Michigan Department of Health and Human Services (MDHHS)

Behavioral Health Home and Community-Based Services (HCBS) Frequently Asked Questions

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Assessment Process

Question	MDHHS Response
Does the Home and Community Based Services (HCBS) Final Rule apply to crisis residential settings?	No, crisis residential settings are not among the settings/services impacted by the rule.
What happens if providers do not complete the HCBS surveys they receive?	Providers must complete the surveys and meet HCBS requirements to receive HCBS Medicaid funding. **Those providers who choose not to complete the surveys will no longer be authorized to receive Medicaid funding for HCB services**. Medicaid beneficiaries will be transitioned from those services/settings to compliant settings if they wish to continue receiving Medicaid-funded HCBS services.
What is the purpose of the provisional approval process?	The provisional approval process was developed by MDHHS Behavioral Health to ensure that new providers or providers who begin to provide new services compliant with the HCBS Final Rule. Because these providers would not yet have Medicaid beneficiaries to survey in the setting/service, MDHHS requires the Prepaid Inpatient Health Plan (PIHP) to conduct this screening to identify providers that would likely not be HCB and require heightened scrutiny. Only those providers who receive provisional approval or who have been found compliant with the rule through the assessment process will be able to provide Medicaid-funded services to HCBS Medicaid beneficiaries. It is our intention to reduce the possibility that an individual will move into a setting and later need to transition out of the setting based on its heightened scrutiny status or be faced with a decision to stay and thus lose the ability to receive Medicaid funding.

Question	MDHHS Response
What should providers expect from the provisional approval process?	Providers will be asked a set of questions designed to ensure the setting/service is not isolating or institutional in nature. The PIHP leads, as representatives for MDHHS, will review the setting and attest to the department that they have reviewed the setting, and it does not appear to be isolating or institutional. If a setting does appear to be institutional or isolating, the PIHP leads will deny provisional approval. The setting may then make the required changes and reapply for provisional approval. Until and unless a setting is granted provisional approval, they may not receive Medicaid HCBS funding. PIHP leads may also request a provisional consultation with MDHHS. This consultation will provide an avenue for the PIHP to identify any extenuating circumstance or additional information related to the setting. MDHHS has the sole authority to approve or deny approval for the setting to receive Medicaid funding for services. Providers and Medicaid beneficiaries will receive a comprehensive assessment once the setting is actively providing services and any required corrective action or HS reviews will occur.
Is there Personal Protected Health Information on the HCBS survey?	There is no identifying information on the survey. This includes the individual's name, date of birth, Medicaid recipient identification number or any other identifying information. Individuals are de-identified using a randomly selected identification number. There are no health-related questions on the survey and no diagnosis information is present or requested.
How do we know if we our home received the HCBS survey?	If you are unsure if you received an assessment check with the Community Mental Health Services Programs (CMHSP) or PIHP lead you work with.

Compliance Remediation

Question	MDHHS Response
Can a state "grandfather" existing sites under the Home and Community-Based settings standard?	No. States cannot continue to provide Home and Community-Based Services in non-compliant settings under a "grandfathering" approach.
Is it possible that residential settings could have several Corrective Action Plans (CAPs) because they are individual specific?	Yes. Since CAPs are tied to Medicaid beneficiaries, more than one CAP may need to be completed if a provider serves more than one Medicaid waiver beneficiary. Also, if a provider is contracted with multiple PIHPs, they may have CAPs with more than one PIHP.
What about CAPs (corrective action plans) from providers who work with multiple PIHPs? (Might they be relevant to more than one PIHP?)	CAPs are tied to Medicaid beneficiaries, so the remediation should be unique for each CAP.
Is there a minimum number of residential settings that must be offered to an individual during the person-centered planning process?	There is no minimum number, but an individual must be able to select among options that include non-disability-specific settings and an option for a private unit in a residential setting. The individual's person-centered plan must document the options and different types of settings considered by the individual during the person-centered planning process. And it provide evidence that the person chose the setting in which they receive services.
Can you provide more general guidance about how rural providers will be treated because their geography can 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.
Please clarify what is meant by the individual's "ability to come and go."	Individuals must be able to come and go as they please from the setting in which they live or receive services/supports. The ability to safely do so may require support, and that support must be provided. The ability to come and go as one wishes cannot be restricted based on the provider's needs or convenience or as a requirement to live or receive services in the setting.

