Home and Community Based Services Waiver
Frequently Asked Questions

ASSESSMENT

Question	MDHHS Response
The information from the statewide transition plan indicates that if the physical location of the setting is part of or attached to an institution, then the setting is automatically presumed not to be home and community-based. Is institution defined as a hospital, nursing home, ICF/IID or IMD?	*Yes, MDHHS would also add CCI's as institutional.*
In reference to the above question, IMD is defined to mean "a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services." Does this definition potentially include a licensed adult foster care facility of more than 16 beds which is providing services to persons with mental illness?	*MDHHS does not interpret AFC's as IMD's, please see following excerpt taken from* http://dhhs.ne.gov/Medicaid/Documents/4390.pdf *There are no expected changes to the current waiver restriction on bed size under the 1115 Waiver*
Can a state "grandfather" existing sites under the Home and Community- Based settings standard?	*No, a state cannot choose to continue to provide Home and Community-Based Services in non-compliant settings under a "grandfathering" approach*.

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Are there specific variables or dimensions of a residential setting beyond those in the flow chart that would trigger the Heightened Scrutiny (HS) provisions? There is conjecture and rumor that the location of a setting on the campus of an institution, number of residents, or other variables would preclude a setting from being HCBS compliant. Dispelling or confirming these conjectures/rumors would be very helpful to providers across the state in achieving HCBS compliance?	*The final rule identifies other settings that are presumed to have institutional qualities, and do not meet the threshold for Medicaid HCBS. These settings include those in a publicly or privately owned facility that provides inpatient treatment; on the grounds of, or immediately adjacent to, a public institution; or that have the effect of isolating individuals receiving Medicaid-funded HCBS from the broader community of individuals not receiving Medicaid-funded HCBS. (CMS Fact Sheet: Summary of Key Provisions of the Home and Community-Based Services (HCBS) Settings Final Rule 1/10/14).* *CMS public notice and comments on HCBS FINAL REGULATIONS 42 CFR Part 441: QUESTIONS AND ANSWERS REGARDING HOME AND COMMUNITY-BASED SETTINGS:*
Is there a minimum number of residential settings that must be offered to an individual?	*There is no minimum number of options, but an individual must be able to select among setting options that include non-disability-specific settings and an option for a private unit in a residential setting. The individual's person-centered plan should document options and different types of settings considered by the individual during the person-centered planning process*

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Do the Home and Community-Based (HCB) setting requirements address the number of individuals living in a residential HCB setting?	*No. While size may impact the ability or likelihood of a setting to meet the HCB settings requirements, the regulation does not specify size. Even a very small residential setting may have policies that restrict individual access to things such as food and telephone use that would not be consistent with HCB requirements, while facilities that serve a larger number of individuals may have structured their system in a manner that comports with the qualities required. The HCBS rule defines the minimum qualities for a HCB setting as experienced by the individual; states may set a higher threshold for HCB settings than required by the regulation, including the option to establish size restrictions and limitations.*
Are there other variables that would preclude a setting from being HCBS compliant:	*For additional information related to the HCBS final rule visit the CMS website.*
When will members be transitioned from providers who do not intend to comply with the HCBS Settings Rule?	*When MDHHS receives notification that a provider does not intend to comply with the HCBS Rule, the regions PIHP and the department will immediately begin working with you to develop a plan to transition individuals receiving services into another care setting. Providers are required to provide, at a minimum, 30 days' notice prior to transitioning the individual. More than 30 days may be needed and shall be determined on a case basis.*

If a provider offers two different services at the same location is it the expectation that the provider close one of the businesses or relocate?	*Providers are permitted to provide multiple HCBS services at the same location as long as the location meets the HCBS Rule criteria or provider comes into compliance with the Rule so that the setting meets the criteria. The setting (s) and services provided should not prohibit individuals from being able to access and participate in their broader community. In addition, individuals must have freedom of choice to participate in services from other options available at that setting and understand their rights to request a change if necessary.*
Can you provide more general guidance about how rural providers will be treated because their geography can already be unintentionally "isolating?"	*Individuals receiving HCBS in rural communities must have the same opportunity for community integration as do people without disabilities in that community*.
Do the regulations prohibit individuals from receiving pre-vocational services in a facility-based setting such as a sheltered workshop?	*The federal regulations require that all HCB settings must support full access of individuals receiving Medicaid HCBS to the greater community, including facilitating opportunities to seek employment in competitive settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS All settings must have the characteristics of HCB settings, not be institutional in nature and not have the effect of isolating individuals from the broader community. Please see the CMS Informational Bulletin on Employment Services found at: http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-09-162011.pdf.*

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IMPLEMENTATION

Question	MDHHS Response
If the non-residential services are delivered in a setting that is disability-specific, when compliance is achieved through contact / connection with individuals from the community / public, what is the extent of such contact/connection required to achieve compliance, and how can providers effectively demonstrate this?	*Michigan would look for any evidence of contact/connection each time a person is accessing their community.* *In order to submit a claim for a service under the HCBS waiver it must be a community based contact and meet the requirements as specified in the rule for being a community based contact. Any service that is billed as an HCBS service and does not meet the rule must have a modification clearly identified in the individuals IPOS and state why a modification is required. All modification requirements outlined by CMS and detailed in the evidence tables developed by MHDDS must be present in the individuals IPOS and approved by the individual or their legal representative.*
If compliance is achieved through interaction with others who do not have disabilities, to what extent, and how can providers effectively demonstrate this?	*Michigan would look for any evidence of interaction with others not receiving Medicaid HCBS services in all disability specific settings or services.* *HCBS compliance should be evident in progress notes indicating where the service was provided. If a service is not being provided in an HCBS compliant setting there must be a modification in the individuals IPOS that meets all requirements for modifications. It is not sufficient to say that this is the service chosen by the individual. Anything that is being identified as an HCBS service must meet the criteria. If the service does not met the criteria it can be provided but cannot be billed as an HCBS service.*

