS must be reviewed and established through the person-centered planning process, with the beneficiary's specific needs identified that outline health and safety concerns and a history of behavior or action that has placed the beneficiary at risk of obtaining or maintaining their independent living arrangement. Each provider of OHSS services will ensure the provision of, or provide as its minimum responsibility, overnight supervision activities appropriate to the beneficiary's needs to achieve or maintain independent living, health, welfare, and safety. For purposes of this service, "overnight" includes the hours a beneficiary is typically asleep for no more than 12 hours in a 24-hour period. The purpose of OHSS is to enhance individual safety and independence with an awake provider supervising the health and welfare of a beneficiary overnight. OHSS is defined as the need for an awake provider to be present (i.e., physically on-site) to oversee and be ready to respond to a beneficiary's unscheduled needs if they occur during the overnight hours when they are typically asleep. OHSS services are generally furnished on a regularly scheduled basis, for multiple days per week, or as specified in the IPOS, encompassing both health and safety support services needed for the beneficiary to reside successfully in their own home and community-based settings. OHSS may be appropriate when: ▪ Service is necessary to safeguard against injury, hazard, or accident. ▪ A beneficiary has an evaluation that includes medical necessity that determines the need for OHSS and will allow a beneficiary to remain at home safely after all other available preventive interventions/appropriate assistive technology, environmental modifications and specialty supplies and equipment (i.e., Lifeline, Personal Emergency Response System [PERS], electronic devices, etc.) have been undertaken to ensure the least intrusive and cost-effective intervention is implemented. ▪ A beneficiary requires supervision to prevent or mitigate mental health or disability related behaviors that may impact the beneficiary's overall health and welfare during the night. ▪ A beneficiary is non-self-directing (i.e., struggles to initiate and problem solve issues that may intermittently come up during the night or when they are typically asleep), confused or whose physical functioning overnight is such that they are unable to respond appropriately in a non-medical emergency (i.e., fire, weather-related events, utility failure, etc.).

- A beneficiary has a documented history of a behavior or action that supports the need to have an awake provider on-site for supported assistance with incidental care activities that may be needed during the night that cannot be pre-planned or scheduled.
- A beneficiary requires overnight supervision in order to maintain living arrangements in the most integrated community setting appropriate for their needs.

The following exceptions apply for OHSS:

- OHSS does not include friendly visiting or other social activities.
- OHSS is not available when the need is caused by a medical condition and the form of supervision required is medical in nature (i.e., nursing facility level of care, wound care, sleep apnea, overnight suctioning, end-stage hospice care, etc.) or in anticipation of a medical emergency (i.e., uncontrolled seizures, serious impairment to bodily functions, etc.) that could be more appropriately covered under PERS or medical specialty supplies.
- OHSS is not intended to supplant other medical or crisis emergency services to address acute injury or illness that poses an immediate risk to a person's life.
- OHSS is not available to prevent, address, treat, or control significantly challenging anti-social or severely aggressive individualized behavior.
- OHSS is not available for a beneficiary who is anxious about being alone at night without a history of a mental health or disability related behavior(s) that indicates a medical need for overnight supports.
- OHSS is not intended to compensate or supplant services for the relief of the primary caregiver or legal guardian living in the same home or to replace a parent's obligations and parental rights of minor children living in a family home.
- OHSS is not an alternative to inpatient psychiatric treatment or other appropriate levels of care to meet the beneficiary's needs and is not available to prevent potential suicide or other self-harm behaviors.

COORDINATION OF SERVICES AND CARE

The service normally involves the co-provision of several services through an awake provider in order to achieve the purpose of the service. OHSS services typically fall into a category of "round-the-clock" by the nature and institutional level of care required for Home and Community Based Services (HCBS) Waiver beneficiaries. OHSS is intended to supplement other HCBS (i.e., CLS, respite, etc.) that are provided to the beneficiary as part of a comprehensive array of specialized waiver or developmental disabilities services (i.e., supports coordination, peer-delivered, etc.).

