

## MDHHS Home and Community-Based Services Waiver Frequently Asked Questions

Question	MDHHS Response
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, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), or Institution for Mental Disease (IMD)?	Yes. MDHHS also considers Child Caring Institutions (CCIs) to be institutional settings.
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 (AFC) of more than 16 beds which is providing services to persons with mental illness?	MDHHS does not consider AFCs to be (IMDs). There are no expected changes to the approved 1115/1915(i) State Plan or Habilitation Supports waivers on bed size
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.
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 participants are expected to utilize these services rather than going out to the community.

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<p>Do the Home and Community-Based (HCB) setting requirements address the number of individuals living in a residential HCB setting?</p>	<p>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.</p>
<p>Is there a minimum number of residential settings that must be offered to an individual during the person-centered planning process?</p>	<p>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 should document the options and different types of settings considered by the individual during the person-centered planning process.</p>
<p>When will members be transitioned from providers who do not intend to comply with the HCBS Final Rule?</p>	<p>When MDHHS receives notification that a provider does not intend to comply with the Rule, the region's PIHP will be notified. The PIHP will notify the CMHSP and supports coordinator working with the individual. Person Centered planning will begin with the individual, and his or her supports to develop a transition plan. The purpose of these planning sessions will be to identify the goals and wishes of the individual and identify settings and providers that are consistent with these goals and wishes. The PIHP will have a minimum of six months to develop and implement the transition plan with the individual. All individuals who wish to receive HCBS funding for their services must be receiving services from HCBS compliant providers no later than March 17, 2023 and as outlined by the PIHP.</p>

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If a provider offers two different services at the same location, is the provider expected to 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 Final Rule criteria or the provider comes into compliance with the Rule. The setting(s) and services 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 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: <a href="http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-09-162011.pdf">http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-09-162011.pdf</a> .
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.

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<p>The HCBS Medicaid chapter says the setting needs to be “accessible” but it does not address access to kitchen/laundry areas. What are the requirements regarding access to the kitchen or laundry areas of the home? Can these rooms be locked?</p>	<p>This language from the Medicaid Provider Manual addresses the requirement that settings must be fully accessible to the individuals who live there. This includes the following prohibition against locked doors:</p> <p><b>Medicaid Provider Manual- Home and Community Based Services Section 3.1.A.8. Accessibility</b></p> <ul style="list-style-type: none"> <li>- “Each setting must be physically accessible to the individuals residing there so the individuals may function as independently as they wish. Individuals must be able to move around in the setting without physical barriers getting in their way.”</li> </ul>
<p>What are the specific requirements related to the types of doorknobs and locks on bedroom and bathroom doors?</p>	<p>All bedroom doors must have keyed locks. Only appropriate staff may have a key. This means that not all staff members may have keys and the keys must not be kept in a location that is easily accessible to other residents. Bathroom doors must also be lockable. A keyed lock is not required for bathrooms (pop locks are acceptable).</p> <p>It is not sufficient for an individual to state they do not wish to have locks on their doors. Residents do not have to use locks if they choose not to.</p> <p>A lockable door is a side-hinged, permanently mounted door that is equipped with positive-latching, non-locking-against-egress hardware. The hardware must be able to be opened from the inside of a room with a single motion; such as a turn of a knob or push of a handle, even if the door is locked.</p> <p>Round knobs are permissible if the individuals living in the home are able to open doors with round knobs independently. If there are individuals who are unable to doors with round knobs, the provider must install lever type handles on the bedroom and bathrooms that the individual will need to access.</p>