Compliance Remediation

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Does every provider receive a survey? Or are they randomly picked?	Every setting will be assessed for compliance for every Medicaid beneficiary to whom they provide services/supports.
Please provide a definition for "Continuum of Care."	Our definition of a continuum of care is that individuals do not go out into the community, or have the support of the provider, to go out into the community to access services such as doctor appointments, attending church, getting a haircut, etc. Instead, these services and supports are brought into the setting and HCBS Medicaid beneficiaries are expected to utilize these services rather than going out to the community.
Do the HCBS 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 setting 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 requirements. The HCBS Final Rule defines the minimum qualities for an 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.
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 are required to respond to each notification letter they receive.

Compliance Remediation

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A provider-owned and controlled setting in our region has three residents who all have corrective action plans (CAPs). The setting can come into compliance with two of the residents' CAPs, but the provider feels that they cannot come into compliance for the third CAP due to the individual's behaviors. If the PIHP shows the CAP for that individual is not in compliance, is the entire setting considered out of compliance such that all residents would need to transition out of the setting, and no new admissions can occur? Or is the setting out of compliance until that individual can be placed in another setting?	If a home has multiple HCBS Medicaid beneficiaries, compliance is considered separately for each of them. If one individual's care cannot not be provided in a manner consistent with the HCBS Rule, then that individual will require transition planning unless they wish to stay in the setting (though Medicaid funding will likely be affected). This presumes that the provider is not exhibiting behaviors toward the individual that call into question the safety of any person who lives there. Transition planning should begin as soon as is possible. Any new HCB Medicaid beneficiaries who move in the setting will need to be assessed according to our standard assessment process going forward.
How would a provider address the issue of accessibility to funds for a Medicaid beneficiary if the Medicaid beneficiary's guardian does not want them to have access? The individual asks for funds to attend various community activities?	If an individual's guardian does not want to allow the Medicaid beneficiary access to their funds, this information should be shared with the Medicaid beneficiaries supports coordinator. This restriction on the individual's rights must be justified in the individual's Individual Plan of Service (IPOS) following the modification requirements outlined by CMS. The supports coordinator can work with the guardian to identify concerns and work toward a plan that allows freedom for the individual while providing supports as appropriate while the individual increases their skill level and ability to manage their funds safely. Providers should not be in the position of having to address this issue with the guardian without the support of the support's coordinator. Additional information related to the authority of guardians and the HCBS rule can be found on the MDHHS HCBS webpage "MDHHS BHDDA HCBS Guardianship FAQs."

Compliance Remediation

Question	MDHHS Response
I have an Adult Foster Care Home that has one bathroom with a pocket door, so the door slides between the wall to open. Is there any exception to the door lock rule for these types of doors? I do not think the hardware even exists for it be both locking and non-locking against egress.	HCBS-compliant hardware is available for pocket doors and is required.
Please provide information regarding how to support Medicaid beneficiaries who have NGRI (Not Guilty by Reason of Insanity) status and are in the community.	The PIHP lead will focus only on those services that are governed by the Home and Community Based waiver (Community Living Supports and Skill Building). If there are restrictions on those services that have been put into place by the court system based upon safety of the individual or the community, these issues should be clearly outlined in the individual's IPOS. The IPOS should specify what the court order requires. The individuals IPOS must follow the modification requirements identified by Centers for Medicare and Medicaid Services (CMS) regardless of court order. For further detail regarding modifications or restrictions on individuals' freedoms, please see the Michigan Medicaid Provider Manual HCBS chapter https://www.michigan.gov/documents/mdhhs/MSA_17-42_606958_7_003_618616_7.pdf
If compliance is achieved through interaction with others who do not have disabilities, to what extent and how can providers effectively demonstrate this?	MDHHS would look for 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. Providers may also provide activity logs as evidence of community integration and when doing so should take care to identify where the activity occurred in addition to what the activity was.