If a beneficiary is receiving CLS or respite supports and demonstrates the need for OHSS, the IPOS must document coordination of services to ensure the scope, nature of supervision and/or provider differ from the

	other community support services to prevent issues of duplicative services. OHSS is complementary of other habilitative services, but typically does not comprise the entirety of the supports a beneficiary may need to obtain or maintain their independence in their community. OHSS services are enhanced services that are in addition to or concurrent with other waiver services, as outlined in the IPOS, and allow for the provision of supervision to ensure the health and safety of a beneficiary overnight. **PROVIDER SERVICES** Providers have the responsibility for the health, welfare, and safety of the beneficiary overnight and must be awake to have the ability to intervene on behalf of the beneficiary. This assistance may take the form of observation and minor redirection of the beneficiary to perform tasks that will enable the beneficiary to maintain their overnight health and sleep safety. Providers may perform minor redirection and/or prompting that are incidental to the care and supervision of the beneficiary over the course of the night such as: ▪ The ability to intervene on behalf of the beneficiary supervision of overnight activities, such as reinforcing independent living skills and minor redirection of their independent daily living tasks. ▪ Provide the level of supervision needed to ensure a beneficiary's safety, along with the actions required if a beneficiary's health or welfare are at risk. ▪ Safeguard the individualized supports needed overnight appropriate to the beneficiary's needs. Common issues include fire and evacuation ability, ability to respond independently to health needs during the night, and safety awareness.
Personal Emergency Response Systems (PERS)	Electronic devices that enable beneficiaries to secure help in the event of an emergency. The beneficiary may also wear a portable "help" button to allow for mobility. The system is connected to the beneficiary's phone and programmed to signal a response center once the button is activated. The response center is staffed by trained professionals. This service includes a one-time installation and up to 12 monthly monitoring services per year. PERS coverage should be limited to beneficiaries living alone (or living with a roommate who does not provide supports) or who are alone for significant parts of the day; who have no regular support or service provider for those parts of the day; and who would otherwise require extensive routine support and guidance.
Prevocational Services (This is a habilitative service.)	Prevocational services involve the provision of learning and work experiences where a beneficiary can develop general, non-job-task-specific strengths and skills that contribute to individual CIE. Services are expected to occur over a defined period of time and provided in sufficient amount and scope to achieve the outcome, as determined by the beneficiary and their care planning team in the ongoing person-centered planning process. Services are expected to specifically involve strategies that enhance a

	beneficiary's employability. Individual CIE or supported employment are considered successful outcomes of prevocational services. However, participation in prevocational services is not a required prerequisite for individual CIE or receiving supported employment services. Prevocational services should enable each beneficiary to attain individual CIE in the community in which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities, and matched to the beneficiary's interests, strengths, priorities, abilities, and capabilities. Services are intended to develop and teach general skills that lead to employment including, but not limited to: ▪ ability to communicate effectively with supervisors, co-workers and customers; ▪ generally accepted community workplace conduct and dress; ▪ ability to follow directions; ▪ ability to attend to tasks; ▪ workplace problem-solving skills and strategies; ▪ general workplace safety; and ▪ mobility training. Support of employment outcomes is a part of the person-centered planning process and emphasizes informed consumer choice. This process specifies the beneficiary's personal outcomes toward a goal of productivity, identifies the services and items, including prevocational services and other employment-related services that advance achievement of the beneficiary's outcomes, and addresses the alternatives that are effective in supporting their outcomes. Prevocational services provide learning and work experiences, including volunteering, where the beneficiary can develop general, non-job-task-specific strengths and skills that contribute to employability in CIE. Beneficiaries who receive prevocational services during some days or parts of days may also receive other waiver services, such as supported employment, out-of-home non-vocational habilitation, or CLS, at other times. Beneficiaries who are still attending school may receive prevocational training and other work-related transition services through the school system and may also participate in prevocational services designed to complement and reinforce the skills being learned in the school program during portions of their day that are not the educational system's responsibility, e.g., after school or on weekends and school vacations. Beneficiaries participating in prevocational services may be compensated in accordance with applicable federal laws and regulations, but the provision of prevocational services is intended to lead to permanent integrated employment.

