MDHHS Michigan Department of Health & Human Services

Medical Services Administration

BULLETIN MSA

Bulletin Number: MSA 17-42

Distribution: Integrated Care Organizations, MI Choice Waiver Agencies, Prepaid Inpatient Health Plans

Issued: November 27, 2017

Subject: New Medicaid Provider Manual Chapter for Home and Community Based Services (HCBS)

Effective: January 1, 2018

Programs Affected: MI Health Link HCBS Waiver, MI Choice Waiver, Habilitation Supports Waiver, Managed Specialty Services & Supports Waiver

The purpose of this bulletin is to require HCBS providers to comply with federal requirements for Medicaid beneficiaries who receive HCBS.

On January 16, 2014, the Centers for Medicare & Medicaid Services (CMS) issued the HCBS Final Rule (CMS 2249-F/2296-F). The HCBS Final Rule specifies requirements for programs that offer HCBS to Medicaid beneficiaries. CMS requires all state Medicaid agencies to comply with the HCBS Final Rule. The Michigan Department of Health and Human Services (MDHHS) is responsible for ensuring that all providers meet federal requirements. The HCBS Final Rule will maximize the opportunities for beneficiaries in HCBS programs to have access to the benefits of community living and to receive services in the most integrated setting.

MDHHS has developed a new Medicaid Provider Manual chapter for HCBS describing the requirements under the HCBS Final Rule. These requirements aim to improve the quality of the lives of beneficiaries and allow them to live and receive services in the least restrictive setting possible with full integration in the community.

As applicable, all providers in the provider networks of the affected programs must be in compliance with the HCBS Final Rule requirements set forth by the state and federal governments.

Public Comment

The public comment portion of the policy promulgation process is being conducted concurrently with the implementation of the change noted in this bulletin. Any interested party wishing to comment on the change may do so by submitting comments in writing to:

Attn: Heather Hill
MDHHS/MSA
PO Box 30479
Lansing, Michigan 48909-7979
Or
E-mail: HillH3@michigan.gov

If responding by e-mail, please include "Medicaid Provider Manual Chapter for Home and Community Based Services" in the subject line.

Comments received will be considered for revisions to the change implemented by this bulletin.

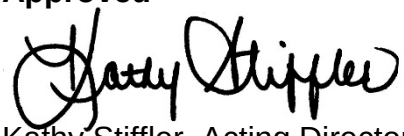
Manual Maintenance

Retain this bulletin until the information is incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved



Kathy Stiffler, Acting Director
Medical Services Administration

HOME AND COMMUNITY BASED SERVICES

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SECTION 1 – GENERAL INFORMATION

1.1 OVERVIEW

On January 16, 2014, the Centers for Medicare & Medicaid Services (CMS) released the Home and Community Based Services (HCBS) Final Rule (CMS 2249-F/2296-F). The HCBS Final Rule specifies requirements for programs offering HCBS under the 1915(c), 1915(i), 1915(k), some 1915(b)(3) and 1115 authorities of the Social Security Act. These requirements, as further specified in this chapter, aim to improve the quality of the lives of individuals, allowing them to live and receive services in the least restrictive setting possible with full integration in the community. The Michigan Department of Health and Human Services (MDHHS) is responsible for ensuring all requirements are met.

The HCBS Final Rule includes the following:

- Requirements for the person-centered planning process to ensure individuals are involved in planning their services and supports to the maximum extent possible and that their wishes are reflected in the person-centered service plan.
- Requirements for HCBS and the settings in which they are provided. Settings in which individuals live (residential) and settings where individuals go to receive services (non-residential) are affected by the HCBS Final Rule. The settings requirements aim to ensure community integration and to ensure individuals receiving Medicaid HCBS have the same opportunities as individuals in those settings who are not receiving Medicaid HCBS.
- Allows CMS to approve or renew demonstration and waiver programs for five years if individuals are dually eligible for Medicare and Medicaid.
- Requires a 30-day public notice and comment period, including at least one non-electronic form of communication, for:
  - Substantive changes, including but not limited to, revisions to services available under the waiver including: elimination or reduction of services, or reduction in the scope, amount, and duration of any service; a change in the qualifications of service providers; changes in rate methodology; or a constriction in the eligible population; and
  - Any significant proposed change in its methods and standards for setting payment rates for services in accordance with federal law.
- Allows states to combine target groups based on diagnosis, disability, Medicaid eligibility groups, and/or age under one waiver authority.
- Provides requirements for independent assessment. This is a face-to-face assessment, conducted by a conflict-free individual or agency. The assessment is based on the individual's needs and strengths and is part of the person-centered planning process. Telemedicine is an acceptable method of assessment. Federal statute requires the State to provide for an independent assessment of need to establish a person-centered service plan. The assessment must be conducted at least every 12 months, or as requested by the individual or his/her representative, and/or as needed when there is a significant change in the individual's services or support needs. The individual's person-centered service plan must be updated to reflect this change in needs. For more information, refer to the federal regulation.

- Clarifies the scope of the term "individual representative." An individual representative may be:
  - The individual's legal guardian or other person authorized by state law to represent the individual in decision-making related to the individual's care or well-being. CMS offers that, in instances where state law gives decision-making authority to an individual representative, the individual receiving services will lead the person-centered planning process where possible and the individual representative will participate as needed and desired by the individual receiving services;
  - Any other person authorized under federal law or state policy to represent the individual, including but not limited to a parent, family member, or other advocate; and
  - If the representative is authorized by the state, the state must have policies in place that describe the authorization process, the extent of the decision-making authority, and safeguards to ensure the representative is acting on behalf of the individual with exceptions in cases where the individual's wishes cannot be determined or if the individual's wishes would be harmful.

1.2 Effective Date

The HCBS Final Rule was effective March 17, 2014. With the exception of the Home and Community Based (HCB) settings requirements, all topics covered by the HCBS Final Rule were effective on this date. The HCBS Final Rule requires programs approved by CMS after March 17, 2014, to be in immediate compliance with the entire HCBS Final Rule, including the settings requirements. The MI Health Link HCBS Waiver was initially approved by CMS for January 1, 2015, and must be in immediate compliance with the HCBS Final Rule.

Programs in existence before March 17, 2014 must be compliant with the federal HCB Settings Requirement on or before March 17, 2022:

- MI Choice Waiver
- Habilitation Supports Waiver
- Children's Waiver Program
- Children with Serious Emotional Disturbance Waiver Program
- Managed Specialty Services and Supports Waiver Program

Providers should refer to the relevant program chapter in this manual for requirements unique to that program.

SECTION 2 – PERSON-CENTERED PLANNING

The HCBS Final Rule provides guidance regarding the person-centered planning process. The HCBS Final Rule requires the individual to direct the process and lead it to the extent possible and desired by the individual, with participation of people chosen by the individual and to the extent desired by the individual. The individual's representative, if applicable, should have a participatory role as needed and defined by the individual unless decision-making authority has been granted to the representative by State law. The person-centered planning process must:

- Occur in a timely manner and at times and locations of the individual's choosing;
- Provide information and support to the individual in order to ensure maximum direction from the individual and to enable informed choice;
- Provide an informed choice of supports and identify who provides them;
- Include a mechanism to request updates in the plan;
- Document alternative(s) considered but not chosen;
- Include strategies for resolving disputes and identifying conflicts of interest; and
- Be free from conflict of interest, meaning those persons who have an interest in or are employed by a provider of HCBS for the individual must not be involved in case management or development of the person-centered service plan, except when the State demonstrates that the entity is the only willing and qualified entity available to complete these functions and also provide HCBS.

The person-centered service plan must be in written format and signed by the individual and his/her representative, as applicable, and providers responsible for the implementation of the plan (at a minimum, this includes the person or entity responsible for coordinating the individual's services and supports). The person-centered service plan must be distributed to the individual and any others involved in the plan. The plan must be reviewed at least every 12 months, or more frequently if the individual chooses or has a change in service needs.