Guidance is needed relative to the evidence necessary to meet the following considerations cited in the Chart 4 flowchart: "The individual participates regularly in typical community life activities outside of setting to the extent the individual desires. Such activities do not include only those organized by the provider agency specifically for a group of individuals with disabilities and/or involving only paid staff; community activities should foster relationships with community members unaffiliated with the setting." "Services to the individual, and activities in which the individual participates, are engaged with the broader community."	*Michigan would look for evidence of planned and unplanned activities that the person has participated in which there was interaction with unaffiliated community members representative of their home community such as family/school friends/volunteers/ faith based members etc.* *Evidence that the individual is participating in community based activities should be present in the IPOS, progress or contact notes. Additional information can be found in the evidence table specific to the residential setting.*
Does the term "living unit" mean that the individual should have a key to the residence as well as his or her bedroom?	*Yes. It is expected that individuals would have keys to the residences in which they live. If there are circumstances that would prevent an individual from having a key to the residence, these should be discussed during the person-centered planning process and described and documented in the person-centered plan*.

REMEDIATION

Question	MDHHS Response
Is it possible that residential settings may have several CAPs because it is individual specific?	*CAPs will be should be a CAP for each participant specific so there may be multiple CAPs for any service provider.*
What about CAP (corrective action plans) from providers for multiple PIHP's? (Might they be relevant to more than one PIHP?)	*CAP's will be tied to an individual so the remediation should also be unique.*
When submitting evidence/supporting documentation is a sample size required (percentage of individuals supported)?	*Providers will work with their PIHP regional leads to bring their settings into compliance. Providers will be required to respond to each notification letter they receive.*
With regard to Continuum of Care, please clarify how to interpret "Continuum of Care'.	*Continuum of care in this context refers to a setting bringing services into the setting rather than facilitating opportunities for participants to receive their services and supports in the community similar to individuals who do not receive HCBS. Examples of services would include medical appointments, going to a hair stylist/ barber.*
With regard to people's ability to come and go as they please clarify.	*Individuals must be able to come and go as they please. The ability to safely do so may require support and in this case support must be provided. The ability to come and go as one wishes cannot be restricted based on the provider's needs.*

Is it possible that residential settings may have several CAPs because it is individual specific?	*CAPs will be participant specific so there may be multiple CAPs for any service provider.*
Question	**MDHHS Response**
What about CAP (corrective action plans) from providers for multiple PIHP's? (Might they be relevant to more than one PIHP?) If, after reviewing the information collected, MDHHS will apply to CMS for heightened scrutiny, the evidence required for compliance includes: "The setting is integrated in the community to the same extent that a person without disabilities in the same community would not associate the setting with the provision of services to persons with disabilities." Community rehabilitation organizations, offering employment settings in both facility-based and community-based settings, were established all over Michigan. Guidance is needed as to how such organizations can demonstrate evidence that the setting is not associated with the provider's mission.	*CAP's will be tied to an individual so the remediation will also be unique. If a provider is contracted with more than one PIHP they may have CAPs with more than one PIHP.* *Please see Chart 4 of the STP. Included in this document are evidence tables. These table show some of the documentation a provider may submit during a HS process. These tables are not necessarily inclusive of all documentation providers may wish to submit. It is the provider's responsibility to submit any evidence it believes will support its HCBS status.*

HEIGHTENED SCRUTINY

Question	MDHHS Response
What will be the process to apply for Heightened Scrutiny?	*Providers will be notified if they require a Heightened Scrutiny (HS) review.* *A MDHHS representative will reach out to the provider and the participant to determine 1). If the participant wishes to remain in the testing and 2). If the provider wishes to submit to the HS process.* *If the answers to both questions are yes then the MDHHS rep. will work with the provider to gather evidence needed to determine whether the state of Michigan believes that the setting is home and community based. Some of this evidence may be reviewed remotely. MDHHS may review policies and other documents electronically. A site visit will also occur.* *Once the evidence is gathered a review committee will review the evidence and make a recommendation to MDHHS related to whether the setting is home and community based. MDHHS will review all the available information, including the recommendations of the review committee and make the final determination.* *If MDHHS believes that the setting has proven that it is home and community based the provider information will be published for public comment allowing the public to provide any information they may have related to the setting and whether it is HCB. Should MDHHS believe that the setting can meet the standards outlined by CMS the evidence will be submitted to CMS who will make the final determination about the providers eligibility to provide HCB services*

HEIGHTENED SCRUTINY cont.

Question	MDHHS Response
What if I don't agree with the findings of MDHHS or CMS about my HCB status?	*Decisions made by MDHHS and/or CMS are final. These decisions are not open to appeal. Providers may work to change those factors that placed them in HS and request a re-survey to determine if they are able to meet the HCBS requirements.*