Compliance Remediation

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If a person has an IPOS that says they need to go on an outing weekly, but the person refuses because they are not feeling well, etc., how do we chart that and comply?	Providers should document when a Medicaid beneficiary was offered an activity and whether they chose to participate in the activity or declined. This will allow settings, those who contract with them, and MDHHS to see the frequency with which an opportunity to engage in community activities was offered.
Can an individual go into another individual's room without permission since they are able to access any place in the home?	Medicaid beneficiaries must have full access to all the common spaces within their home. Areas that are not considered common area include other individuals' bedrooms, office spaces and medication storage or distribution rooms.
If an individual does not have the mental capability to know the difference between what a dangerous situation is and is not, are we supposed to let them go with a stranger that may cause harm?	Individuals must be assumed to have the same rights and freedoms as the rest of us enjoy. When there are legitimate health and/or safety concerns that dictate a person needs additional support to engage with the community, this must be addressed through the person-centered planning process, included in the IPOS **following the modification requirements identified by the Centers for Medicare and Medicaid Services (CMS) and outlined elsewhere in this document**.
Can you have alarms on the windows if you have someone with elopement behavior, if it is in their plan?	If there is a modification in the individual's IPOS that meets the requirements of CMS and MDHHS (identified in this document and in the Medicaid Provider Manual), then this type of a modification can be used. However, this restriction *cannot* impact anyone else in setting who does not have the need in their IPOS for such a modification.
If you have someone who needs a door alarm and the others don't, what do you do?	Any persons living in the home who do not require an alarm must have the means to come and go freely. This might be accomplished by knowing the code on an alarm. Your PIHP lead can work with you to develop a compliant process specific to your setting /needs.

Question	MDHHS Response
Please provide clarification regarding the requirement that individuals have access to food at any time.	CMS specifies that individuals must have access to food/beverages at any time. This does not mean that the setting must provide a full meal outside of their regular schedule. If there are restrictions related to the type of food available based for a Medicaid beneficiary based upon a documented health or safety need, it must be discussed in a person-centered planning meeting and reflected the beneficiary's IPOS in a manner consistent with the modification requirements identified by CMS and MDHHS.
How should a provider ensure that HCBS Medicaid beneficiaries have access to laundry facilities when they wish? Sometimes washers and dryers may be in a basement where residents are not allowed to enter.	Medicaid beneficiaries should have the freedom to access laundry machines as desired. There may be a need to support the individual in completing laundry tasks and in this instance, it is reasonable to determine a time together when the individual will be assisted in completing the task. If the laundry facilities are in an area that is restricted due to licensing or there are concerns about safely navigating stairs, then this should be viewed as a restriction and a plan that outlines how the individual will be supported in doing their own laundry (if that is their wish) should be outlined. This may include providing regular and reasonable transportation to a community-based laundry facility or other appropriate plan based upon the individual's needs and desires. Individuals must have access to laundry facilities to clean clothes, and care must be taken to ensure that the ability to access or pay for public laundry access is not prohibitive.
What should be done if the guardian wants a Medicaid beneficiary to receive services from a specific provider, but the Medicaid beneficiary expresses their desire to receive services from a different provider?	HCBS Medicaid beneficiaries have the same right to choose where and from whom to receive their services as do non-HCBS Medicaid beneficiaries. Any restriction on these rights must follow the modification process as outlined in the final rule and the Michigan Medicaid Provider Manual HCBS chapter. Additional information regarding the rights of HCBS Medicaid beneficiaries can be found in the MDHHS BHDDA HCBS Guardianship FAQs on the HCBS

	webpage: Information for Participants, Family Members, or Guardians (michigan.gov)