The person-centered service plan must:

- Reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need;
- Include what is important to the individual regarding their preferences for the delivery of the services and supports;
- Reflect that the individual has chosen the setting in which he or she resides, also including non-disability specific settings;
- Reflect the individual's strengths and preferences;
- Reflect the clinical and support needs as identified through an assessment of functional need;
- Include individually identified goals and desired outcomes;
- Reflect services and supports that will assist the individual to achieve the identified goals, and identify the providers of those services and supports;

- Reflect risk factors and measures in place to minimize them, including backup plans and strategies;
- Identify the person or entity responsible for monitoring the plan;
- Be finalized and agreed to with the informed consent of the individual;
- Include self-directed services;
- Prevent the provision of unnecessary or inappropriate services and supports;
- Document that any modifications of the HCB settings requirements are based upon a specific assessed health and safety need and justified in the person-centered service plan;
  - Identify the specific assessed need(s);
  - Document the positive interventions and supports used previously;
  - Document less intrusive methods that were tried and did not work, including how and why they did not work;
  - Include a clear description of the condition that is directly proportionate to the assessed need;
  - Include regular collection and review of data to measure the effectiveness of the modification;
  - Include established time limits for periodic review of the modification;
  - Include informed consent of the individual; and
  - Include assurances that the modifications will cause no harm to the individual.

The person-centered service plan must be written in plain language that is easily understood by the individual and others supporting him/her. The language in the service plan must also be understandable by individuals with disabilities and those with limited English proficiency, in accordance with federal law.

SECTION 3 – HOME AND COMMUNITY BASED SETTINGS

3.1 CHARACTERISTICS OF A HOME AND COMMUNITY BASED SETTING

Through the HCBS Final Rule, CMS imposed certain requirements for HCB settings which consist of those settings where individuals live (residential settings) and those where individuals go to receive services (non-residential settings). All HCB settings where people live or receive Medicaid HCBS must have the following characteristics to the same extent as those individuals not receiving Medicaid HCBS:

- Be integrated in, and support full access to, the greater community, including opportunities to seek competitive and integrated employment, control of personal resources, and access to community services;
- Be selected by the individual from among a variety of setting options and, for residential settings, consistent with the individual's available resources to pay for room and board;
- Ensure individuals have the right to privacy, dignity and respect, as well as freedom from coercion and restraint;
- Optimize but not regiment the individual's autonomy and independence in making life choices regarding what they participate in and with whom; and
- Facilitate the individual's choice of services and supports as well as who provides them.

When an individual chooses to receive Medicaid HCBS in a provider-owned and/or -controlled setting where the provider is paid a single rate to provide a bundle of services, the individual is choosing that provider, and cannot choose an alternative provider, to deliver all services that are included in the bundled rate. For any services that are not included in the bundled rate, the individual may choose any qualified provider, including the provider who controls or owns the setting, if the provider offers the service separate from the bundle. Any home owned or leased by a provider must adhere to the additional requirements described in federal law.

Settings that are presumed to not meet the HCB settings requirements are:

- Those in a publicly or privately-owned facility providing inpatient treatment;
- On the grounds of, or adjacent to, a public institution; or
- Any that otherwise have the effects of isolating individuals from the broader community of individuals who are not receiving Medicaid HCBS.

Settings that are on the grounds of, or adjacent to, a private institution are not automatically presumed to have the characteristics of an institution. However, if the setting isolates the individual from the broader community (or otherwise has the characteristics of an institution) or fails to meet the characteristics of an HCB setting, the setting would **not** be considered to be compliant with the regulation.

All settings, including facility- or site-based settings (e.g. pre-vocational services in a facility-based setting such as a sheltered workshop or dementia-specific adult day care centers) must demonstrate the qualities of HCB settings, ensure the individual's experience is HCB and not institutional in nature, and does not isolate the individual from the broader community. In particular, if the setting is designed specifically for people with disabilities, or individuals in the setting are primarily or exclusively people with disabilities and

on-site staff provides many services to them, the setting may be isolating unless the setting facilitates and encourages people going out into the broader community.