	Prevocational services needed for each beneficiary are documented, coordinated, and non-duplicative of other services otherwise available under a program funded under Section 110 of the Rehabilitation Act of 1973 or Section 602(16) and (17) of IDEA (20 U.S.C. 1401[16 and 17]). Prevocational services may be provided to supplement, but may not duplicate, services provided under supported employment or out-of-home non-vocational habilitation services. Coordination with the beneficiary's school is necessary to ensure that prevocational services provided in the waiver do not duplicate or supplant transition services that are the responsibility of the educational program. Transportation provided between the beneficiary's place of residence and the site of the prevocational services, or between habilitation sites, is included as part of the prevocational and/or habilitation services. Assistance with personal care or other ADL that are provided to a beneficiary during the receipt of prevocational services may be included as part of prevocational services or may be provided as a separate State Plan Home Help service or CLS service under the waiver, but the same activity cannot be reported as being provided to more than one service. Only activities that contribute to the beneficiary's work experience, work skills, or work-related knowledge can be included in prevocational services
Private Duty Nursing (PDN)	Private Duty Nursing (PDN) services are skilled nursing interventions provided to beneficiaries age 21 and older, up to a maximum of 16 hours per day, to meet an individual's health needs that are directly related to their developmental disability. PDN includes the provision of nursing assessment, treatment and observation provided by licensed nurses within the scope of Nurse Practice Act, consistent with physician's orders and in accordance with the written health care plan which is part of the beneficiary's individual plan of services (IPOS). PDN services are for beneficiaries who require more individual and continuous care than periodic or intermittent nursing available through state plan services, e.g., Home Health. The beneficiary receiving PDN must also require at least one of the following habilitative services: ▪ CLS. ▪ Out-of-home non-vocational habilitation. ▪ Prevocational or supported employment. To be determined eligible for PDN services, the PIHP must find that the beneficiary meets Medical Criteria I as well as Medical Criteria III, or meets Medical Criteria II as well as Medical Criteria III. Regardless of whether the beneficiary meets Medical Criteria I or II, the beneficiary must also meet Medical Criteria III. **Medical Criteria I** – The beneficiary is dependent daily on technology-based medical equipment to sustain life. "Dependent daily on technology-based medical equipment" means:

	▪ Mechanical rate-dependent ventilation (four or more hours per day), or assisted rate-dependent respiration (e.g., some models of Bi-PAP); or ▪ Deep oral (past the tonsils) or tracheostomy suctioning eight or more times in a 24-hour period; or ▪ Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility; or ▪ Total parenteral nutrition delivered via a central line, associated with complex medical problems or medical fragility; or ▪ 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 beneficiaries age 21 and 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.
	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) due to a substantiated medical condition directly related to the developmental disability. Definitions: ▪ "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. "Medical instability" means emergency medical treatment in a hospital emergency room or inpatient hospitalization related to the underlying progressively debilitating physical disorder. ▪ "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. "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 individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

For beneficiaries described in II above, the requirement for frequent episodes of medical instability is applicable only to the initial determination for PDN. A determination of need for continued PDN services is based on the continuous skilled nursing care.

- "Directly related to the developmental disability" means an illness, diagnosis, or syndrome occurred during the developmental period prior to age 22, is likely to continue indefinitely, and results in significant functional limitations in three or more areas of life activity. Illnesses or disability acquired after the developmental period, such as stroke or heart conditions, would not be considered directly related to the developmental disability.
- "Substantiated" means documented in the clinical/medical record, including the nursing notes.

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

Definitions:

- "Continuous" means at least once every three hours throughout a 24-hour period and/or 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.
- "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:
  - 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;
  - managing mechanical rate-dependent ventilation or assisted rate-dependent respiration (e.g., some models of Bi-PAP) that is required by the beneficiary four or more hours per day;
  - deep oral (past the tonsils) or tracheostomy suctioning;
  - injections when there is a regular or predicted schedule, or prn injections that are required at least once per month (insulin administration is not considered a skilled nursing intervention);

	➢ nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility; ➢ total parenteral nutrition delivered via a central line and care of the central line; ➢ 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 age 21 and 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; ➢ 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.
	Once the Medical Criteria eligibility for PDN has been established, and as part of determining the amount of PDN a beneficiary is eligible for, the Intensity of Care category must be determined. This is a clinical judgment based on the following factors: ▪ The beneficiary's medical condition; ▪ The type and frequency of needed nursing assessments, judgments and interventions; and ▪ The impact of delayed nursing interventions. Equipment needs alone do not determine intensity of care. Other aspects of care (e.g., administering medications) are important when developing a plan for meeting the overall needs of the beneficiary but do not determine the amount of hours of nursing for which the beneficiary is eligible.