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<p>A kitchen set up at an AFC appears to be open and blends in like a typical home setting; however, the AFC deals specifically with dementia/Alzheimer clients so the kitchen is sectioned off from the clients preventing them from getting into it; thus keeping them from danger. It was discussed that as long as there was a logical reason stated in the care plan as to why the client required that kind of environment, it should be ok with HCBS. How does that would play into further contract agreements with Tri-County Area on Aging (TCOA) given that some of their AFCs/HFAs would have to do major renovations to become compliant with the new standards. Would they be grandfathered in as an exception? Would AFCs/HFAs that predated the standards have a grandfather clause as long as there was rational and logical reason stated in the care plan?</p>	<p>Individuals, including individuals with dementia, should have access to common parts of the house such as kitchens, bathrooms, living rooms, and laundry rooms. A setting cannot restrict access to all individuals because all individuals will not have the same needs. Any modification to the rule must be done on a case by case basis and should never apply to all. Any modification must be documented in the person-centered service plan. Any modifications must be consistent with the process outlined in the final rule and the Medicaid Provider Manual HCBS chapter.</p>
<p>I would like to request some clarification on chimes or non-restrictive alarms on doors, which alert people that someone is coming or going from the home but do not restrict access. Can you clarify whether chimes are HCBS compliant?</p>	<p>Chimes / alarms do not restrict an individual's ability to come or go, nor do they necessarily impact only specific individuals in the setting and therefore are compliant with the rule. Individuals who live or receive services in a setting where there is an alarm or chime have the right to voice concerns with the existence of the alarm/chime and to request alternative methods for monitoring doors. Additionally if setting providers are not willing to remove the chimes/alarms individuals must be supported in any desire to move to a new setting.</p>

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<p>My question is in regard to cameras. I cannot find a concrete answer to whether cameras in common areas that do not record are ok. Can someone please clarify this for me?</p>	<p>Cameras are allowed in common areas of the home only. Cameras may NOT record images or sound. Cameras are not allowed in bedrooms or bathrooms.</p> <p>There must be a legitimate reason for the cameras to be in place and the required health and/or safety modification process must be documented in the IPOS of the individuals who requires the additional support. Cameras may not be in place for ease of monitoring by AFC staff. Other individuals who are impacted by the cameras in the setting must give consent to have the cameras running while they are present, this consent must be documented in each person’s record. Settings will place advisory’s in areas where there are cameras to notify individuals of their presence.</p>
<p>Many places around the country are developing intentional (clustered) communities for individuals with intellectual/developmental disabilities (I/DD). Does MDHHS have any guidance on how these communities are being implemented and whether they can be in compliance with the HCBS Final Rule?</p>	<p>In updated guidance CMS released in March 2019 (<a href="https://www.medicaid.gov/federal-policy-guidance/downloads/smd19001.pdf">https://www.medicaid.gov/federal-policy-guidance/downloads/smd19001.pdf</a> ) CMS states;</p> <p>CMS intends to take the following factors into account in determining whether a setting may have the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving HCBS:</p> <ul style="list-style-type: none"> <li>• Due to the design or model of service provision in the setting, individuals have limited, if any, opportunities* for interaction in and with the broader community, including with individuals not receiving Medicaid-funded HCBS;</li> <li>• The setting restricts beneficiary choice to receive services or to engage in activities outside of the setting; or</li> <li>• The setting is physically located separate and apart from the broader community and does not facilitate beneficiary opportunity to access the broader community and participate in community services, consistent with a beneficiary’s person-centered service plan.</li> </ul>

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*The above response replaces in totality prior guidance<sup>3</sup> published on the criteria of an isolating setting under 42 CFR 441.301(c)(5)(v); 441.530(a)(2)(v); and 441.710(a)(2)(v). The criteria of an isolating setting have been revised and examples of settings that may have isolating effects have been removed.*

CMS rescinded language that had previously identified the following:

**CMS defines common characteristics of intentional/gated or secure communities:**

- Gated communities typically consist primarily of people with disabilities and the staff that work with them.
- Often, these locations will provide residential, behavioral health, day services, social and recreational activities, and long-term services and supports all within the gated community.

“Intentional communities, farmsteads and other large congregate residential settings that have the effects of isolation are presumed not to be home and community based and must go through Heightened Scrutiny if a state feels the setting is home and community based and does not have institutional characteristics”.

