POLICY AND PROCEDURE MANUAL

SUBJECT: Home and Community Based Services Provisional Approval and Ongoing Monitoring	ACCOUNTABILITY The NMRE and its Member CMHSPs	Effective Date: October 7, 2025	Pages: 2
REQUIRED BY Home and Community Based Services Final Rule	BBA Section: PIHP Contract Section: Other: HBCS Final Rule, 42 CFR § 441.530	Last Review Date:	Past Review Date:
Policy: ☒ Procedure: ☐	Review Cycle: Annual Author: NMRE Chief Clinical Officer	Responsible Department: Clinical/Waivers	Reviewers: NMRE CEO

Definitions

Community Mental Health Services Program (CMHSP): For the purposes of this document, a CMHSP member is one or more of the following: AuSable Valley Community Mental Health Authority, Centra Wellness Network, North Country Community Mental Health, Northeast Michigan Community Mental Health Authority, and Northern Lakes Community Mental Health Authority.

Corrective Action Plan (CAP): Improvements to an organization's processes taken to eliminate causes of non-conformities or other undesirable situations.

Home and Community Based Services (HCBS): Provides Medicaid beneficiaries opportunities to receive services in their own home or community rather than institutions or other isolated settings.

The Home and Community Based Services (HCBS) Final Rule: A regulation that ensures people with disabilities receive services in integrated community settings. The rule also protects their right to make choices and control their lives.

Individual Plan of Services (IPOS): The written details of the supports, activities, and resources required for the individual to achieve personal goals. An individual and his/her team are responsible for developing the individual plan of services.

Network Provider: Any provider that receives Medicaid funding directly or indirectly to order, refer, or render covered services pursuant to the NMRE's Specialty Supports and Services Contract with the State, including its five member CMHSPs and the Substance Use Disorder Provider Panel.

Northern Michigan Regional Entity (NMRE): Region 2 PIHP covering Alcona, Alpena, Antrim, Benzie, Charlevoix, Cheboygan, Crawford, Emmet, Grand Traverse, Iosco, Kalkaska, Leelanau, Manistee,

Missaukee, Montmorency, Ogemaw, Oscoda, Otsego, Presque Isle Roscommon, and Wexford counties in northern Lower Michigan.

Prepaid Inpatient Health Plan (PIHP): An organization that manages the Medicaid mental health, intellectual/developmental disabilities, and substance use disorder services in their geographic area under contract with the State.

Purpose

The purpose of this policy is to establish the NMRE's process for complying with Home and Community Based Services Final Rule requirements.

Policy

It is the NMRE's policy to ensure that settings for home and community-based services participants are not institutional or isolating in nature. Provisional approval allows NMRE providers to contract new providers who do not have a current HCBS participant receiving services in their setting from the region. Provisional approval is required for any new HCBS provider or any existing provider who wishes to provide a new service to an HCBS participant. The NMRE Home and Community Based Services Provisional Approval and Ongoing Monitoring Procedure will outline the provisional approval process required to utilize a restrictive setting and the NMRE's ongoing HCBS monitoring.

Approval Signature

NMRE Chief Executive Officer	October 7, 2025 Date

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I. Provisional Approval Procedures

A. NMRE and CMHSP network providers may receive provisional approval to provide HCBS services based on the satisfactory completion of a new provider application. The provisional approval status will remain in place until the provider and the individual receiving services have completed an HCBS comprehensive assessment. Assuming appropriate responses are given, the provisional approval process status will update to approved.

B. Completion of the provisional approval process will be required of all new HCBS providers.

C. Completion of the provisional approval process will be required of any existing provider that wishes to begin providing a new service that was not previously provided.

D. The provisional application must be complete to begin providing HCBS services. This process will be completed and approved by the CMHSP prior to the provision of any HCBS services. This provisional application process is intended to provide *initial* and *provisional* approval to provide Medicaid Behavioral Health HCBS services. The HCBS Residential Provider Application and Non-Residential Provider Application can be found on NMREs website.

E. Elements of the provisional approval process will include:

1. The provider will complete the provisional application in coordination with the CMHSP. This includes:

   a. An interview with the provider

   b. Review of policies and procedures regarding the implementation of the HCBS rule.

   c. Onsite Assessment of the physical structure.

      i. This is required of all provisional approval requests.

      ii. If there are any restrictions on individuals' freedom of movement, they will be identified.

