

HCBS RESIDENTIAL PROVIDER APPLICATION

The completion of this application is required to provide for provisional approval to provide HCBS services.

The purpose of the provisional approval application is to ensure that the settings in which new or existing providers wish to provide services to HCBS participants are not institutional, isolating or restrictive in nature. Provisional approval allows PIHPs to contract with new providers who do not have a current HCBS participant receiving services in their setting and for whom an HCBS assessment has not yet been conducted by the PIHP. Provisional approval is required before the provision of services to an HCBS participant to ensure HCBS funding will be accessible.

This application is required for providers /settings who are not currently providing services to HCBS participants or for existing providers within the PIHP or who are opening new settings or wish to add services to their array.

An onsite review of every setting requiring provisional approval is required. PIHP leads may utilize reciprocity as defined by the MDHHS HCBS behavioral health team.

PIHP HCBS leads will ensure that the initial HCBS comprehensive setting assessment is conducted *within 90 days* of an individual's IPOS in order to maintain the ability to provide HCBS services. PIHP leads will ensure an annual physical assessment has been conducted with the setting within one year (reciprocity allowed see below) and will conduct the physical review when there is no current review on record.

Failure to complete the provisional approval process or the ongoing assessment process *will* result in the suspension of the provider's ability to provide Medicaid funded HCBS services.

PIHPs must complete this initial application with *all providers* who meet the criteria identified above. The individual provider application must be available upon request of MDHHS. Providers who do not meet the initial standards, including the updated HS review standards outlined *are not* eligible to provide HCBS services to Medicaid recipients. **Settings that are identified as restrictive following the completion of this application are not eligible for provisional approval by the PIHP and will require a provisional consultation with MDHHS HCBS staff.** The PIHP may reassess the provider if remediations have been made that result in the provider becoming compliant.

Expected respondent: The PIHP lead will complete this application through an interview with the setting. **When a setting is part of a larger entity the PIHP lead must ensure that accurate information relative to the daily operations of the specific setting identified is being provided.** The PIHP lead should interview the setting manager and or staff who has direct knowledge of the settings day-to-day supports and/or the operational and administrative activities and policies of the provider agency. PIHP leads do not provide this document to the setting to complete.

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How to complete and submit this document: the PIHP lead, or heir designees conduct a review of the setting including any additional evidence identified. If the PIHP lead determines based upon the information provided that the setting is not restrictive in nature and will not require an HS review provisional approval may be granted and the form will be maintained in the PIHP's records but does not need to be submitted to MDHHS.

If upon review the setting is a secured setting, then an HCBS Provisional consultation must occur, and the setting must be approved by MDHHS before the setting can receive HCBS funding. Secured or restrictive settings require a provisional consultation for every individual who wishes to receive services in the setting.

If there are features of a setting that may *require* an HS review and those features are different than those identified as a secured setting, such as settings on the ground of a psychiatric hospital, you must contact the HCBS specialist directly to consult on the case and receive guidance for next steps.

All the above steps must be completed without exception order to access Medicaid funding.

Provide the contact information of the setting representative interviewed for further questions

Name: Click or tap here to enter text.

Position/Title: Click or tap here to enter text.

Contact Phone Number: Click or tap here to enter text.

Contact Email Address: Click or tap here to enter text.

Instructions: The PIHP lead will provide a response to each question, respond based upon the policies, procedures, and physical environment of the setting. Responses to this survey and supporting information may be verified at a later date with an on-site visit.

Name of the Setting or Location: Click or tap here to enter text.

Provider: Click or tap here to enter text.

Address: Click or tap here to enter text.

City, State, Zip Code: Click or tap here to enter text.

Contact Phone Number (if different than the person identified above): Click or tap here to enter text.

Michigan Department of Human Services, Bureau of Children and Adult Licensing BCAL) License Number* (if applicable):Click or tap here to enter text.

* If BCAL number is not available, enter National Provider Identification (NPI) number

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Is this an ICTS referral

☐ Yes

☐ No

Is the setting more or less restrictive than the current setting where the participant resides?

☐ More restrictive

☐ Less restrictive

Section 1: Provider Information

Type of Residence (see definitions below)

☐ **Specialized residential home:** "Specialized program" means a program of services or treatment provided in an adult foster care facility licensed under this act that is designed to meet the unique programmatic needs of the residents of that home as set forth in the assessment plan for each resident and for which the facility receives special compensation." (Adult Foster Care Facility Licensing Act 218 of 1979 as Amended, Section 400.707)

☐ **Living in a private residence:** that is **owned or controlled** by the Prepaid Inpatient Health Plan (PIHP), Community Mental Health Service Program (CMHSP), alone or with spouse or non-relative

☒ **Adult Foster Care home:** "Adult foster care facility" means a governmental or nongovernmental establishment that provides foster care to adults. Subject to section 26a(1), adult foster care facility includes facilities and foster care family homes for adults who are aged, mentally ill, developmentally disabled, or physically disabled who require supervision (2) on an ongoing basis but who do not require continuous nursing care." (Adult Foster Care Facility Licensing Act 218 of 1979 as Amended, Section 400.703)

Institution for Mental Disease (IMD): The term "institution for mental diseases" means 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. [Source: Social Security Act, Sec. 1905. [42 U.S.C. 1396d]

Child Caring Institution (CCI): Child caring institution' means a childcare facility which is organized for the purpose of receiving minor children for care, maintenance, and supervision, usually on a 24-hour basis, in buildings maintained by the institution for that purpose, and operates throughout the year. An educational program may be provided, but the educational

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program shall not be the primary purpose of the facility. Child caring institution also includes institutions for intellectually and/or developmentally delayed or emotionally disturbed minor children. Child caring organization does not include a hospital, nursing home, or home for the aged.

