REGION 3B AREA AGENCY ON AGING

CareWell services SOUTH WEST

PROMOTING HEALTH • INDEPENDENCE • CHOICE

Guidelines for Contract Services and General Operating Standards

Table of Contents

Overview of Programs within CWS

Region 3B Area Agency on Aging dba CareWell Services Southwest (CWS) serves as a contract agent to the Michigan Department of Health and Human Services (MDHHS) for the provision of the Home and Community Based Waiver Services for Elderly and Disabled (HCBS/ED) and Waiver Program (MI Choice Waiver). CWS program serves Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, and Van Buren counties. The MI Choice Waiver program funds a variety of home and community based services to functionally frail and medically comprised adults aged 18 years and older who, without such assistance, would require a nursing facility level of care. In addition, MI-Choice Waiver increases traditional Medicaid services to enable people needing nursing facility care to remain in their community to receive their long-term care.

Ongoing Care Management (CM) services are a vital program component. CM services help individuals access needed home and community-based care. CM identifies the needs of participants through a comprehensive assessment for specifying and managing these home care services according to the participant's choices for services. All services are delivered with the participant's needs, wishes, preferences, and desires in mind—this philosophy of care is known as person-centered care.

Community-Based Programs and Services

In addition to the MI Choice Waiver Program, CWS offers various services to meet the needs of seniors, persons with disabilities, and caregivers in our service area, funded by a combination of state and local funding sources. CWS is designated as an Area Agency on Aging (AAA) servicing Barry and Calhoun counties. In addition to direct services provided through CWS, AAA administers grants provided by local agencies to fund programs and services that include long-term care, transportation, home delivered and congregate meals, kinship support programs, legal services, adult day care and respite, senior center programming, and health education and evidence-based programs.

Care Management

Funding through the Older Americans' Act and Older Michiganian Act from the Bureau of Aging, Community Living, and Supports (ACLS Bureau) provides nursing home-eligible seniors who desire to remain home access to services that support their independence. Services include ongoing care management, personal care, other in-home services, nursing facility transition, housing support, transportation, respite care, etc. In addition, state-funded care management serves seniors over age 60, while Medicaid-funded care management is available for persons 18 and over who are medically frail.

Health Access Hub

The Health Access Hub includes programs that promote health, independence, and choice for seniors and caregivers. Programs include resource navigation and referral; supportive health coaching and care decision support for persons navigating health care systems; evidence-based health and wellness programs such as Matter of Balance, Positive Action Toward Health, and the Aging Mastery Program®. Other programs offered include elder abuse prevention and case management services; Dementia Friendly Communities initiatives and specialized dementia training and care support programs; State Health Insurance Assistance Program (SHIP); and the Home Safe PERS program.

MI Coordinated Health

MI Coordinated Health, funded by the Centers for Medicare and Medicaid (CMS) through Integrated Care Organizations (ICO), serves dual-eligible adults aged 21 and over, providing a coordinated, full continuum of care through a broad range of services that incorporate physical health, mental health, and community-based long-term care support and assistance. CWS, through a non-profit corporation consisting of 10 Area Agencies on Aging throughout the state (Michigan Community Care Collaborative) is contracted with ICO health plans to arrange services for and support the health plans' efforts. The health plan partnering with CWS in 2026 is Priority Health Choice, Inc.

Direct Service Purchase System

CWS purchases needed services for participants from competing community and regional service providers. Our agency selects these providers according to the types of services offered, service areas covered, and proposed reimbursement costs. In addition, the Direct Service Purchase (DSP) pool is established through formal agreements with chosen providers who submit 'per unit' bids for each service they plan to provide.

The number of enrolled providers in the DSP pool is regulated to ensure an adequate number of providers within each geographic location and to allow the participants a definite choice. For example, service providers may only deliver services to CWS participants through a formal subcontract agreement between CWS and the enrolled provider agency.

NOTICE: Obtaining a contract and being listed on our Provider Referral Listings does NOT guarantee referrals, as participants choose providers under "person-centered planning."

CWS's CM component authorizes requested services and establishes the frequency and duration for all services purchased. Services available for bid are:

- Adult Day Health
- Chore Services
- Community Living Supports (CLS)
- Community Transportation
- Counseling Services
- Financial Management Services
- Home Delivered Meals
- In-Home Respite Care/Out of Home
- Respite Care
- Nursing Services (Med Sets)
- Personal Emergency Response System (PERS)
- Training Services
- Private Duty Nursing
- Homemaker Services (for ACLS Bureau)
- Personal Care Services (for ACLS Bureau)
- CLS in an Assisted Living
- Direct Care in Assisted Living

Additional Services available through the MI Choice Waiver Program:

- Fiscal Intermediary Services*
- Goods and Services*
- Nursing Facility Transition
- Environmental Accessibility Adaptations
- Specialized Medical Equipment and Supplies

(*Applies to participants enrolled in the self-determination program*)

Contracting Providers

Notice of Compliance and Review Requirements

CWS retains the right to access records, review, approve, and monitor the Provider or the Provider's compliance with all rules, regulations, and requirements applicable to the CWS Care Management Programs and guidelines for all other programs. CWS, MDHHS, ACLS Bureau, and Centers for Medicare and Medicaid Services reserve the right, as a condition of funding, to require the development and implementation of necessary policies and procedures, along with staff training for compliance and corrective action plans, if the provider demonstrates inadequate performance.

CWS retains the right to immediately terminate contractual agreements with any provider who, during the course of service delivery or by business practices, endangers the health and welfare of any participant by being found to be in serious violation of any contractual requirements and fails a Corrective Action of said violations, and have been found to violate federal, state or local laws or statutes directly (also applying to fraudulent billing practices under the Federal and Michigan False Claims Acts). Appeals and Grievances do not apply in this contractual decision.

Funding Structure

CWS uses a unit cost reimbursement structure to purchase direct care services. The Bid Agreement form (submitted when a provider is accepted for a contract) is the formal agreement establishing a fixed unit cost reimbursement rate for each service unit and type of service to be delivered. Monthly reimbursement from CWS is based on the number of service units ordered by CM, provided by the service agency, and verified as delivered during the month.

NOTE: A Bid Agreement is only completed by Adult Foster Care and Homes for the Aged residential service providers to provide base rates for the facility, as Community Living Supports (CLS) units ordered are determined on a per-participant basis and do not apply to "room and board" costs.

Target Population

Medicaid-funded programs serve persons eighteen (18) and over who are medically frail, while ACLS Bureau serves seniors over sixty (60). "Participants" are qualified as determined to be medically eligible for nursing home placement (utilizing the Michigan Nursing Home Level of Care Determination) and as financially eligible for Medicaid under the special expanded income guidelines. In addition, the participant(s) require at least one waiver service to receive services within CWS programs. CWS' CM staff determines participant eligibility for all services; it is the responsibility of the CM to determine appropriate service interventions.

Service Provider Eligibility Standards

Eligible Organizations

A public, private non-profit, or profit-making service organizations and political subdivisions of the state offering services meeting CWS' DPOS minimum service standards are eligible to apply, providing we have sufficient participants in the system warranting increased providers.

Assurances

Providers Must comply with equal employment, service opportunity, and disability/discrimination regulations in compliance with state and federal contracts. Therefore, providers must complete and sign Assurances upon initiating an agreement with CWS and annually to continue their contract with CWS.

Assurances are the agreements signed by all service providers receiving funds from CWS covering their delivery of ordered services. They are the provider's "assurance/promise" of continued compliance with

CMS, MDHHS, ACLS Bureau and CWS, and all other program collaborators' service definitions, unit definitions, and minimum service standards as prescribed, along with all federal, state, and local laws.