         - The NMRE and its CMHSPs use the HCBS Provisional Site Review Checklist. For cases that are located out of the NMRE region, reciprocity for these onsite reviews will be upheld.

2. If the provider/setting presents with any physical restrictions it will be reviewed in consultation with MDHHS prior to the provision of any services. Failure to request consultation with MDHHS will result in denial of Medicaid HCBS funding until a consultation is completed that identifies the setting as the least restrictive option for the individual.

F. Provisional approval will allow a new provider and/or new service to be provided to HCBS participants for 90 days. Providers will be added to the HCBS comprehensive assessment schedule, and a comprehensive assessment must be completed within 90 days of their provisional approval.

G. Failure to complete the provisional approval process and the ongoing approval process will result in the suspension of the provider's ability to provide HCBS services.

H. If an existing provider, that has been in a contractual agreement to provide services in the NMRE region prior to October 1, 2017, begins to provide a new service, it is required to obtain provisional approval.

I. Providers will be required to complete the provisional application process for the first HCBS participant only, except for physically restrictive settings.

<u>The Member CMHSP is responsible for the following:</u>

- Ensuring that new providers complete the provisional application prior to serving HBCS participants.
- Ensuring that any existing providers that wish to begin providing services that they have not previously provided complete the provisional approval application prior to serving HCBS participants.
- Guaranteeing that a consultation with the NMRE, the CMHSP requesting the contract, and MDHHS occurs for any physically restrictive settings prior to placement or implementation of a physical restriction.
- Ongoing monitoring of the provider will occur annually, using the MDHHS approved tool, to ensure that the location remains in compliance with the requirements.
- Ensuring that Individual Plans of Services (IPOS) contain all the necessary elements per the HCBS Final Rule and Person-Centered Planning Policy, including documentation showing that providers responsible for the implementation of beneficiaries' IPOS are trained on the IPOS prior to the implementation/start date of the IPOS.
- Tracking provisional approval surveys and adding new providers into the HCBS comprehensive assessment schedule.
- Ensuring a comprehensive assessment is conducted within 90 days.
- Conducting any required follow-up on comprehensive assessments to ensure all standards are met as required by the HCBS Final Rule.
- Maintaining documentation that provisional applications and comprehensive assessments were completed, and all remediations/validations were completed within the timeframe outlined by MDHHS.
- Monitoring individual plans of services for compliance with all necessary elements.

<u>The NMRE is responsible for the following:</u>

- Ongoing monitoring of CMHSPs to ensure compliance with the Final HCBS Rule.

II. HCBS Monitoring Procedures

A. To maintain compliance with the HCBS Final Rule, the following must be completed per the MDHHS HCBS Monitoring Requirements Technical Advisory:

1. Annual Physical Setting Assessment must be completed by the CMHSP; this will ensure that the setting follows HCBS standards that are related to the physical structure of the setting.

a. Evidence of annual physical assessments will be available to MDHHS upon request.

b. The CMHSP will ensure the implementation of corrective measures for any setting that is out of compliance during the annual physical assessment.

2. Comprehensive assessments will be completed by CMHSP holding the contract every three years and will focus on the experiences of individuals served in the setting and include but not be limited to freedom of movement.

a. Evidence of the comprehensive assessment will be available to MDHHS upon request.

b. Each beneficiary's satisfaction with services and services provider will be assessed annually and be documented in the health record.

3. If, through the comprehensive assessment process, a setting is found to have qualities of an institution (operationally unrelated with treatment facility or that are located on the grounds of an institution) such as characteristics that isolate HCBS beneficiaries (do not encourage and/or facilitate interaction with the greater community in the manner and to the extent the person desires, or settings that bring services and supports into the home rather than assisting participants in accessing their services in the greater community may be isolating), which the setting is not able to overcome, the CMHSP/NMRE will identify them as a Heightened Scrutiny setting. Those settings determined to be Heightened Scrutiny are not eligible for Medicaid HCBS funding.

B. The comprehensive assessment will ensure that settings are assessed for compliance with the HCBS rule by utilizing the review tools provided on a frequency identified by MDHHS.

1. The CMHSP/NMRE will:

a. Provide MDHHS an assessment schedule to ensure all HCBS settings and beneficiaries are assessed as specified in this policy.

b. Develop a proposal to address settings that do not comply with the ongoing monitoring and provide it to MDHHS.

c. Send MDHHS ongoing progress on conducting assessments, remediation, and validating assessment responses per the MDHHS reporting schedule.