Group Settings:

- Any setting for which individuals are being grouped or clustered for the purpose of receiving HCBS must be assessed by the state for compliance with the HCBS rule.
- <https://arcmi.org/content/uploads/sites/15/2016/07/ARC-of-Michigan-Serena-Lowe.pptx>

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What happens if providers do not complete the HCBS surveys they receive?	Providers must complete the surveys and meet HCBS requirements in order to receive HCBS Medicaid funding. Those providers who choose not to complete the surveys will no longer be authorized to provide HCB services. Participants will be transitioned from those services/settings to compliant settings if they wish to continue receiving HCBS services.
If a participant is unable to make their wishes known regarding whether they should receive services from a specific provider, is it acceptable to ask the participant’s guardian?	During the person-centered planning process all efforts should be made to gain input from the individual. In the event that individual cannot make their wishes known the person is assumed to have all the rights and freedoms enjoyed by non HCBS participants. 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 participants can be found in the MDHHS BHDDA HCBS Guardianship FAQs on the HCBS webpage: <a href="https://www.michigan.gov/mdhhs/0,5885,7-339-71547_2943-334724--,00.html">https://www.michigan.gov/mdhhs/0,5885,7-339-71547_2943-334724--,00.html</a>
What should be done if the guardian wants a participant to receive services from a specific provider, but the participant expresses their desire to receive services from a different provider?	HCBS participants have the same right to choose where and from whom to receive their services as do non HCBS participants. 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 participants can be found in the MDHHS BHDDA HCBS Guardianship FAQs on the HCBS webpage: <a href="https://www.michigan.gov/mdhhs/0,5885,7-339-71547_2943-334724--,00.html">https://www.michigan.gov/mdhhs/0,5885,7-339-71547_2943-334724--,00.html</a>



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Can settings have locked dementia units?	<p>Individuals, including individuals with dementia, should have access to common parts of the house such as kitchens, bathrooms, living rooms, and laundry rooms. A setting cannot restrict access to all individuals because all individuals will not have the same needs. Any modification to the rule must be done on a case by case basis and should never apply to all. Any modification must be documented in the person-centered service plan.</p> <p>Note: States and settings are able to allow for modifications to the settings criteria in the rule that may pertain to these types of settings. However, when modifications to the settings criteria in the rule are implemented in a setting, it is the state’s responsibility to ensure the requirements around these modifications (42 CFR 441.301(c)(4)(F)) are met.</p>
Are there other requirements that would preclude a setting from being HCBS compliant?	<p>For additional information related to the HCBS Final Rule, visit the CMS website <a href="https://www.medicaid.gov/medicaid/hcbs/guidance/hcbs-final-regulation/index.html">https://www.medicaid.gov/medicaid/hcbs/guidance/hcbs-final-regulation/index.html</a></p>
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.	<p>Any agreements between providers and participants 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 individuals Individualized Plan of Service following the guidelines required by CMS and the state of Michigan.</p>
I have a question about the requirement to have 12 or less in order to receive HAB wavier monies. 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.	<p>The federal requirement for the Michigan Habilitation Supports Waiver is that bed size cannot be larger than 12.</p> <p>If you would like to learn more, please see the full HSW Application at this link: <a href="https://www.michigan.gov/documents/mdhhs/Habilitation_Supports_Waiver_Amendment_extended_634215_7.pdf">https://www.michigan.gov/documents/mdhhs/Habilitation_Supports_Waiver_Amendment_extended_634215_7.pdf</a></p>

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<p>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?</p>	<p>The state would look for any evidence of contact/connection happening each time an individual accesses their community.</p> <p>In order to submit a claim for a service under the HCBS waiver it must be a community-based contact and must meet the requirements specified in the HCBS Rule for being a community-based contact. Any service that is billed as an HCBS service and does not meet the rule must have any modification clearly identified in the participant’s Individual Plan of Service (IPOS) and clearly indicate why the 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.</p>
<p>If compliance is achieved through interaction with others who do not have disabilities, to what extent, and how can providers effectively demonstrate this?</p>	<p>Michigan would look for any evidence of interaction with others not receiving Medicaid HCBS services in all disability specific settings or services.</p> <p>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 meet the criteria it can be provided but cannot be billed as an HCBS service.</p>