The following laws are highlighted and are mandatory in the Assurances agreement:

1. Civil Rights Compliance/Equal Opportunity - Employment, Programs, and Services:

   Service providers must not discriminate against any employee, applicant for employment or assignment, or against any CWS applicant or participant.

   Each service provider must complete an appropriate Federal Department of Health and Human Services form assuring compliance with the Civil Rights Act of 1964. Direct service providers must also 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.

   NOTE: As a contracted provider, your business' compliance is affirmed when signing these Minimum Standards Assurance forms upon initial contracting (and annually after that), indicating your business administration/ownership has read the CWS Contract with your agency, the DPOS Minimum Service Standards Manual and the Service Descriptions Minimum Service Standards and understands your responsibility for compliance under the contract for each service to be performed and delivered.

2. Debarment and Suspension policies:

   Vendors providing services for any CWS programs must verify that their owners and employees are not individually debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any department or contractor from receiving federal, state, or local funds. This check includes all administrative staff accessing participant records, claims data, and direct service staff. Employees must be checked upon hire and monthly after that. Proof of checking should be printed and kept in the employee or an electronic database for verification.

   Providers must assure and certify to the best of their knowledge and belief that they, their employees, and their approved subcontractors are complying and are regularly screened for debarment and suspension.

   This information is available by checking the USOIG (Office of Inspector General) database: https://oig.hhs.gov/, clicking "Exclusions," and loading your information. You should also check through the SAM.gov (System for Award Management) site: https://www.sam.gov/portal and click "Search Records" to load your data. In addition, licensed staff should be checked through LARA: https://www.lara.michigan.gov/ (Department of Licensing and Regulatory Affairs) for present or past suspensions on record.

   Further, as stated in the DPOS service contract and this manual, the provider agrees to notify CWS should it or any of its owners, staff, or approved subcontractors becomes debarred, suspended, or voluntarily excluded during the term of this agreement.

3. Drug-Free Workplace:

   The Federal Government and the Michigan Department of Health and Human Services (MDHHS) prohibit the unlawful manufacture, distribution, dispensing, possession, or use of controlled substances in all service provider workplaces. This will also require up-to-date

Michigan Medical Marijuana policies/procedures for working with those participants and employees holding an authorized Michigan Medical Marijuana Usage Card.

4. Confidentiality:

   Each provider must have written policies and procedures and regularly scheduled training for all employees to protect the confidentiality of information about participants and persons seeking services collected while conducting business. In addition, the procedures must ensure that no information about a person seeking assistance or a present/past participant, obtained from the participant /person/family, or shared by a service provider (CWS) is disclosed in a way that identifies the person or discloses any personal information without the informed consent of that participant or their legal representative.

   Participants referred for service to the provider will have signed consent from CWS but must also have signed consent given to the direct service provider for any outside information request(s). This general "Release of Information Form" issued by your agency and signed by the participant allowing your agency's participation in service delivery will not be sufficient to release any additional information to outside sources separate from CWS. Contact the Supports Coordinator of record for the participant to notify our agency of a request for information regarding our participants' file/service records to obtain our agency's written permission.

5. HIPAA:

   Upon contracting with CWS, the provider will review and sign the HIPAA Business Associate Agreement issued with the CWS contract. This Agreement is the statement of HIPAA compliance responsibilities for both the Contracting Agency (CWS) and the Subcontractor Agency (the Provider) that requires both the Contracting Agency and the Subcontracting Agency to protect all information forms of PHI for participants in our service system. Only Authorized Signatures or Owners of the business can sign this document, as it is a legal part of your contract agreement with CWS.

   Providers must comply with all HIPAA/HITECH/Omnibus 2013 regulations before contracting with CWS. Before awarding a contract and during a scheduled Monitoring visit, we will review your procedures regarding the following:

   a) Written, oral, verbal, and electronic records/information.
   b) Utilizing a standard "Release of Information" form, identifying all entities with which the provider will share PHI. This form must be signed/dated by the participant and reissued annually.
   c) Transmission of data (e-mail, fax, cell phones)
   d) Handling and storage of data/information
   e) Controlled access for all employees
   f) Sharing and access for/with participants of their Protected Health Information (PHI)
   g) Your location and access for secure long-term records storage (both on and offsite),
   h) Monitoring internal and external data transmission
   i) Complete policies and procedures and set scheduling regarding training all staff. This training includes all administrative staff accessing participant records, claims data, and direct service staff.

j) Employees must be trained upon hire prior to entering the participant's home/delivering services, or working with PHI records.
k) Additional training must occur twice a year after that. When a privacy/confidentiality situation or breach presents itself, immediate refresher training is mandatory. Proof of training should be printed and kept in employee files or a separate binder for audit verification.

All Providers must maintain all records relating to participants (present and past) in hard copy and electronic forms for at least ten years* after the service request ends. (Please refer to the Business Associate Agreement for additional information.) * Requirement as of 2018.

Providers must also obtain their own HIPAA Business Associate Agreements from any health service provider, contractor, or outside business that will receive and access PHI of any participants/clients in the provider's care and are shared with CWS. These providers would include subcontracting businesses such as staffing agencies, physicians, and outside medical personnel - OT, PT, and electronic computer repair agencies. In addition, CWS must be notified in advance and approved in writing of external subcontractors performing services that we are paying our contracted provider (subcontractor) to perform regarding our participants. In addition, only outside subcontractors may perform services for our participants with written permission from CWS.

Also, pursuant to the HIPAA/I-IITECH/OMNIBUS 2013 Rule - providers should have a HIPAA compliance officer who monitors and reviews all areas of risk, use, storage, and communication of PHI information and annually perform a "Risk Assessment" of the handling of HIPAA sensitive information by all staff. (These requirements also apply to AFC-HFA facilities, regardless of the size of the facility.) A copy of this annual "Risk Assessment" can be requested for review by CWS and the Federal departments HHS and Office of Civil Rights, who oversee HIPAA, as proof of ongoing compliance.

6. Standard/Universal Precautions:

Service providers must evaluate employees' occupational exposure to blood or other potentially infectious materials that may result from the employee's performance of duties. In addition, service providers must establish appropriate standard/universal precautions based on the potential for this type of exposure. They must also develop an exposure control plan/procedure which complies with the Federal and State regulations set by OSI-IA (Occupational Safety and Health Act) and MIOSI-IA (Michigan's OSI-IA).

Application Process

CWS application information for all our programs is on our website: www.carewellservices.org by clicking "Doing Business with Us" under Providers at the top of the home page. This takes you to our provider page featuring information that directs you to contact the Network Data and Contracts Manager.

NOTE: Any service providers applying for consideration for contracted provider status must comply with all requirements noted in this Contract Service Guidelines and General Operating Standards Manual and the Minimum Service Definitions and Standards for each service/program you propose to deliver. (This is especially important regarding insurance coverage, background checking, and training requirements, as there are no exceptions). The most recent version of the standards manual is found on our website. Please check back frequently for updated versions as regulations change.

Vendor-Provider Selection

CWS is responsible for offering participants a wide range of providers to choose from and a full selection of the needed services for the participants. In addition, providers are selected by the participant (person-centered choice) from a list of available, contracted, and approved providers offering to deliver the needed services. In addition, Supports Coordinators provide a group of contracted providers delivering services that fit the CM care plans around the location of the participant's residence to give the participant choices of providers.

***NOTE:** Providers must deliver services as specified in CWS CM care plans the participant approves.

Service Delivery and Proposed Contracting Review Criteria

Providers are selected for our prefixed, contracted provider pool by CWS utilizing specific criteria set up to promote participant choice by CMS, MDHHS, ACLS Bureau, and our other collaborating agencies. The requirements facilitate offering provider choices and service selections for participants, keeping the number of contracted providers at a manageable number required for regular monitoring of quality/compliance, and keeping at capacity levels expected for our Agency within our Agency' eight county coverage area.