	High Category	Medium Category	Low Category
	Beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time each hour throughout a 24-hour period when delayed nursing interventions could result in further deterioration of health status, in loss of function, death, or in acceleration of the chronic condition.	Beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time every three hours throughout a 24-hour period, or at least one time each hour for at least 12 hours per day, when delayed nursing interventions could result in further deterioration of health status, in loss of function, death, or in acceleration of the chronic condition. This category also includes beneficiaries with a higher need for nursing assessments and judgments due to an inability to communicate and direct their own care.	Beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time every three hours for at least 12 hours per day, as well as those beneficiaries who can participate in and direct their own care.
	The amount of PDN hours authorized represents a monthly total determined by calculating an average amount of PDN per day multiplied by the number of days in the month. The beneficiary has the flexibility to use the hours as needed during the month, not to exceed the total monthly authorized amount. The amount of PDN (i.e., the number of hours that can be authorized for a beneficiary) is determined through the person-centered planning process to address the beneficiary's unique needs and circumstances. Factors to be considered should include the beneficiary's care needs which establish medical necessity for PDN; the beneficiary's and family's circumstances (e.g., the availability of natural supports); and other resources for daily care (e.g., private health insurance, trusts, bequests). Although the person-centered planning process is used to determine the exact amount of PDN specified in the IPOS, in general, a beneficiary who has Low Category PDN needs would require eight or fewer hours per day, a beneficiary who has Medium Category PDN needs would require 12 or fewer hours per day, and a beneficiary who has High Category PDN needs would require 16 or fewer		

hours per day.

The nurse may provide personal care only when incidental to the delivery of PDN (e.g., diaper changes) but may not provide routine personal care. The provision of personal care in unlicensed homes is through Home Help, a state plan service. (Refer to the Home Help chapter of the MDHHS Medicaid Provider Manual for additional information). If the beneficiary receiving PDN services demonstrates the need for Home Help services, the IPOS must document coordination of Home Help and PDN to ensure no duplication of services.

Licensed nurses provide the nursing treatments, observation, and/or teaching as ordered by a physician, and that are consistent with the written individual plan of services.

These services should be provided to a beneficiary at home or in the community. A physician's prescription is required as defined in the General Information section of this chapter.

The PIHP must assess and document the availability of all private health care coverage (e.g., private or commercial health insurance, Medicare, health maintenance organization, preferred provider organization, Civilian Health and Medical Program of the Department of Veterans Affairs [CHAMPVA], Worker's Compensation, an indemnity policy, automobile insurance) for PDN and will assist the beneficiary in selecting a PDN provider in accordance with available third-party coverage. This includes private health coverage held by, or on behalf of, a beneficiary.

If a beneficiary is attending school and the IEP identifies the need for PDN during transportation to and from school and/or in the classroom, the school is responsible for providing PDN during school hours. For adults up to age 26 who are enrolled in school, PDN services are not intended to supplant services provided in school or other settings or to be provided during the times when the beneficiary would typically be in school but for the parent's choice to home-school.

An exception process is available to ensure the beneficiary's health, safety and welfare if the beneficiary's needs exceed the 16-hours-per-day maximum for a time-limited period not to exceed six months. Factors underlying the need for additional PDN must be identified in the IPOS, including strategies directed toward resolving the factors necessitating the exception, if applicable. Documentation must substantiate all of the following:

- Current medical necessity for the exception; and
- Additional PDN services are essential to the successful implementation of the beneficiary's IPOS and are essential to maintain the beneficiary within the least restrictive, safe, and humane environment suitable to their condition.

