MEDICAID POLICY INFORMATION SHEET

Policy Analyst: Dana Moore

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Initial ☐ Public Comment ☒ Final ☐

Brief description of policy:

The purpose of this bulletin is to update policy in accordance with the Home and Community-Based Services (HCBS) final rule. This policy identifies specific HCBS requirements for Behavioral Health service providers to ensure compliance.

Reason for policy (problem being addressed):

To provide guidance specific to Behavioral Health providers regarding compliance with the HCBS final rule.

Budget implication:

☒ budget neutral
☐ will cost MDHHS $, and (select one) budgeted in current appropriation
☐ will save MDHHS $

Is this policy change mandated per federal requirements?

Yes, in response to CAP from CMS related to HCBS behavioral health onsite review.

Does policy have operational implications on other parts of MDHHS?

These changes do not have an operational impact on other areas of MDHHS. However, it is important to note that there is an HCBS chapter currently in the MDHHS Medicaid Provider Manual that does apply to other program areas. Because these changes are specific to Behavioral Health, behavioral health needed its own policy so it did not impact the other program areas that must comply with HCBS but do not have the exact same requirements.

Does policy have operational implications on other departments?

No

Summary of input:

☐ controversial
☒ acceptable to most/all groups
☐ limited public interest/comment

Supporting Documentation:

State Plan Amendment Required: ☐ Yes ☒ No If Yes, please provide status: ☐ Approved ☐ Pending ☐ Denied Date: Approval Date:	Public Notice Required: ☐ Yes ☒ No If yes, Submission Date:

DRAFT FOR PUBLIC COMMENT Michigan Department of Health and Human Services		
	Project Number: 2529-BH	**Date:** July 18, 2025

Comments Due: August 22, 2025
Proposed Effective Date: October 1, 2025
Direct Comments To: Dana Moore
Address:
E-Mail Address: Moored61@michigan.gov
Phone: **Fax:**

Policy Subject: Home and Community-Based Services (HCBS) Final Rule - Behavioral Health

Affected Programs: Medicaid, Healthy Michigan Plan, Habilitation Supports Waiver

Distribution: All Providers

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Purpose: To provide guidance specific to Behavioral Health providers regarding compliance with the HCBS final rule.

Cost Implications: Budget neutral

Potential Hearings & Appeal Issues: None

State Plan Amendment Required: Yes ☐ **No** ☒ **If yes, date submitted:**	**Public Notice Required: Yes** ☐ **No** ☒ **Submitted date:**

Tribal Notification: Yes ☐ **No** ☒ **- Date:**

THIS SECTION COMPLETED BY RECEIVER

☐ **Approved**	☐ **No Comments**
	☐ **See Comments Below**
☐ **Disapproved**	☐ **See Comments in Text**

Signature:	**Phone Number**
Signature Printed:	
Bureau/Administration *(please print)*	**Date**

Proposed Policy Draft

Michigan Department of Health and Human Services
Health Services

Distribution: All Providers

Issued: August 29, 2025 (proposed)

Subject: Home and Community-Based Services (HCBS) Final Rule – Behavioral Health

Effective: October 1, 2025 (Proposed)

Programs Affected: Medicaid, Healthy Michigan Plan, Habilitation Supports Waiver

I. General Description

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. The HCBS Final Rule is intended to improve the quality of the lives of beneficiaries by providing them with opportunities to live and receive services in the least restrictive setting possible with full integration in the community. This policy identifies specific HCBS requirements for Behavioral Health service providers to ensure compliance.

The Michigan Department of Health and Human Services (MDHHS) is responsible for ensuring all requirements are met. Further information regarding the HCBS Final Rule can be found in the Home and Community-Based Services chapter of the MDHHS Medicaid Provider Manual.

II. Person-Centered Planning

The HCBS Final Rule provides guidance regarding the person-centered planning. The HCBS Final Rule requires the beneficiary to direct and lead the process to the extent possible and desired by the beneficiary. The beneficiary will choose who will participate in the meeting and the extent of that participation.

The beneficiary's guardian, if applicable, should have a participatory role as needed and defined by the beneficiary unless decision-making authority has been granted to the guardian by State law. The person-centered planning must:

- Occur in a timely manner and at times and locations of the beneficiary's choosing.
- Provide information and support to the beneficiary in order to ensure maximum direction from the beneficiary and to enable informed choice.

- Provide an informed choice of supports and identify who provides them.
- Include a mechanism to request updates in the Individual Plan of Service (IPOS).
- Document alternative(s) considered but not chosen.
- Include strategies for resolving disputes and identifying conflicts of interest.
- Be free from conflict of interest, meaning those persons who have an interest in or are employed by a provider of HCBS for the beneficiary must not be involved in case management or development of the person-centered planning, except when the State demonstrates that the entity is the only willing and qualified entity available to complete these functions and also provide HCBS.
- Discuss self-directed service arrangements including how budgets are developed and can be flexibly used to implement services, summary of methods to implement self-directed service arrangements, and the allowable use of budget dollars to spend on all components of medically necessary service.
- Discuss with the beneficiary during the person-centered planning all components of services (i.e., for Community Living Supports (CLS), this includes components such as transportation, activities, staff wages, employer costs, training time) as well as the amount, scope, duration, and frequency of each such component that may be medically necessary for the beneficiary. Components of services are defined in relevant service sections of the MDHHS Medicaid Provider Manual and MDHHS-developed Healthcare Common Procedure Coding System (HCPCS) Code Chart.