The provider service review criteria are as follows:

1. Participant Preference:

   Some participants may prefer specific providers through previous or current experience. For example, CWS will honor participant requests, providing a current contract exists with CWS and the requested credentialed provider. In addition, new providers will be considered as service capacity mandates or if the requested provider proves to be able to add to new or increased offerings of services and passes the required pre-contract credentialing requirements.

2. Ability to Provide Quality Services:

   Includes proof of quality service delivery performance, participant outcome, accountability as monitored by Care Managers, the accuracy of billing, records, and files, and positive results of monitoring assessments and satisfaction surveys. Managing staff levels to ensure the delivery of services to all participants as requested in their Plan of Care (POC) and Service Order.

3. Comprehensive Care:

   The effort of CWS is to minimize the number of agencies involved in each case. Access to the full ray of pertinent services the provider offers is considered. Provider staffing levels are essential in collaborating with us to provide the POC the participant has requested. Continuity of care for the participant is also crucial in this collaboration and adds to the plan of care's success.

4. Accessibility:

   Practical application in streamlining intake/office services, prompt response or referral (to Supports Coordinator) of participant questions and concerns, avoiding duplicating assessments, and ability to work cooperatively with CWS's CM to meet the participant-approved care plan. Other considerations include the geographic area of service and ease and dependability of service delivery to CM participants.

5. Cost:

   Selection is competitive as the primary focus, and the State of Michigan's requirement is cost effectiveness.

Minimum Requirements and Application Instructions

The minimum requirements to apply for a subcontractor status include the following:

1. A minimum of five (5) direct care employees to start, especially if multiple counties are proposed for coverage area.
2. To have at least six (6) months of operational service delivery experience for the named business.
3. A licensed RN supervising the training of direct service workers is suggested. Without an RN on staff, the person responsible for hands-on training will need to be identified and approved by CWS before contracting.
4. Written policies/procedures for the business (other than an employee manual.)

Instructions to begin your application:

1. After reviewing this document, determine if your business can comply with all requirements.
2. Contact the Network Data and Contracts Manager (contact information on the website) to discuss your interest in joining the provider network
3. Complete the "New Provider Application" form and follow the instructions on the back of the application, which requests several items/copies to be included and sent with your initial application request. Answer all questions as applicable.
4. On your business letterhead, include the listing of services your business plans to provide and your bid for services and pricing (using the "15 minutes per unit" rate noted in the Service Descriptions) and send it with the application.
5. Send the requested information to our offices (address and e-mail is on the form), and we will review your application and bid and reply within ten (10) business days.
6. Potential providers must verify Articles of Incorporation (State of Michigan (SOM) Corporate Status – a copy of official certificate) before approval as a new provider. Your business's legal name/dba Ownership identity must be noted on the New Provider Application.
7. Potential providers must also carry (and include copies of current certificates) all required insurance coverage as described in the Manual. You will also need to include a copy of your IRS notice of assignment for your EIN (Employer Identification Number) and a copy of your assignment of NPI (National Provider Identifier number for Medicare/Medicaid providers), if applicable. Final consideration of your application will only proceed with all the requested documents. Contact the Network Data and Contracts Coordinator with any questions.

***NOTICE:** Applying does not guarantee a contract with our agency, we regularly assess the number of providers per service and area on our listing, and we may already find our listing at full-service capacity in any or all of our eight-county coverage area.

Contracting Acceptance - Completing the Process

CWS Contract department will notify you after the initial application is reviewed and accepted to inquire if you are ready to proceed with the contract process. A complete package of contract documents will be emailed to you for your review and the required signatures. Copies of the completed contract will be issued to you upon finalization and completion of the New Provider Orientation.

The Contract documents include the following parts:

1. Medicaid Subcontractor Enrollment Agreement (with initial Assurance and HIPAA Business Associate Agreement).
    - This main contract document requests information regarding ownership, legal business name (and, if applicable, dba name), IRS' Employer Identification Number (EIN),

National Provider Identifier number (NPI) for Medicare/Medicaid, and other information to register your business as a provider.

- The body of the contract notes other stipulations required by CWS and requirements by CMS, MDHHS, ACLS Bureau, and other collaborating entities for which you choose to provide services. The initial copy of legal "Assurances" is also attached, along with the HIPAA Business Associate Agreement.' This completes the enrollment agreement contracting document.

NOTICE: Only Owners/Authorized Signatories are permitted to sign these legal documents, and the originals must be returned to the CWS office to open the contract. By signing the Assurances and the first page of our contract, you (the provider) establish a commitment to assure a priority for delivering your services within all funding sources' regulatory and capacity limits.

2. IRS W-9 Form.
    - This is the IRS document our Finance Department uses to open and process your account.

NOTE: Line 1 (Name) is the name in which the IRS Form 1099 will be issued for year-end tax purposes. Line 2 (Business Name) is the name to which the reimbursement check will be written.

3. New Provider Contact Information Form
    - All information requested on this form is needed for service referral, billing, and specific contacts for your contract/account. Include all applicable information to prevent delays in opening your contract.
4. Vendor Billing Agreement/Certificate with Signature
    - Fill out a sheet for each staff person who will process your billing for us.
5. Vendor View Enrollment Form
    - Vendor View is a HIPAA-protected communication program utilized by SOM and all PARP agencies in Michigan as the primary electronic communication tool for all messaging relating to participant information and issues for service delivery and billing. Assistance is available from CWS Data staff for initial use and setup.

NOTE: If you are registered to use Vendor View through another Waiver Agent, please use the same username and password on our form. If not, ensure each person has their username and password, as this program is HIPAA-protected and monitored. Do not use another staff member's Vendor View sign-on or communicate HIPAA/PHI-protected information to any of our staff by e-mail.

6. At Risk Participant Information and Contingency Plan for Emergencies Signature form
    - This document explains the required written "Contingency Plan for Emergencies" (how you plan to deliver services and notify participants and our agency in the event of any emergency), especially for serving "At Risk" participants. In addition, CWS requires your agency to inform us of your ability to accept at-risk participant assignments by reviewing and signing this document as part of your contract.

NOTE: A copy of your policy/procedure for handling emergencies must be submitted with your application. For AFC-HFAs - this policy and procedure are required to include your arrangements for alternative housing, meals, and delivery of medications to your participants in the event your facility is rendered uninhabitable due to a weather or fire event.

7. Proof of Required Valid Insurance Documents

- (See page 16 of this document for list of required insurance coverages and maintenance of these certificates with our agency.)

8. Bid Agreement
    - CWS will complete this document using the services and unit rates that we have agreed upon with your business. Please keep a copy for your files. (See below for more information.)

***NOTE:** Future changes to your services should be sent to us in an e-mail in which a "Bid Addendum" will be completed.

9. Examples of Billing Forms, Billing Instructions, Examples of Insurance Certificates
    - We will include copies of the Billing forms for your review. All our Billing documents are also on our website under the Provider page. We will also have examples of various insurance documents to answer questions regarding formats.
10. Service Description Information/Bid Agreement
    a. The Service Description Minimum Standards attached to this Manual and found on our website explain how each service should be bid on and must be billed by your agency/facility. Look over the descriptions for the requirements of delivering each service and use this to formulate your bid to submit to us for the services you will provide and the rate you would request for the service(s).
    b. Providers should consider all potential costs incurred during service delivery when establishing their unit rates for bid submission. In addition, CWS will review your per service unit rate bids presented with your application. (Costs ineligible for reimbursement through our program are anything we do not authorize outside of the plan of care, bad debts, capital expenditures, construction, entertainment, severance, or holiday pay and penalties.)
    c. After your business is accepted as a contracted provider, CWS completes the formal Bid Agreement with the accepted services/unit rates and will forward it to you for your owner/authorized signatory to sign and return a copy to our offices to open your preferred provider referral status.