3.1.A. Requirements for Residential Settings

The requirements for residential settings apply to provider-owned or controlled settings. An individual's private home is presumed to be compliant with the HCB requirements. Individuals receiving Medicaid HCBS shall enjoy the same rights, protections and assurances in all living arrangements as those not receiving Medicaid HCBS.

3.1.A.1. Meals

Individuals must have access to food at any time. This does not mean the residential setting must be prepared to make a full meal at any time, but the individual must have access to some type of food when he/she chooses. The type of food offered must be something that the individual likes to eat.

3.1.A.2. Visitors

Individuals must be allowed to have visitors of their choosing at any time.

3.1.A.3. Lockable Doors

Residential settings must have bedroom and bathroom doors that are lockable by the individual, with only appropriate staff having keys to the doors. The doors must be lockable from the inside of the room and equipped with positive-latching, non-locking-against-egress hardware. This means the door should open from the inside in one single motion such as the turn of the knob or handle. If a setting has private bedrooms that include private bathrooms, only the main door to the bedroom/unit must be lockable, though MDHHS encourages that both the bedroom door and bathroom door be lockable.

3.1.A.4. Freedom to Furnish and Decorate Room

Individuals must have the freedom to furnish and decorate their room however they choose. In the case of a shared room, the furnishings and decor may be a collaborative effort with roommates.

3.1.A.5. Choice of Roommate

Individuals must have their choice of roommate if possible. In some circumstances, there may only be limited beds available at the residence so if the individual chooses that setting, he/she may also be choosing that bed without the ability to choose the roommate. Different arrangements may be made as the individual continues to live in that setting.

3.1.A.6. Freedom to Control Schedule, Activities and Resources

Individuals must have freedom to control their own schedules, activities and resources to the extent they desire. If they choose to receive assistance, that should be provided as needed and desired by the individual.

3.1.A.7. Privacy

Individuals must have privacy in their unit. This includes physical privacy as well as keeping any of the individual's confidential information private. Protected health information and other confidential personal information must not be kept in an open, common, unlocked area.

3.1.A.8. Accessibility

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. This is especially true for individuals in wheelchairs or who require walking aids. Furniture must be placed in such a way that individuals can easily move around it, with pathways large enough for a wheelchair, scooter or walker to navigate easily if individuals with these types of mobility aids reside in the setting.

3.1.A.9. Evictions and Appeals

Individuals receiving services must have a lease or other legally enforceable agreement that offers comparable responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city or other locality.

For settings in which landlord/tenant laws do not apply, MDHHS or its designee must ensure that a lease or other written agreement is in place for each individual and that the lease or agreement provides protections that address eviction processes and appeals similar to that of landlord/tenant laws.

3.1.A.10. House Rules

Although house rules are optional under State of Michigan licensing rules for Adult Foster Care and Homes for the Aged, for the purposes of the HCBS Final Rule, house rules will not be permitted.

3.1.A.11. Control of Personal Resources

The HCBS Final Rule requires that individuals be able to control their personal resources.

3.1.B. Requirements for Non-Residential Settings

The requirements of non-residential settings apply to provider owned or controlled settings. Individuals receiving Medicaid HCBS shall enjoy the same rights, protections and assurances as others receiving the same service.

3.1.B.1. Skill-Building Assistance

Skill-building assistance must provide opportunities for regular meaningful non-work activities in integrated community settings for the period of time desired by the individual. This service assists individuals in increasing their self-sufficiency or to develop the skills needed to engage in meaningful community based activities such as school, work or volunteer activities.

3.1.B.2. Community Living Supports

Community Living Supports (CLS) must promote community inclusion and participation and facilitate an individual's independence and productivity. Services should provide opportunities for integration with the community and participation in activities comparable to activities for individuals of similar age or with similar interests who do not receive Medicaid HCBS.