Compliance Remediation

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If a Medicaid beneficiary is unable to make their wishes known regarding whether they should receive services from a specific provider, is it acceptable to ask the Medicaid beneficiary's guardian?	During the person-centered planning process all efforts should be made to gain input from the individual. If individual cannot make their wishes known, the person is assumed to have all the rights and freedoms enjoyed by non-HCBS Medicaid beneficiaries. Any restrictions upon those rights must be outlined in the person-centered planning meeting and follow the required steps for modification as outlined in the final rule and the Michigan Medicaid Provider Manual HCBS chapter. The person to the extent of their ability must agree to the restrictions/modifications and when unable to do so, the guardian may substitute. Additional information regarding the rights of HCBS Medicaid beneficiaries can be found in the MDHHS BHDDA HCBS Guardianship FAQs on the HCBS webpage: Information for Participants, Family Members, or Guardians (michigan.gov)
Please clarify the use of leases and whether agreements can be made on a lease that limits an individual's access to things such as alcohol, cigarettes, or other freedoms.	Any agreements between providers and Medicaid beneficiaries must be consistent with an individual's legal rights. These rights can only be restricted when based upon a documented health and/or safety need that is outlined in the individual's Individualized Plan of Service following the guidelines required by CMS and the state of Michigan. It is common for public and some private spaces to identify smoking areas out of doors. This is permissible if the accommodation is easily accessed by those who wish to smoke; a setting may not put impediments such as distance or crossing major roads in place that impact the individual's ease of access.

Compliance Remediation

Question	MDHHS Response
How do these changes impact clients currently in settings that have locked fences or locked rooms if this is not already addressed in a behavior treatment plan.	Settings must be fully compliant with the rule to access Medicaid funding. MDHHS will continue to assess and monitor settings for compliance with the rule. There are no exceptions for settings that already have non complaint structures, policies, or procedures in place. All settings must be 100% compliant with the rule to access Medicaid funding. If you receive services in or operate a setting that is not compliant with the rule, you should reach out to the CMHSP or PIHP with which you work to make the required changes to come into compliance. Stakeholders or concerned others who feel a setting is not compliant can reach out the CMHSP or the HCBS transition team at HCBSTransition@michigan.gov
I have a question about the requirement to have 12 or less individuals residing in a licensed AFC to receive f Habilitation Supports Waiver funding. I have been told that large facilities are not able to have wavier residents in them. I just want to get clarification on this rule.	The federal requirement for the Michigan Habilitation Supports Waiver (HSW) is that licensed AFC bed size cannot be larger than 12. If you would like to learn more, please see the full Habilitation Supports Waiver application at this link: https://www.michigan.gov/documents/mdhhs/Habilitation_Supports_Waiver_Amendment_extended_634215_7.pdf Medicaid beneficiaries who receive services and supports through the 1915i waiver are eligible at present to reside in settings larger than 12 beds.

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. An MDHHS representative 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.
What happens if a provider doesn't agree with the findings of MDHHS/CMS about their HCB status?	Decisions made by MDHHS and/or CMS are final. These decisions are not open to appeal. Providers may work to change the factors that placed them in HS and request a reassessment to determine if they are able to meet the HCBS Final Rule requirements at a future date.
As part of the transition from a non-compliant setting to a compliant setting, does MDHHS have to include appeal rights in a letter that is sent a beneficiary who chooses to reside in a non-compliant setting?	MDHHS' contractors are expected to provide appeal rights when a beneficiary's choice to remain with a particular provider will impact their Medicaid HCBS eligibility. Please note that the state is only expected to offer the beneficiary access to other qualified providers in the state's delivery system and is not expected to provide access to those providers that the state has determined do not qualify. In other words, the beneficiary cannot appeal simply because the provider of his or her choice has been removed from the state's waiver program because they no longer meet the state's provider qualifications criteria.