***NOTE:** Complete your capacity estimate (potential units you believe you could deliver to us for purchase monthly) and verify the geographic area served.

Billing and Reporting

Upon finalization of your contract, CWS will issue a copy of our "Billing Instructions," detailing the process of submitting your bills to us for payment. All our billing forms and a copy of these instructions can be found on our website at the bottom of the page For Providers Page.

The completed forms are verified against Care Management Service Orders/Care Plans, with payment issued on the last business day of the month. Payment will be delayed if the information submitted needs to be completed or corrected. If services billed exceed the amount pre-authorized in the Service Order/Plan of Care, they will be denied payment. (If extenuating circumstances occurred, this must be communicated to the Supports Coordinator through Vendor View within twenty-four (24) hours from the time of the event to be considered. (First business day of the week if it occurs on the weekend.) Faxed reports are only accepted with prior permission from the Data Department (only in extreme cases) at the sole discretion of the Data Department.

Reporting fraud, waste, or abuse by Subcontractors/Network Providers to either CWS or the MDHHS-OIG may be reported anonymously.

CWS Compliance Hotline
compliancehotline@carewellservices.org
1-877-342-6495
Website report: www.carewellservices.org

MDHHS Office of Inspector General
www.michigan.gov/fraud
855-MI-FRAUD (643-7283)
P.O. Box 30062
Lansing, MI 48909

Billing Forms

CWS utilizes three reporting tools:

1. **Direct Service Purchase Monthly Service Report/Payment Voucher:** Record services delivered to each participant individually.
2. **Direct Service Purchase Monthly Service Summary Report:** Totals payment due for all participants served within the billing month.
3. **Non-Service Delivery Form/Notice:** To report Non-Delivery of Services as ordered, whether canceled by the participant, not delivered due to staffing issues, or for any other reason. This form must be submitted by fax to CWS within 24-48 hours of the occurrence. You may also issue a Vendor View Message to the Data Department on the date the service is not delivered as ordered; for occurrences on the weekend, please submit it on Monday after the weekend.

Vendor Electronic Billing

Electronic Billing is currently in process at CWS for all providers. Please contact Data for more information or if you still need to sign up with CWS for Vendor Electronic Billing.

The section below will detail the requirements for program/service delivery as noted by CWS' contractual provider agreement, supported by regulatory requirements of CMS, MDHHS, ACLS Bureau, and our other collaborating providers and programs.

General Operating Standards:

Required Program Components for Contracted Direct Service Providers

All contracted providers are required to comply with All general program requirements established by the Center for Medicare/Medicaid Services (CMS), the Michigan Department of Health and Human Services (MDHHS), the Michigan Aging and Adult Services Agency (ACLS Bureau), CWS and all of our other collaborating programs. All Contracted providers are required to be enrolled in the Michigan Medicaid Program via the State's Medicaid Management Information System.

Compliance Requirements and Contract Continuation Notice

Authorized representatives of CWS, CMS, MDHHS, ACLS Bureau, and our collaborating programs, along with Federal or State OIG auditors and any other funding representatives, must be permitted to inspect any HIPAA/PHI records, related Human Resources employee files, participant, and other business-related records/books/folders as a condition of accepting Medicaid and additional funding from our agency programs. The provider will also permit access to the provider facility and its policies/procedures related to the contract for service provision. CWS, MDHHS, ACLS Bureau, and our other collaborating programs also reserve the right, as a condition of funding, to require the development and implementation of corrective action plans if the provider demonstrates inadequate performance.

Contract Continuation Notice

CWS reserves the right to immediately terminate contractual agreements with any provider who, during the course of service delivery, by business practices, or due to an issue found in the course of CWS performing a required Monitoring Visit, endangers the health and welfare of any participant by being found in serious violation of any contractual requirements and failure to complete Corrective Action(s) of said violations satisfactorily, and has been found to violate federal, state or local laws or statutes directly (also applying to fraudulent billing practices under the Federal and Michigan False Claims Acts).

NOTE: Appeals and Grievances do not apply in these contractual decisions.

Contractual Agreement

Service providers may only deliver MDHHS (MI Choice Waiver, MI Health Link), ACLS Bureau, and other collaborating programs' services through a formal sub-contractual agreement between CWS and the service provider agency. In addition, each sub-contract must contain and be able to comply with all applicable contract components required by CMS, MDHHS, ACLS Bureau, and other collaborating programs' requirements.

Compliance with Service Definitions

State and/or Federal funds awarded through MDHHS and other fund sources to CWS may only pay for those services MDHHS, ACLS Bureau, and CWS' other programs have included and defined in the CMS-approved contract with CWS (Direct Purchase of Service contract.) MDHHS, ACLS Bureau, and the other programs have defined minimum standards, which are the basis of services we contract from our providers.

NOTE: Each direct service provider is required to adhere to the services definitions and minimum services standards and their established unit rates, applied through our Plan of Care/Service Order for each participant, to be eligible to receive reimbursement of allowable expenses.

Contributions-Solicitations

- No service provider under contract with CWS may require monetary donations from CWS program participants as a condition of participation. In addition, each direct service provider is required to accept CWS' payments for services as payment in full for all such ordered services.

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

Provider Requested Closure or Contract Terminated Providers and Staff

Service providers that have voluntarily requested contractual closure or that CWS has terminated the contractual agreement are prohibited from contacting and/or soliciting CWS participants after the closure and will be considered in violation of the HIPAA/HITECH/OMNIBUS 2013 regulations, thereby mandating CWS to report this violation to State and Federal officials.

Vulnerable Adult Act & Abuse, Neglect and Exploitation, and Mandated Reporting

All providers are provided to have written policies/procedures in place, and annual employee training and take appropriate action when they or their employees suspect, become aware of, or witness incidents of abuse, neglect, and/or exploitation that have occurred. In addition to the witness reporting to APS, local law enforcement and CWS must also be contacted. (AFC/HFA should also follow their Licensing Regulations for reporting.)

Person-Centered Planning Process

Person-Centered Planning (PCP) is a process for planning and supporting the participant that builds on the individual's (participant) ability to engage in the activities that promote "community life" and honors that participant's preference, choices, and abilities. PCP includes the participant in the planning of service to honor and apply their preferences in every aspect of coordinating and arranging services and supports. This collaboration allows building upon their abilities instead of solely focusing on their limitations in delivering their needed and desired services.

1. Direct service providers are required to utilize a person-centered planning process, and knowledge of person-centered planning must be evident throughout service delivery and through documented, proven training sessions for all staff/employees.
2. In addition, PCP includes respecting the needs and desires of participants, utilizing CWS's CM Plan of Care service/support plans (developed by the participant and CM staff), continuously updating and revising those plans by keeping up with Vendor View participant Plan of Care Reassessments and working with CWS's CM staff to modify those plans as you and your staff become aware needs and preferences have changed with the participant.
3. Direct service providers are required to implement person-centered planning in accordance with the MDHHS Person-Centered Planning Guidelines. This process originates from the notation on the service order: “Date/Days and hours may vary." (For the participant’s benefit, not the provider's scheduler.) Contact CWS for more information regarding the MDHHS guidelines for person-centered planning.

Dignity and Respect for Participants

Participants will always be treated with consideration and respect, with due recognition of an individual's dignity, individuality, and the right to receive quality care from providers. This is a requirement under "person-centered planning.”

NOTE: CWS reserves the right to terminate a contractual agreement, effective immediately, if a participant's health and/or welfare are believed to be in jeopardy.

Confidentiality

Each direct service provider must have procedures in practice and written business policy/procedures to protect the confidentiality of information belonging to participants or persons seeking services and collected or shared during business conduct.