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What is the purpose of the provisional approval process?	<p>The provisional approval process was developed by MDHHS BHDDA as a means to allow PIHPs to contract with new providers after the “close the front door” date effective 10/1/2017. This is the means to ensure that new providers or providers who begin to provide new services after 10/1/2017 are compliant with the HCBS Final Rule. Because these providers would not yet have participants to survey in the setting/service, MDHHS is screening to identify providers that would likely not be HCB and require Heightened Scrutiny. Only those providers who receive provisional approval will be able to provide services to HCBS participants. 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.</p>
What should providers expect from the provisional approval process?	<p>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.</p> <p>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.</p> <p>Providers and participants will receive a comprehensive survey once the setting is actively providing services and any required corrective action or HS reviews will occur.</p>

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<p>Please provide clarification regarding the requirement that individuals have access to food at any time.</p>	<p>CMS specifies that individuals must have access to food at any time. If there are restrictions related to the type of food available based upon a documented health or safety need it must be identified and discussed in a person-centered planning meeting. If there will be limits to the type or amount of food that is accessible the individual will need to agree to those limits as part of the PCP. The state of Michigan has identified that modifications to an individual's rights will only be acceptable if they are based upon documented health or safety needs.</p>
<p>Guidance is needed relative to the evidence necessary to meet the following considerations cited in the Chart 4 flowchart:</p> <p>“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.”</p> <p>“Services to the individual, and activities in which the individual participates, are engaged with the broader community.”</p>	<p>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.</p> <p>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.</p>

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How should a provider ensure that HCBS participants have access to laundry facilities when they wish? Sometimes washers and dryers may be in a basement where residents are not allowed to enter.	Participants 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.
Please provide information regarding how to support participants 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, Supported Employment, 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 individuals IPOS. The IPOS should specify what the court order requires. The individuals IPOS must follow the modification requirements identified by CMS regardless of court order. For further detail regarding modifications or restrictions on individuals freedoms please see the Michigan Medicaid Provider Manual HCBS chapter <a href="https://www.michigan.gov/documents/mdhhs/MSA_17-42_606958_7_003_618616_7.pdf">https://www.michigan.gov/documents/mdhhs/MSA_17-42_606958_7_003_618616_7.pdf</a>
How would a provider address the issue of accessibility to funds for a participant if the participants 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 participant access to their funds this information should be shared with the participants supports coordinator. This restriction on the individuals rights must be justified in the individuals 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.

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Is it possible that residential settings could have several CAPs because they are individual specific?	Yes. Since CAPs are tied to participants a provider may need to complete more than one. 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 participants, so the remediation should be unique for each CAP.
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.
I have an AFC 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 don't think the hardware even exists for it be both locking and non-locking against egress.	HCBS compliant hardware is available for pocket doors.

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<p>The Medicaid Provider Manual HCBS chapter indicates that the state must be in full compliance with the HCBS Final Rule by March 17, 2022. Why are providers being asked to complete corrective action plans (CAPs) now?</p>	<p>The state intends to keep the original 3/17/2019 due date.</p> <ul style="list-style-type: none"> <li>- There were delays with the b (3) services surveys due to the need to obtain CMS clarification on whether these services fall under the rule.</li> <li>- We continue to consider 3/17/2019 as the compliance due date, but we recognize that heightened scrutiny will likely continue to be dealt with beyond that date.</li> <li>- CAPs should be underway for both waivers in advance of the 3/17/2019 timeline. The CAPs can remain works in progress beyond the 90-day corrective action plan remediation timeframe. As PIHPs accept CAPs, it is known that some issues will take longer to resolve and will exceed the 90 days.</li> <li>- Providers should have the time they need to accomplish compliance and to complete necessary fixes in a planned fashion with regular updates to the PIHP.</li> </ul>
<p>A provider-owned and controlled setting in our region has three residents who all have corrective action plans (CAPs). The setting is able to 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?</p>	<p>If a home has multiple HCBS participants, 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 participants who move in the setting will need to be assessed according to our standard assessment process going forward.</p>