Definitions:

Reciprocation Allowance: PIHP leads may utilize an onsite physical assessment conducted by another region if the review was conducted not more than 12 months prior.

Section 2: Physical Location and Operations of Service Providers

A. Is the setting separate from, outside of the building, and off the grounds of a psychiatric hospital?

☐ Yes

☐ No (if the answer to this question is 'no' you must complete the HS review section of this document)

B. Is evidence provided that confirms residents are encouraged and supported to receive services and supports within the community rather than bringing these services and supports to the setting?

☐ Yes

☐ No (if the answer to this question is 'no' you must complete the HS review section of this document)

C. Is the residence located outside of a building and off the campus of an education program, school, or child caring institution?

☐ Yes

☐ No (if the answer to this question is 'no' you must complete the HS review section of this document)

Section 3 : Secure or Restrictive Setting Identification:

The PIHP lead will endorse all features present in the setting including restrictive policies that disallow any activity or right setting wide and will provide additional information for any restrictive feature not identified below. All restrictions must be identified.

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- ☐ Fence that exceeds four foot in height
- ☐ Gate that is locked against egress (padlocked or otherwise)
- ☐ Windows or doors that are locked against egress
- ☐ Policies are in place that restrict participants freedoms (this is different than IPOS modifications consistent with the rule).
- ☐ The setting has areas that are locked against all persons living in the home and are considered public spaces
 - ☐ Kitchen is locked without accommodations for those who do not require it
 - ☐ Residents cannot freely access the grounds of the setting
 - ☐ Residents cannot open and exit from any door
 - ☐ The setting restricts access to any item or activity as a condition of living or receiving services in the setting in the setting
 - ☐ Exits doors are locked with only staff members being able to open them
 - ☐ Residents cannot exit the setting and *move freely* away from the property and into the greater community
 - ☐ PIHP lead must identify any and all restrictions including those not identified above. Please add any additional restrictions here:

Additional Information [Click or tap here to enter text.](#)

When evidence gathered shows that a setting is restrictive in its policies or physical structure a provisional consultation with the MDHHS HCBS team is **required prior to placing an individual in the setting in order to receive Medicaid funding**. Please see Provisional Application Guidance document for detailed requirements.

Heightened Scrutiny Provisional Approval Documentation

If, when reviewing a setting for provisional approval it is determined that the setting is on the grounds of an institution, additional information must be gathered to assess whether the settings is likely to be able to successfully navigate the HS process.

In order to overcome its HS status settings must be able to show:

- That they are not isolating and instead support and encourage access to the greater community
- Waiver participants are not expected/required to receive their services and supports within the setting and that the setting assists participants in accessing their services in the community to the extent and in the manner, they prefer
- The setting is not on the grounds of an institution including a private mental health treatment center or hospital

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Because the provisional assessment occurs before waiver participants from your region are in the setting you may have to rely upon written policies and procedures, video tours of the setting and/or information related to participants from other regions who receive services in the setting for guidance.

Evidence gathered in these situations must be documented and available for review upon request. If, based upon evidence gathered the lead believes the setting will require an HS review the lead must request a consultation with MDHHS BHDDA HCBS team staff prior to approving the setting. If the evidence provided demonstrates that the setting is not institutional or isolating in nature provisional approval may be granted.

Section for PIHP representative:

The Centers for Medicare and Medicaid have identified that the following settings are considered not to be Home and Community Based:

- Nursing facilities,
- Institution for Mental Disease
- Intermediate Care Facilities
- Hospitals
- Other locations that have the qualities of an institutional setting as determined by the Secretary of HHS

Heightened Scrutiny Review this section must be completed when the answer to A, B, or C above is “No”

Date of review: Click or tap here to enter text.

Name of person who conducted the review Click or tap here to enter text.

Has the PIHP or CMHSP reviewed the physical location of the setting?

☐Yes

☐No if a physical review of the setting was not conducted and reciprocity was utilized identify the date and region that reviewed the setting Click or tap here to enter text.

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Does the PIHP/ CMHSP attest that the setting is not institutional in nature and does not appear to be isolating consistent with the requirements outlined above?

☐ Yes

☐ No

Note: If the PIHP representative believes the setting may be isolating or has the qualities of an institution provisional approval should not be granted and a comprehensive assessment should be conducted.

Additional Heightened Scrutiny Documentation: (complete the section below by checking the box corresponding to the type of evidence you have reviewed).

Please identify the evidence received and reviewed to support that the setting is not institutional or isolating and submit this document together with a consultation request prior to granting provisional approval. You do not need to submit the supporting evidence to MDHHS at this time.

Polices/procedures that confirm the individuals have the following freedoms

☐ Ability of waiver participants to come and go as they choose with or without support

☐ Ability to move freely within the setting without barriers to access public areas of the home including the kitchen

☐ Freedom to choose which services they will receive and where those services are provided

☐ Accessible transportation to assist individuals who wish to receive their services/supports within the community to the extent and in the manner preferred by the individual

By signing this document, you attest that the information provided is accurate.

X

PIHP lead or designee

Date