NOTE: CWS requires that all providers notify the Supports Coordinator of record for the participant if a breach of information occurs or a request for records is received before releasing any information to any entity.

Record Retention

Each direct service provider is required to keep all records related to or generated from the provision of services to CWS and our collaborating programs' participants for at least ten (10) years. Providers must inform CWS about the location of the secure storage of these records. Closed Providers are also required to keep records remaining after the closure date for at least ten (10) years* and to notify CWS about the location of the secure storage of these records within ten (10) business days of the confirmed closure date. (See the Business Associate Agreement for more information on this requirement.)
*Requirements change as of 2018.

Insurance Coverage

Each direct service provider is required to have sufficient insurance to indemnify the loss of Federal, State, and local resources due to casualty or fraud. Insurance coverage should be adequate to reimburse CWS for the asset's fair market value at the time of loss, which shall cover all buildings, equipment, supplies, and other property purchased in whole or in part with funds awarded by MDHHS to CWS participants.

NOTE: To continue to be listed on the Active provider referral list, all providers must always have proof of valid insurance on file with CWS.

The following insurance is required for each direct service provider:

1. General liability and hazard insurance (including facilities coverage)
2. Worker's compensation *
3. Unemployment (proof of coverage certificate or statement) *
4. Property and theft coverage
5. Fidelity bonding/Surety Certificate* (for persons handling cash)
6. Sexual Abuse and Molestation Liability
7. Privacy and Security Liability (Cyber Liability)
8. No-fault vehicle insurance* (for agency-owned vehicles when transporting participants or performing shopping/errands)

NOTE: A Waiver of Coverage form is available, when appropriate, to show the reason for noncoverage under state/local requirements regarding Workers' Compensation, Unemployment Insurance, No-Fault Auto Insurance, Fidelity/Surety coverage (Sole Proprietary or Family business, not handling funds, not transporting clients.)

MDHHS recommends the following insurances for additional agency protection:

1. Insurance to protect the waiver agency or direct service provider from claims against waiver agency or direct service provider drivers and/or passengers.
2. Professional liability (both individual and corporate)
3. Umbrella liability

4. Errors and Omission Insurance for Board Members and officers
5. Special multi-peril
6. Reinsurance/Stop-Loss Insurance (for all other non-specific events/situations and possible unexpected gaps in coverage loss)

Staffing - Provider Requirements

Each direct service provider shall:

- Employ and provide training to personnel to have the necessary skills to provide quality support and services to participants at skill levels expected to be compliant with our contractual agreement. Including but not limited to: a. Person-Centered Planning
  b. Fraud, Waste, and Abuse
  c. Reporting Abuse, Neglect, and Exploitation
  d. Demonstrate an organizational structure including established lines of authority.
  e. Identify a contact person with whom the waiver agency can discuss work orders, service delivery schedules, problems, and billing issues.
  f. Always maintain a valid picture driver's license or Michigan/Indiana (for employees near border counties) Picture ID on file for each employee and volunteer in their personnel files.
  g. Assure participants will always be treated with consideration and respect, with due recognition of an individual's dignity, individuality, and the right to receive quality care from providers.

NOTE: CWS reserves the right to terminate a contractual agreement, effective immediately, if a participant's health and welfare are believed to be in jeopardy.

General Requirements - Staff

1. Employ or use volunteers who are 18 years and older.
2. Wear picture identification. Every direct service provider staff person paid or volunteer who enters a participant's home or delivers a service to a participant must display proper identification.
3. Refrain from intimidation or threat - a direct service provider must not threaten or coerce participants in any way; failure to meet this standard is grounds for immediate discharge.

Valid Auto Insurance/Waiver, Transporting Participants, Using Participant's Vehicle

1. Direct service workers' vehicles used in the delivery of services shall be in good working order.
2. Proof of valid vehicle insurance is required to be on file in the employee personnel file if the provider is authorizing services to transport participants or perform shopping/errands in the company or personal vehicles. For liability reasons, valid private insurance includes naming the employee as a covered driver on the insurance certificate. If workers are not covered by insurance, they should not transport participants or drive any other vehicle.
3. Providers should have a signed waiver on file stating that the uninsured employee or one without a valid Michigan/Indiana Driver's license understands they cannot drive participants or perform shopping/errands in a company or personal vehicle.

4. Providers who state they cover their employees for driving any vehicle must show proof of Business or Commercial Auto coverage.
5. CWS disapproves of providers allowing direct service workers to drive participants' vehicles and will not be a liable party in the event of any accident or violations (moving or otherwise) or personal injuries incurred.

Criminal Background Checking

All providers must conduct, or cause to be conducted, a criminal background check 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, and volunteer who has in-person client contact, in home client contact, access to a client's personal property, or access to confidential client information:

I-CHAT:	http://apps.michigan.gov/ichat
Michigan Public Sex Offender Registry:	http://www.mipsor.state.mi.us/
National Sex Offender Registry:	http://www.nsopw.gov/

Criminal background checks for new hires must be completed before the individual works directly with clients or has access to a client's personal property or confidential client information.

Each provider is required to update criminal background checks for all employees and volunteers every thirty (30) days to identify convictions in the event they occur while an individual is employed or providing volunteer service:

- All employees and volunteers hired before the effective date of this policy must be rescreened within ninety (90) days from the effective date of this policy. After that, criminal background checks for these employees and volunteers must be completed no later than thirty (30) days from the date of the last background check.
- Updated criminal background checks for employees and volunteers hired after the effective date of this policy must be completed no later than thirty (30) days from the date of the last background check.

All AAAs are required to maintain a copy of the results of each criminal background check for paid and volunteer staff in a confidential and controlled access file.

Exclusions: No employee or volunteer shall be permitted to work directly with clients or have access to a client's personal property or confidential client information if:

Mandatory Exclusions: The results of the criminal background check show that the person has a federal or state felony conviction related to one or more of the following crimes:

1. Crimes against a "vulnerable adult" as outlined in MCL 750.145n et seq.
2. Violent crimes including, but not limited to, murder, manslaughter, kidnapping, arson, assault, battery, and domestic violence.
3. Financial crimes include but are not limited to fraud, forgery, counterfeiting, embezzlement, and tax evasion.
4. Sex crimes include, but are not limited to, rape, sexual abuse, criminal sexual conduct, and prostitution.
5. Cruelty or torture.
6. Abuse or neglect; or
7. Felony involving the use of a firearm or dangerous weapon.

Felony convictions: The results of the criminal background check show that the person has a federal or state felony conviction within the preceding ten (10) years from the date of the background check, including but not limited to:

1. Crimes involving state, federal, or local government assistance programs.
2. Theft crimes including, but not limited to, larceny, burglary, robbery, extortion, false pretenses, false representation, and conversion; or
3. Drug crimes include, but are not limited to, possession, delivery, and manufacturing.

Misdemeanor Convictions: The results of the criminal background check show that the person has a federal or state misdemeanor conviction within the preceding five (5) years from the date of the background check, including but not limited to:

1. Crimes involving state, federal, or local government assistance programs.
2. Crimes against a "vulnerable adult" as outlined in MCL 750.145n et seq.
3. Financial crimes include but are not limited to fraud, forgery, counterfeiting, embezzlement, and tax evasion.
4. Theft crimes include but are not limited to larceny, burglary, robbery, extortion, false pretenses, false representation, and conversion.
5. Sex crimes include, but are not limited to, rape, sexual abuse, criminal sexual conduct, and prostitution.
6. Drug crimes include, but are not limited to, possession, delivery, and manufacturing.
7. Cruelty or torture.
8. Abuse or neglect.
9. Home invasion.
10. Assault or battery; or
11. Misdemeanor involving the use of a firearm or dangerous weapon with the intent to injure, the use of a firearm or dangerous weapon that results in a personal injury, or a misdemeanor involving the use of force or violence or the threat of the use of force or violence.