Exceptions must be based on the increased identified medical needs of the beneficiary or the impact on the beneficiary's needs due to the unavailability of the primary unpaid caregiver. Consideration for an

exception is limited to situations outside the beneficiary's or family's control that place the beneficiary in jeopardy of serious injury or significant deterioration of health status. Exceptions may be considered for either of the following general situations:

- A temporary alteration in the beneficiary's care needs resulting in one or both of the following:
  - A temporary increase in the intensity of required assessments, judgments, and interventions.
  - A temporary need for additional training to enable the primary caregiver(s) to identify and meet the beneficiary's care needs.

  The total number of additional PDN hours per day will be based on the physician's documentation of the extent and duration of the beneficiary's increased medical needs for a maximum of six months.
- The temporary inability of the primary unpaid caregiver(s) to provide the required care as the result of one of the following:
  - In the event the caregiver is hospitalized, a maximum of 24 hours per day can be authorized for each day the caregiver is hospitalized. Upon discharge from the hospital, or in the event of an acute illness or injury of the caregiver, the total number of additional PDN hours per day will be based on the physician's documentation of the extent and duration of the caregiver's limitations and the needs of the beneficiary as it relates to those limitations, not to exceed six months.
  - The death of the primary caregiver. The initial amount of hours allowable under this exception is 24 hours per day for 14 days. Subsequent exceptions can be approved up to an additional 60 days, with monthly reviews thereafter by the PIHP/CMHSP.
  - The death of an immediate family member. "Immediate family member" is defined as the caregiver's spouse, partner, parent, sibling, or child. The maximum number of hours allowable under this exception criterion is 24 hours per day for a maximum of seven days.

  "Inability" is defined as the caregiver is either unable to provide care or is prevented from providing care.

  "Primary caregiver" is defined as the caregiver who provides the majority of unpaid care.

  "Unpaid care" is defined as care provided by a caregiver where no reimbursement is received for those services, e.g., is not being paid as a Home Help provider or CLS staff.

  This exception is not available if the beneficiary resides in a licensed setting or in a home where all care is provided by paid caregivers.

	If a transition plan has been developed wherein PDN services are to be reduced or eliminated based on a determination of medical necessity, the PIHP may provide PDN for a period of time (not to exceed three months) for the purpose of training the CLS or respite aides or family and ensuring a smooth transition. In those cases, the transition plan, including amount, scope, frequency and duration of the training by nurses to aides, must be documented in the IPOS. A transition process is not intended to provide two-to-one (nurse and aide) staffing for any purpose other than for training (with limitations on duration and frequency noted in the IPOS) while the aide or family member becomes familiar with the beneficiary's care needs. This transition period is only permitted when it has been determined that PDN is not medically necessary and the beneficiary's care needs can be met by a trained CLS or respite aide. The services under PDN are limited to additional services not otherwise covered under the state plan, including EPSDT. PDN is a Medicaid coverage for beneficiaries under age 21 who meet the medical criteria for eligibility. Refer to the Private Duty Nursing Chapter of this manual for additional information.
Respite Care	Respite care services are provided to a waiver-eligible beneficiary on a short-term, intermittent basis to relieve the beneficiary'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. ▪ "Short-term" means the respite service is provided during a limited period of time (e.g., a few hours, a few days, weekends, or for vacations). ▪ "Intermittent" means the respite service does not occur regularly or continuously. The service stops and starts repeatedly or with periods in between. ▪ "Primary" caregivers are typically the same people who provide at least some unpaid supports daily. ▪ "Unpaid" means that respite may only be provided during those portions of the day when no one is being paid to provide the care, i.e., not a time when the beneficiary is receiving a paid State Plan (e.g., home help) or waiver service (e.g., CLS) or service through other programs (e.g., school). Since adult beneficiaries living at home typically receive home help services and hire their family members, respite is not available when the family member is being paid to provide the home help service but may be available at other times throughout the day when the caregiver is not paid.

