Home and Community Based Services Waiver
Technical Guide

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?	11.17.16 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?	11.17.16 MDHHS does not interpret AFC's as IMD's, please see following excerpt taken from http://dhhs.ne.gov/Medicaid/Documents/4390.pdf 11.17.16 There are no expected changes to the current waiver restriction on bed size under the 1115 Waiver

Question	MDHHS Response
Are there specific variables or dimensions of a residential setting beyond those in the flow chart that would trigger the Heightened Scrutiny (HS) provisions?	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:
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.

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?	11.17.16 Michigan would look for any evidence of contact/connection each time a person is accessing their community. 12.20.16 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 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?	11.17.16 Michigan would look for any evidence of interaction with others not receiving Medicaid HCBS services in all disability specific settings or services. 12.20.16 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."	11.17.16 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. 12.20.2016 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.

REMEDIATION

Question	MDHHS Response
Is it possible that residential settings may have several CAPs because it is individual specific?	1.19.17 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?)	1.19.17 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)?	It is not expected that evidence is provided on an individual level. For many questions, a policy that governs your agency- and therefore would apply to all individuals served- will suffice. This will demonstrate that there is no blanket policy against locking doors or accessing food, for example. It is not practical, and may not always be possible to provide evidence specific to every individual. For example, there may be some individuals who do have restrictions, but the expectation would be that those restrictions are exceptions and part of the Person Centered Plan. We recommend supplementing the broader policies you provide with personal accounts, like letters of support from individuals and/or discussion summaries from Stakeholder Meetings to support your compliance with the HCBS Rule.

With regard to Continuum of Care, please clarify how to interpret "Continuum of Care'.	Continuum of Care means all services and supports are provided within the setting. The way to interpret compliance is: if these are on-site services available and utilized by an individual, are those services determined in consultation with the person supported, and are they part of a persons centered plan? Do individuals served have the option to receive those services in an off-site, community location? If not, then a transition plan is necessary.
With regard to people's ability to come and go as they please clarify.	The ability to come and go at any time from one's residence does not conflict with needing assistance to do so. The point of the question is: Can a person develop and implement their own schedule with r without support as needed? If not, then this restriction must be supported by the person-centered plan. Providers need to assess their organizations to ensure there are no policies, training materials, etc. that prohibit a person's right to come and go. If modifications to the Rule are needed on an individual basis that will be determined through the Person Centered Plan, documented in the Behavior Treatment Plan and monitored for effectiveness and appropriateness of continued implementation. Otherwise, a transition plan is necessary. With regard to those needing 24 hour support should not be limited in when they come and go based on their personal choice. This does not imply that a person needing supports not receive these supports when exercising choice.

HEIGHTENED SCRUTINY

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What about CAP (corrective action plans) from providers for multiple PIHP's? (Might they be relevant to more than one PIHP?)	1.19.17 CAP's will be tied to an individual so the remediation should also be unique.
If, after reviewing the information collected, MDHHS determines it 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.	11.17.16 Chart 4 flowchart Handout sent electronically 12.20.2016 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.