For purposes of the excluded offenses identified above, an individual is considered to have been convicted of a criminal crime when:

1. A judgment of conviction has been entered against the individual or entity by a federal, state, tribal, or local court, regardless of whether an appeal is pending.
2. There has been a finding of guilt against the individual by a federal, state, tribal, or local court; or
3. A plea of guilty or nolo contendere by the individual has been accepted by a federal, state, tribal, or local court.

Arrest records, by themselves, do not disqualify an individual.

Providers must maintain documentation of all criminal background checks, including a list of all paid and volunteer staff subject to this policy, the date of the most recently completed criminal background check, and the source of the background check. Employees hired before the effective date of this policy are not exempt from this requirement.

***NOTE:** Contact CWS Provider Relations Manager with any questions regarding CBC results and for assistance understanding these eligibility determinations/guidelines before allowing employees to provide services to participants.

Background & Reference Checks for Adult Foster Care and Homes for Aged

Michigan Requirements state that a qualifying health facility/agency shall not employ, independently contract with, or grant clinical privileges to an individual who regularly has direct access to or provides direct services to patients or residents in the health facility/agency or AFC until the health facility/agency or AFC conducts a fingerprint-based criminal history check. An individual who applies for employment either as an employee or as an independent contractor or for clinical privileges with a health care facility/agency or AFC and has received a good faith offer of employment, a separate contract, or clinical privileges shall give written consent at the time of application for the health care facility/agency or AFC to contact a criminal history check, including a state and Federal Bureau of Investigation (FBI) fingerprint-based check, and shall give a written statement disclosing that they have not been convicted of a crime that would prohibit employment.

Information and forms needed to conduct these checks are available at the https://miltcpartnership.org/ site. AFC- HFAs should follow the LARA Licensing requirements for Criminal Background Checking their employees through Michigan Workforce Background Checking.

NOTE: January 2018 - MDHHS/LARA notice to HFAs regarding the reduction of Background Checking reimbursement reductions (to 40 checks) will not release your facility from performing the MWBC under the CWS contract requirements on additional applicants or workers after reimbursement runs out.

Professional/Employment Reference Checks

All providers are required to conduct, at minimum, two confirmed reference checks. Documentation that the checks were completed will be verified during a monitoring visit. Verification proof should include a reference check document (kept in the personnel file), a notation of the date the reference check was completed, and the signature of the staff person conducting the review.

NOTE: A "letter of reference" requires a phone call to the writer to confirm authenticity as proof of verification, and the same confirmation notations should be included on this document.

Fraud, Waste and Abuse/Debarment and Suspension Checks

All providers are required to verify upon hire and monthly after that, that their owners, employees, and, if applicable, subcontractors are not individually debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any department or contractor from receiving federal, state, or local funds in compliance of the Social Security Act.

NOTE: This includes all administrative staff having access to participant records and/or claims data and direct service staff. Employees must be checked upon hire and monthly after that. Proof of checking should be printed and kept in employee files for audit verification.

TB Testing

It is only recommended that all direct purchases of service staff have a current and negative TB screening, except as may be required by individual licensing requirements or at the recommendation of local/state health officials. For example, if providers choose to do this, a Symptom Check statement from employee physicians or agency nursing staff would also be accepted bi-annually after the initial hire. *Adult Foster Care and Homes for the Aged providers are required to follow TB Testing regulations as identified by The Bureau of Children and Adult Licensing and LARA.

Position/Job Descriptions/Performance Evaluations

All providers' paid staff and volunteers must receive a written position description upon hire, new hire orientation training, and a yearly performance evaluation, as appropriate. These position descriptions should be copied into employee files at the monitoring visit.

Smoking Policy

Direct service workers are prohibited from smoking while performing services for a participant in any location (i.e., participant's home, parking lot, or vehicle) per state and local law. This includes electronic cigarettes (vaping) and chewing tobacco. - No Exceptions.

Drug-Free Workplace

The unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in all service program workplaces, per the federal Drug-Free Workplace Act of 1988. CWS reserves the right to terminate a contractual agreement effective immediately if a participant's health and/or welfare are believed to be in jeopardy. Therefore, all providers should have postings in their human resources and/or employee notification areas regarding this requirement.

Waiver Sponsored Training

It is recommended that all direct service workers, supervisors, and program staff participate in CWS topic-relevant sponsored in-service training workshops, as appropriate. These trainings usually take place twice a year.

Emergency/Weather Service Delivery Plans

All providers are required to be prepared to make arrangements for the availability of services to CWS's participants in weather-related emergencies and/or natural disasters (including fire and flood), updating and forwarding this plan to CWS Contracts Department annually. This plan should include communication with participant emergency contacts, law enforcement/emergency response agencies, contacting CWS, alternate ways to deliver services, and obtaining assistance from local and state agencies, if necessary. RE: AFC-HFAs - this plan should also indicate communications that will occur, whether you have a power generator, make arrangements to relocate participants (if your building is uninhabitable), keep participants safe during the situation, and obtain participant medications and food sources.

Universal Precautions/MIOSHA-OSHA Compliance

All providers are required to evaluate employees' occupational exposure to blood or other potentially infectious materials that may result from performing the employee's duties and establish appropriate universal precautions. In addition, each provider with employees who may experience occupational exposure must develop an exposure control plan and policy/procedures that comply with Federal and State regulations implementing the Occupational Safety and Health Act.

Business Policies and Procedures for Contract-Specific Requirements

Each provider is required to have written policies and/or procedures indicating the person/department responsible for implementation for the following topics:

1. Participant Complaint Resolution/Critical Incidents:

   The provider will have a policy/procedure to protect information gathered on the complaint to maintain participant confidentiality and show action relating to resolving the issue and how it will be prevented. This policy/procedure is to be a written procedure to record, investigate and report concerns/complaints from participants regarding their DPOS workers to CWS staff.

   a. The report should be submitted to CWS staff within 1-2 days of receiving information from the participant. Information should include an incident/complaint form with the date(s) of the reported situation, details of concern reported, name of staff person receiving and investigating concern, and include results of investigation/action taken by provider staff.
   b. The provider will identify staff persons who will be responsible for working to resolve complaints with both participant and CWS staff.

2. Reporting Suspected Abuse, Neglect, and Exploitation:

   Reporting of Abuse, Neglect, and/or Exploitation must be reported to the Michigan Department of Human Services (DHS)/Adult Protective Services (APS).

   All providers must have a written policy/procedure to record, investigate, and report any suspected abuse, neglect, and/or exploitation of participants observed during interaction with and/or delivering services to a participant.

   a. The provider is required to submit this observation/information to law enforcement authorities (APS, Law Enforcement-911) as part of the Mandated Reporting requirements with the SOM.
   b. This information should also be reported to CWS staff as soon as possible after the discovery and reported to law enforcement.
   c. Information gathered during this investigation is also required to be held confidential to protect the participant.

3. Participant Confidentiality:

   All providers are required to have policies/procedures to protect all aspects of participant confidentiality in accordance with federal and state HIPAA/HITECH/OMNIBUS requirements. Procedures shall include provisions for orientation and annual training for all staff regarding written, electronic, and conversational situations relating to participants.

4. Appeals and Grievances:

   a. Each provider must have written appeals procedures for individuals determined to be ineligible for services or recipients who have services terminated.
   b. Persons denied service and service recipients must be notified of their right to complain and/or appeal and the procedure followed. Such notice must advise participants that complaints of discrimination may be filed with the respective CWS, the U.S. Department of Health and Human Services, the Office of Civil Rights, or the Michigan Department of Civil Rights.
   c. Each in-home service and AFC-HFA program is required to establish a written service termination policy which includes, at a minimum, formal notification to the participant of the provider's decision to stop services when a provider becomes unable to continue to serve the participant.

d. Service providers must notify each participant, in writing, when service is initiated of their right to comment about service provision or appeal the termination of services. Such notice must advise the participant that they may file complaints with CWS, the Department of Health and Human Services Office of Civil Rights, or the Michigan Department of Civil Rights.