C. Documentation of HCBS restrictions in the IPOS

1. Any restriction on a person's freedom must be documented in the person's IPOS, developed using the person-centered planning process.
2. No restrictions may be placed on a person's freedom of rights unless the restriction is based on a documented health and/or safety issue.
3. All restrictions must be documented in the IPOS without exception.
4. When there is sufficient evidence to support restrictions on a person's rights based on a health or safety need, the following must be documented in detail in the IPOS. Restrictions may only be placed upon a Medicaid recipient when there is an HCBS compliant modification documented in the person's IPOS
    a. Identify the specific addressed need(s).
    b. Document the positive interventions and supports used/tried previously.
    c. Document less intrusive methods that were tried and did not work, including how the methods that were implemented failed.
    d. Include a clear description of the condition that is directly proportionate to the addressed need.
    e. Include regular collection and review of data to measure the effectiveness of the modification.
    f. Include established timeframes for the periodic review of the modification.
    g. Include a titration or fade plan that outlines the changes in behaviors and associated timeless to reduce and/or remove the need for the modification.
    h. Identified services or support that will be provided to support the development of skills to reduce the need for modification of the HCBS Final Rule.
    i. Include informed consent of the individual.
    j. Include assurances that the modification will cause no harm to the individual.
5. If an individual is adjudicated and/or has an NGRI status, and there are court-imposed restrictions, these will be considered; however, the previous requirements must be upheld as best as possible.
6. All restrictions will be documented in the residents' individual plans of services. Setting-wide restrictions cannot be imposed under any circumstances
7. Restriction solutions for beneficiaries for whom restriction does not apply will be documented in the IPOS and will consist of the following:
    a. Identify that a restriction is present in the setting that is <u>not</u> for the benefit of the person.
    b. Identify agreements around how the person will be able to access whatever item or activity is restricted.

c. Note the person should be able to access the item or activity seamlessly. Requesting staff assistance is not an acceptable solution as waiting for staff assistance does not allow for seamless access.

I. Annual and Ongoing Monitoring

The NMRE's reviews of its Member CMHSPs will include HCBS monitoring; these will be scheduled and conducted on an ongoing basis but not less frequently than annually. The NMRE will work with its Member CMHSPs and related network providers to implement a process consistent with MDHHS guidance and ensure full compliance with HCBS requirements.

Delegated Managed Care Review Activity

A. The NMRE Regional Provider Monitoring and Oversight Procedure will guide the NMRE and its Member CMHSPs in the process of conducting regional on-site monitoring and oversight of its network providers, to ensure compliance with federal and state regulations and contractual requirements and to establish a standard procedure for conducting on-site reviews.

B. The NMRE will incorporate HCBS setting requirements into the delegated managed care review activity in accordance with the NMRE Regional Provider Monitoring and Oversight Policy to ensure:

1. CMHSPs are involved in the reassessment of HCB settings and participants.
2. CMHSPs and Providers are implementing CAPs as needed.
3. HCBS settings remain compliant with the HCBS Final Rule
4. HCBS requirements are included in CMHSP contracts with HCBS provider settings.

C. At least 30 days prior to the site review, the NMRE will send Member CMHSPs a list of all cases selected for the site visit. Cases will be selected for review at random, based on submitted HCBS encounters.

D. At least 30 days prior to the site review, the NMRE will send out a review checklist to allow the CMHSPs and HCBS providers sufficient time to prepare and to submit information, as necessary, prior to the site visit.

E. PIHPs/CMHSPs will develop a tracking mechanism to ensure each HCBS service provider including direct service providers receive training on the HCBS rule at hire and annually thereafter.

REFERENCES

- MDHHS BHDDA New Home and Community Based Services Provider Requirements
- Home and Community Based Settings (HCBS) Monitoring Requirements Technical Advisory
- Behavior Treatment Plan Review Committee Technical Requirements
- HCBS Non-Residential Provisional Provider Survey
- HCBS Residential Provisional Provider Survey
- Medicaid Provider Manual – HCBS Chapter
- Home and Community Based Services Individualized Plan of Service Requirements Guidance

Approval Signature

NMRE Chief Executive Officer

October 7, 2025

Date