3.1.B.3. Supported Employment

Supported employment provides a combination of ongoing support and paid employment that enables the individual to work in the community. Setting options offered should include community-based, integrated work settings where individuals with disabilities work alongside other individuals who do not have disabilities.

3.1.B.4. Adult Day Care

Adult day care programs must offer activities for individuals receiving Medicaid HCBS that are comparable to those tasks and activities for individuals of similar age and ability who are not receiving Medicaid HCBS. There also must be interaction between individuals receiving Medicaid HCBS and those not receiving Medicaid HCBS. Services must provide an opportunity for integration with the larger community. Individuals must not be kept from moving around inside or outside of the non-residential setting. If individuals require supervision to move about the setting or go outside, that supervision must be provided.

3.2 Settings Not Compliant with the HCBS Final Rule Requirements

Some settings have been identified by CMS as not HCB due to institutional status and will never be considered HCB. These settings are:

- Nursing facilities
- Institutions for mental disease
- Intermediate care facilities for individuals with intellectual disabilities
- Hospitals
- Other locations that have characteristics of an institution

3.3 Reverse Integration

According to the HCBS Final Rule, reverse integration does not make a setting HCB. Reverse integration is when the setting brings providers into the setting from the community instead of taking the individual out to the provider. For example, medical providers, members of clergy, hairstylists, or nail artists, among others, are brought into the setting. While it is acceptable to have providers such as these come into the setting, this must not be the only contact with community providers allowed for individuals receiving services. Individuals must also have the option to go out into the community and participate with providers of their choosing.

3.4 Remediation of Settings and Relocation of Individuals

Based on review by MDHHS, some residential and non-residential settings that are not institutions may be considered to be non-compliant with the HCBS Final Rule due to not meeting the characteristics of an HCB setting as defined by CMS. The State and its contracted entities will work with these settings to bring them into compliance if the setting owner chooses to be compliant. If the setting owner declines to come into compliance with the HCBS Final Rule, the State and its contracted entities will work with affected individuals to transition to a different setting that is compliant. As applicable, individuals must be provided with compliant residential or non-residential options from which to choose. If the individual does not want to move to a different, compliant setting, he/she will be disenrolled from the Medicaid HCBS program.

Timeframes for relocation of individuals and continued program participation are dependent on the aforementioned CMS requirements for whether the specific program is considered new or existing as of the effective date of the HCBS Final Rule. Refer to the program chapter of this manual for specific requirements unique to that program.

3.5 Heightened Scrutiny

The State and CMS have a process for “heightened scrutiny” which consists of further review of any settings that wish to participate and are considered compliant with the HCBS Final Rule with all characteristics except some, such as location of the setting close or connected to an institution. This will involve MDHHS and its contracted entities gathering evidence of potential compliance and submitting this to CMS for final approval.

MDHHS is responsible for determining if a setting qualifies for the “heightened scrutiny” process through its assessments of the setting that appears to have qualities which are HCB and does not have qualities that are institutional in nature. MDHHS will request that this type of setting go through the “heightened scrutiny” process with CMS. Only a setting that can comply 100 percent with the federal HCB Settings Requirement will be submitted to CMS for “heightened scrutiny” process.

A setting that will require heightened scrutiny has at least one of the following characteristics:

- Settings located in a building that is also a publicly- or privately-operated facility that provides inpatient institutional treatment.
- Settings in a building on the grounds of, or immediately adjacent to, a public institution.
- Any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.

3.6 New Settings

All new settings (either newly established or new to the specific program) must be immediately compliant with the HCBS Final Rule. Determination of a new setting's compliance with the HCBS Final Rule must be determined after the setting is built and has been operational with residents or individuals receiving services in order for the evaluating entity to have a full understanding of the individual's experience while participating with the setting.

3.7 Ongoing Monitoring

The State and its contracted entities are responsible for conducting ongoing monitoring activities to ensure settings remain in compliance with the HCBS Final Rule. Refer to the program chapter of this manual for specific requirements unique to that program.