5. Participant Feedback/Evaluation:

   Each provider is required to have written procedures for individuals receiving services to comment on the delivery/quality of the services.

   A form and measuring tool should be created to develop/monitor participant satisfaction with services received, program and staff performance, and consistency of services provided. Survey results and participant feedback will be made available for verification to CWS.

6. Participant's Rights and Responsibilities:

   Each provider is required to have written procedures for individuals receiving services indicating the Rights and Responsibilities of the participant while receiving services. These policies and procedures should also include issuing a document to the participant at sign-on, explaining these rights and, giving instructions for questions complaints, and contacting the provider that identifies a designated staff person that handles these inquiries.

7. Emergencies in a Participant's Home and/or During the Delivery of a Service:

   All providers are required to have a policy/procedure outlining service delivery plans to be put in place in the event of a natural, weather-related, or manufactured emergency. This plan relates to all services the provider agreed to provide for any CWS participant. The plan should include a formal notification plan directed toward participants and CWS staff.

8. Contingency/Emergency Service Plans for At-Risk Participants:

   Any agency accepting "at risk" participants must have an extensive backup and contingency plan in place so that all hours and services listed on the service order are performed in the manner listed without exception, regardless of staff illness, holidays, vacation, etc. This requirement is in effect regardless of whether the staff is a family member or traditional personnel and if the participant has people living in their home.

9. Administration of Medication (Prescription and OTC):

   Each provider is required to have written procedures for the administration of both prescription and over-the-counter (OTC) medications to participants. Written procedures (reviewed and approved by a consulting Pharmacist, Physician, or Registered Nurse) govern the assistance licensed staff gives to participants taking medications.

   The policies and procedures must minimally address the following:

   a. Verify the participant's medication regimen, including the prescriptions and dosages.
   b. The training and authority of licensed staff to assist participants with taking their prescribed or non-prescription medications and under what conditions unlicensed staff may cue/assist participants.
   c. Training for unlicensed staff to understand limitations and directives of assistance.
   d. Procedures for medication setup.

e. Secure storage of medications within the participants' home.
f. Instructions for documenting medication information in participant files, including times and frequency/types of assistance.

10. Personnel, Recruitment, Training, and Supervision:

    Each provider must have policies/procedures outlining recruitment, hiring, training, supervision, and all aspects of personnel management. These policies should also include documentation of incidents/accidents, disciplinary action, job descriptions, universal precautions, HIPAA rules, and confidentiality.

    Training topics should include all training requirements for each service provided and all required orientation and annual training as stated in the Waiver contract.

11. Health and Welfare:

    Each provider must have policies and procedures to protect the participant's health and welfare. Such policies are Safety, Abuse/Neglect/Exploitation, Mandated Reporting, Emergency procedures in the participant's home (accidents and incidents), handling weather-related emergencies, client welfare checking (calls to non-at-risk clients when providers cannot deliver services due to weather or for other concerns.)

Worker Service Records

Recordkeeping and Participant Service Requirements

As a requirement of the MI-Choice Waiver Contract, each provider must have procedures in place for obtaining participant signatures on the Worker Service Record or similar documents of direct care workers or AFC-HFAs to verify that the services were provided to the participant as ordered by CWS.

NOTE: **MI Choice Waiver providers must be fully compliant with MDHHS Electronic Visit Verification (EVV) standards by April 1, 2026**. This mandate is supported by the officially issued MDHHS Bulletin MMP 24-21, which outlines EVV requirements for personal care services across Medicaid programs. Direct service agencies must ensure the following minimum recordkeeping requirements for participant case records and include the following in the participant folder:

1. Service work orders/authorizations
2. Assessment parts or all the re-assessments provided by the CWS by Vendor View
3. For Worker Service Records: types of services provided to each participant, i.e., a description of tasks completed by the service date and worker notes describing the tasks completed for each shift. Worker EVV time sheets must have tasks performed to meet these criteria.
4. Ranges of time that each service is provided, i.e., 10:00 am-12:00 pm; (Times are subject to change according to participant preferences and CWS authorization, not for scheduling purposes.)
5. Date of services.
6. Progress notes and supervisory visits
7. Identification of the worker providing each service and that worker's signature on the worker service record.

Orientation and Training of ALL Provider Employees & Volunteers

All training should be recorded on itemized checklists for Orientation and Annual Training. Providers must have training scheduled in advance on a monthly, quarterly, or yearly calendar detailing the topics to be covered. Volunteers should be treated in the same manner as paid direct service workers. This document will be reviewed at the time of the monitoring visit.

Official records documenting the training should include the following:

1. topics covered.
2. materials listings.
3. name and signature of staff person receiving training.
4. date(s) of training.
5. The signature of the person providing the training on behalf of the provider.

A copy of the completed training should be kept in the employee's/volunteer's file and/or a specialized training binder stored in a confidential, secure place.

Required Training Topics

1. Orientation for New Hires

a. Introduction to the MI Choice waiver
b. Maintenance of records and files (as appropriate)
c. Emergency procedures
d. Assessment and observation skills
e. Waiver Agency's Grievance and Appeals process.
f. Ethics:
    1. Acceptable work ethics
    2. Honoring the MI Choice participant's dignity
    3. Respect for the MI Choice participant and their property
    4. Prevention of theft of the MI Choice participant's belongings
g. Working with persons with disabilities
h. Universal Precautions
i. Aging (This may include the aging process and aging network)
j. Mandated Reporting and Critical Incidents (Identifying appropriate actions to determine abuse, neglect, exploitation, and other critical incidents).

2. Annual Staff Development

a. Person-Centered Planning
b. Health, Safety, and Welfare
c. Individualized emergency response procedures
d. Abuse/Neglect & Mandated reporting
e. HIPAA & Privacy/Confidentiality

In addition to the contractually required training, all staff must be trained and capable of performing any tasks necessary (i.e., tasking, CPR, first aid, especially when mandated by LARA, etc.) before entering the participant's home to deliver service or directly providing other services.

Additionally, home-based services and Adult Day Health program staff must receive in-service training (skills/tasking) at least twice each fiscal year, specifically designed to increase their knowledge and

understanding of the program and participants to improve their skills and task performed in service provision.

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 CWS participants. Availability by telephone is considered accessibility. Home-based service providers must conduct in-home Supervisory Visits of their staff at least twice each fiscal year. The staff person must be present and should be in the process of delivering services to a participant. These reviews cannot be conducted over the phone with a participant unless the call is made to speak to a participant after the completed home visit. In addition, a qualified professional must conduct the supervisory visit (i.e., administration staff who is usually involved in the training/assessment process or a registered nurse.)

General Operating Standards for Specific Direct Purchase of Services

In addition to the general operating standards for services requested by CWS for MDHHS, ACLS Bureau, or any other collaborating program, providers and both Home-Based and Community-Based service providers and their direct service workers must follow and comply with the Specific Service requirements for each of the services for which they contract, and the topics listed in this section.