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### HEIGHTENED SCRUTINY

Question	MDHHS Response
<p>What will be the process to apply for Heightened Scrutiny?</p>	<p>Providers will be notified if they require a Heightened Scrutiny (HS) review.</p> <p>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.</p> <p>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 determine whether there is enough evidence of possible compliance to publish for public comment.</p> <p>If MDHHS believes that the setting has proven that it is home and community based, the provider’s information will be published for public comment. If, after the public comment period, MDHHS believes that the setting can meet the standards outlined by CMS in the HCBS Final Rule, the evidence will be submitted to CMS who will make the final determination about the provider’s eligibility to provide HCB services.</p> <p>If MDHHS does not believe the setting meets the standard of compliance the setting will not be included in settings identified for public comment. MDHHS will notify the PIHP and transition planning for HCBS participant(s) will begin.</p>



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<p>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 that the location of a setting on the campus of an institution, specific numbers of residents, or other variables would preclude a setting from being HCBS compliant.</p>	<p>The HCBS Final Rule identifies settings that are presumed to have institutional qualities and do not meet the criteria to be considered HCB. 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.</p> <p>Refer to the following:  <a href="https://www.medicaid.gov/federal-policy-guidance/downloads/smd19001.pdf">https://www.medicaid.gov/federal-policy-guidance/downloads/smd19001.pdf</a></p> <p><a href="#"><u>HCBS FINAL REGULATIONS 42 CFR Part 441: QUESTIONS AND ANSWERS REGARDING HOME AND COMMUNITY-BASED SETTINGS</u></a></p>
<p>What happens if a provider doesn't agree with the findings of MDHHS/CMS about their HCB status?</p>	<p>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 re-survey to determine if they are able to meet the HCBS Final Rule requirements at a future date.</p>
<p>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?</p>	<p>MDHHS is 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.</p>

## MDHHS Home and Community-Based Services Waiver Frequently Asked Questions

Question	MDHHS Response
<p>Can you please provide clarification to a question that we received? –on page 22 of the Final Rule (or page 2968 in the left corner), CMS says,“ We appreciate the comments provided about the challenges of the term rebuttable presumption. The proposed language provided a list of settings that, from our experience in approving and monitoring HCB programs, typically exhibit qualities of an institutional setting. However, we recognize that state innovations, creative and proactive efforts to promote community integration, and market changes could result in the settings being located in a building that also provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to a public institution, that in some instances could be considered home and community-based. In response to public comments, we have revised the regulatory language to say “Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not</p>	<p>This question seems to be about settings that are presumed not to be home and community-based and could potentially require Heightened Scrutiny review under the final settings rule. The highlighted language in the document you attached pertains to the first two prongs of Heightened Scrutiny in the Final Rule (see page 3031), which states the following settings should be presumed not to be HCBS: 1) settings located in the same building as a publicly or privately-owned facility providing inpatient treatment and 2) settings that are on the grounds of, or adjacent to, a public institution. Ralph was likely pointing out that the second prong only pertains to settings on the grounds of, or adjacent to, a public institution, whereas the first prong indicates that any setting in the same building as a public or private inpatient treatment providing HCBS should be considered presumptively institutional and be submitted for Heightened Scrutiny if the state believes the setting overcomes that institutional presumption. For example, if a day habilitation facility is on the grounds of a private nursing home, that facility will not necessarily automatically fall under Heightened Scrutiny based on the second prong. However, if the day habilitation facility is on the grounds of a public nursing facility, then it would fall under Heightened Scrutiny based on the second prong.</p>

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receiving Medicaid HCBS will be presumed to be institutional and not HCB.	
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**OTHER**

Question	MDHHS Response
Does the HCBS Final Rule apply to crisis residential settings?	No, crisis residential settings are not among the settings/services impacted by the Rule.
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 through the use of a randomly selected identification number. There are no health-related questions on the survey and no diagnosis information is present or requested.