	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. The beneficiary's record must clearly differentiate respite hours from CLS services. Decisions about the methods and amounts of respite are decided during the person-centered planning process. Respite care may not be provided by a parent of a minor beneficiary receiving the service, the spouse of the beneficiary, the beneficiary's legal guardian, or the primary unpaid caregiver. Respite services may be provided in the following settings: ▪ Waiver beneficiary's home or place of residence. ▪ Licensed foster care home. ▪ Facility approved by the state that is not a private residence, such as: ➢ Group home; or ➢ Licensed respite care facility. ▪ Home of a friend or relative (not the parent of a minor beneficiary, the spouse of the beneficiary served, or the legal guardian) chosen by the beneficiary; licensed camp; in community settings with respite worker training, if needed, by the beneficiary or family. These sites are approved by the beneficiary and identified in the IPOS. Cost of room and board must not be included as part of the respite care unless provided as part of the respite care in a facility that is not a private residence. Respite provided in an institution (i.e., ICF/IID, nursing facility, or hospital) or MDHHS-approved day program site is not covered by the HSW. The beneficiary's record must clearly differentiate respite hours from CLS services.
Supported Employment (This is a habilitative service)	Competitive integrated employment (CIE) is employment that is found in the typical labor market in the community that anyone can apply for and is the optimal outcome of supported employment services. Supported employment services seek to align with the Work Innovation and Opportunity Act (WIOA) to achieve desired outcomes for beneficiaries. Supported employment services support CIE in the general workforce where an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Supported employment services can be provided through many different service models. Specific supported employment services include the two following categories: ▪ **<u>Individual Employment Services:</u>** ➢ Individual Supported Employment Support services for Job Development/Career Planning support CIE that is found in the typical labor market in the community that anyone can apply for and is the optimal outcome of supported employment services. Such

services may provide ongoing supports to beneficiaries who, because of their disabilities, need some fading level of supports to be successful. Additionally, this service array may include intensive on-going support to obtain or maintain an individual job in competitive or customized employment, or self-employment, in CIE in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Self-employment refers to an individual-run business that nets the equivalent of a competitive wage, after a reasonable period for start-up, and is either home-based or takes place in regular integrated business, industry or community-based settings. This service supports sustained paid employment at or above the minimum wage in CIE in the general workforce, in a job that meets personal and career goals.

- Individual supported employment services are individualized and may include any combination of the following services:
  - vocational/job-related discovery or assessment
  - person-centered employment planning
  - job placement/job development with prospective employers
  - job analysis
  - customized employment and job carving
  - training and systematic instruction
  - benefits management, financial literacy, asset development and career advancement services
  - training and planning
  - transportation
  - other workplace support services, including services not specifically related to job skill training that enable the person to attain a job in a competitive integrated community setting of their choice.

- **<u>Group Employment Services for two to six individuals:</u>**
  - Supported Employment Small Group employment support are services and training activities provided in regular business, industry and community settings for groups of two (2) to six (6) workers with disabilities, paying at least minimum wage in an integrated setting. Examples include mobile crews and other business-based workgroups employing small groups of workers with disabilities in employment in the community. Supported employment small group employment support must be provided in a manner that promotes integration into the workplace and interaction between participants and individuals without disabilities in those workplaces. Funding for

	this service is to support sustained paid employment and work experience leading to further career development in individual competitive integrated community-based employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Small group employment support does not include volunteer work or vocational services provided in facility-based work settings. ➢ Supported employment small group employment supports may include any combination of the following services: ▪ job analysis ▪ training and systematic instruction ▪ job coaching ▪ benefits management support and financial literacy ▪ training and planning ▪ transportation ▪ career advancement services ▪ other workplace support services that may include services not specifically related to job skill training that enable the waiver participant to be successful in integrating into the workplace. Federal Financial Participation (FFP) may not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as: ▪ Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program; ▪ Payments that are passed through to users of supported employment programs; or ▪ Payments for vocational training that is not directly related to a participant supported employment program. Supported employment service component(s) needed for each beneficiary are documented, coordinated, and nonduplicative of other services otherwise available under a program funded under Section 110 of the Rehabilitation Act of 1973, or under IDEA, BSBP, or MRS. Documentation must be maintained by the PIHP that the beneficiary is not currently eligible for work activity or supported employment services provided by MRS. Information must be updated when MRS eligibility conditions change.

Refer to the Behavioral Health Code Charts and Provider Qualifications document for Supports and Services Provider Qualifications.