Home-Based Service Providers

Home-Based services include the following:

1. Community Living Supports
2. Respite Services (provided in the home)
3. Chore Services
4. Personal Emergency Response Systems
5. Nursing Services
6. Private Duty Nursing Services
7. Counseling
8. Home Delivered Meals
9. Training

Community-Based Service Providers

1. Community-based services include:
2. Environmental Accessibility Adaptations
3. Respite Services (provided outside of the home)
4. Specialized Medical Equipment and Supplies
5. Community Transportation

Home and Community-Based Services Final Rule Compliance

Under the Center for Medicare and Medicaid Services (CMS) requirements published on March 17, 2014, CMS created a new set of rules for delivering Home and Community-Based Services through Medicaid Waiver programs. Through these rules, CMS aims to improve the experience of individuals in these programs by enhancing access to the community, promoting the delivery of services in more integrated settings, and expanding the use of person-centered planning.

Each waiver agency and direct service provider must comply with the Federal Home and Community Based Services Settings Requirements as specified in 42 CFR 441.30l(c)(4) as well as in the Home and Community-Based Services Chapter in the Michigan Medicaid Provider Manual. Direct service

providers with subcontracts secured before September 30, 2015, had until March 17, 2019, to fully comply with this regulation unless they are included in the heightened scrutiny process. All direct service providers added to the waiver agency's provider network after September 30, 2015, must comply with this ruling before the direct service provider may provide services to a waiver participant. 2018 and forward. New proposed providers seeking to contract for ADS or AFC/HFA must fully comply with the federal HCBS Final Rule requirements before a contract can be opened or any participant can be referred to the facility per MDHHS' regulatory statement of the HCBS Final Rule.

MDDHS will use the following process to ensure compliance with this requirement:

1. Each waiver agency will assess all applicable providers using the survey in Attachment J to this contract. The results of the surveys will be submitted electronically to MDHHS to determine compliance with the requirements.
2. MDHHS will notify the provider and the MI Choice waiver agency regarding the provider's compliance based on the completed survey tool submitted to MDHHS.
3. For non-compliant providers, the provider will have one to two weeks to correct all issues that cause non-compliance.
4. Once the issues are corrected, the provider will notify the waiver agency and schedule another on-site survey.
5. The waiver agency will have one to two weeks to complete another on-site survey and submit the survey to MDHHS for review.
6. 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.
7. If the provider still needs to resolve the compliance issues satisfactorily, the waiver agency will suspend the provider from receiving new MI Choice participants until the provider complies.
8. Some providers may require Heightened Scrutiny to determine compliance. These providers will follow the Heightened Scrutiny Process defined by MDHHS to assure compliance and to continue participation with the MI Choice program.

For more information, see "Home and Community-Based Service Program Transition" under MDHHS on the Michigan.gov website for details on this HCBS Transition Project and the requirements for compliance or to request compliance assistance from MDHHS.

Additional Conditions and Qualifications - Adherence to Standards

Each direct provider of Home-Based and Community-Based services will assure CWS for MDHHS, ACLS Bureau, or any other collaborating program that employees or volunteers who enter and/or work within participant homes or deliver services to participants within the community abide by the following additional conditions and qualifications. In addition, CWS will promptly inform service contractors and direct service workers of new service standards or any changes to current service standards.

Communication & Ability to Follow Directions

Direct service workers must demonstrate the ability to communicate adequately and appropriately, both orally and in writing, with their employers and the CWS participants they serve. This includes following product instructions properly in carrying out direct service responsibilities (i.e., reading grocery lists, identifying items on grocery lists, and adequately using cleaning and cooking products.

Signatures for Worker Task/Time Sheets

Service providers must have procedures for obtaining participant signatures on the time sheets (or similar documents) of direct care workers to verify that the direct service worker provided the work ordered by the waiver agency. Electronic Visit Verification systems will replace this requirement; when providers utilize electronic visit verification systems, paper time sheets are unnecessary.

Participant Assessments

CWS CM staff complete the state-approved assessment instrument for each participant according to established standards before initiating service. In addition, direct providers of home-based services should avoid duplicating assessments of individual participants to the maximum extent possible.

Home-Based and Community-Based service providers (AFC-HFAs) must accept assessments conducted by CWS and the Plan of Care for each participant and initiate services without completing a separate assessment.

Notification at Sign-On of Participant and Agency Rights and Responsibilities

Each direct provider of home and community-based services must notify each participant, in writing, at the initiation of service of their 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 service delivery agency (CWS), the Department of Health and Human Services Office of Civil Rights, or the Michigan Department of Civil Rights.

Also, upon enrollment, participants should sign a "Rights and Responsibilities" document from the provider that indicates both the understanding of their (the participant's) responsibilities to the agency/facility and the agency/facility's responsibilities for the delivery of services. This document should be kept in the participant's service file.

Provider's Right to Advocate for the Participant's Denial of Services

Providers retain the right, at a MI Choice Waiver, MI Health Link, or ACLS Bureau participant's request, to advocate and assist a participant with a request for review from MDHHS, CWS regarding a denial or cancellation of service. This may be done by requesting information from the Supports Coordination services.

Service Need Level- Priority Levels (for MDHHS and ACLS BUREAU Participants)

CWS CM classifies each participant into a service need level based on the participant's immediacy of the need to provide services and the availability of informal support. CWS is responsible for establishing the service need levels to ensure each participant's needs are met in an emergency. These Service Need Levels/Classifications are indicated on the Service Order for the participant and found in the Back- Up documents in Vendor View. These designations are made so the service provider can target services to the highest priority participants when utilizing their Emergency/Contingency plan.

NOTE: CWS CM staff will designate some "Level I" participants as "At-Risk," while other "Level I" participants are not noted as At-Risk. This is due to CWS CM determining that some at-risk/priority Level I participants have informal support living in the home with them. If this situation changes, it will be reflected on the Service Order and communicated to your agency by the CWS Supports Coordinator or Vendor View messages.

Direct service providers need to be aware of the service need levels/classification of each participant served by that provider (also found in the Back Up documents in Vendor View) to target services to the highest priority participants in emergencies and staffing situations.

1. Immediacy of need for the provision of services

- ***1*** **= Immediate** - the participant cannot be left alone
- ***2*** **= Urgent** - the participant can be left alone for a short time (less than 12 hours)
- ***3*** **= Routine** - the participant can be left alone for a day or two

2. Availability of informal Supports

- ***A*** = No informal supports are available for the participant
- ***B*** = Informal supports are available for the participant
- ***C*** = The participant resides in a supervised residential setting

Participant Records

Each direct provider of home and community-based services must maintain comprehensive and complete participant record/file that contains, at a minimum:

1. Details of the request to provide services (Vendor View).
2. A copy of CWS's evaluation of the participant's need (this may be appropriate portions of the CWS Initial and Reassessments - Vendor View).
3. Service Order authorizations or work orders.
4. Providers with multiple funding sources must specifically identify MI Choice Waiver program participants; records must list all service dates for each participant and the number of units provided during each visit.
5. Notes in response to participant, family, and agency contacts (not required for home delivered meal programs).
6. A record of release(s) of any personal information about the participant and a copy of a "Release of Information" form signed and dated by both the participant and the agency personnel.
7. Worker Time/Task Sheets must have the participant's and the worker's signatures on them with tasks performed, dates, and service times reflected on the sheet; after April 1, 2026, this information should be reflected on EVV entries
8. AFC-HFAs should include all LARA Licensing requirements for participant information and records.

<u>Directives to DPOS Services Descriptions and Minimum Operating Standards</u>

This document will be updated annually with bulletins and all provider policies to ensure that CMS, MDHHS, and the State Unit on Aging meet proper contract requirements. These will be sent to each provider annually at no cost to the provider, along with the Assurance document signed and renewed for your contract. (Copies will also be located on our website: www.carewellservices.org)

These standards apply to each provider interested in providing services to CWS participants and those providers renewing their annual Assurance documents; CWS staff must authorize the provision of each service to their participants as part of the Person-centered Plan of Care. The service descriptions are reviewed each fiscal year and may be changed based on new regulatory demands by CMS, MDHHS, ACLS Bureau, or other collaborating programs.