III. Individual Plan of Service

The person-centered planning includes pre-planning and all planning activities leading up to development of the IPOS. The IPOS is focused on plans to support beneficiaries to increase their own self-determination through independence, productivity, and integrated community inclusion. To be in compliance with the HCBS Final Rule, the IPOS must:

- Be in written format and signed by the beneficiary and their guardian, as applicable, and providers responsible for the implementation of the IPOS (at a minimum, this includes the person or entity responsible for coordinating the beneficiary's services and supports).
- Be distributed to the beneficiary and any others involved in the IPOS. The IPOS must be reviewed at least every 12 months, or more frequently if the beneficiary chooses or has a change in service needs.
- Reflect the services and supports that are important for the beneficiary to meet the needs identified through an assessment of functional need.
- Include what is important to the beneficiary regarding their preferences for the delivery of the services and supports.
- Reflect that the beneficiary has chosen the setting in which they reside, from among a variety of settings including non-disability specific settings. The settings considered will be identified by name within the IPOS.
- Reflect the beneficiary's strengths and preferences.
- Reflect the clinical and support needs as identified through an assessment of functional need.

- Include individual identified goals and desired outcomes, and develop plans to reach these goals.
- Reflect services and supports that will assist the beneficiary 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 IPOS.
- Be finalized and agreed to with the informed consent of the beneficiary. This is reflected by the beneficiary's signature and their guardian (if applicable).
- Include self-directed services.
- Prevent the provision of unnecessary or inappropriate services and supports.

A. Modification Requirements

In circumstances where modifications of the home and community-based settings requirements are needed, it must be based upon a specific assessed health and safety need and justified in the IPOS. In order to be compliant with the HCBS Final Rule, the IPOS must:

- 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.
- Develop a titration or fade plan that outlines the steps and timelines associated that the beneficiary and their support will take to remove the need for the modification/restriction.
- Identify services or supports that will be provided to support the development of skills to reduce the need for modification of the HCBS Final Rule.
- 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 beneficiary regardless of guardianship status.
- Include assurances that the modifications will cause no harm to the beneficiary.

Any modifications to the HCBS Final Rule must be accompanied by all elements of the modification process before the restriction is implemented.

B. Other Required Elements

The HCBS Final Rule also requires that person-centered planning be used to identify and reflect choice of services and supports funded by the mental health system. This includes opportunities to seek employment and work in individual competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving such services and supports.

i. Employment

Beneficiaries must be provided with the opportunity to seek employment or work in individual integrated settings. Therefore, the IPOS must reflect the beneficiary's interest and desires to seek employment and the actions necessary to reach the goal of employment with clearly defined steps that will be taken to support the beneficiary in their goal.

At the IPOS meeting, the case manager will determine the beneficiary's interest in employment or other opportunities such as volunteering. This discussion will be held regardless of the adult person's age or any other factors, including current employment. Employment discussions will include all types of employment and specific settings that can or will be explored. The case manager must ensure the conversation includes non-disability specific and Competitive Integrated Employment opportunities. All settings considered must be identified by name in the beneficiary's IPOS.

If the beneficiary does not wish to pursue this type of opportunity, that will be documented in the IPOS including the types of settings/jobs/volunteer activities discussed; and any barriers identified in the discussion will be outlined in specific with a plan to address these barriers as desired by the beneficiary.

ii. Satisfaction with Living Situation

At the IPOS meeting, the case manager will establish the beneficiary's satisfaction with their current living situation and any interest in exploring other opportunities. The discussion will be reflected in the IPOS and must include:

- An identified goal of changing their living situation with clearly defined steps that will be taken to support the beneficiary if this is their wish.
- All settings (by name) considered when the beneficiary is exploring other living arrangements. This must include non-disability specific settings.
- Any barriers and how they will be addressed.
- Identified satisfaction with their current living situation and no desire to explore other living arrangements.

iii. Community Integration

The HCBS Final Rule prohibits the isolation of beneficiaries and requires they have the same level of access to their community as others who do not receive Medicaid. Therefore, the Prepaid Inpatient Health Plan/Community Mental Health Services Program (PIHP/CMHSP) must ensure that a community integration goal is present in the IPOS of each beneficiary. This goal will be thoroughly discussed and documented each time the IPOS is updated.

Beneficiaries must be supported to the extent needed or desired to engage in a minimum of two meaningful community activities per week. The level of support needed or desired will be identified through the person-centered planning, included in the IPOS, and may be dependent on any of the following:

- The existence of a HCBS compliant modification that limits access to the community without supervision or support.
- The location of the setting the beneficiary resides in and its proximity to the greater community.
- Access and ability to use public transportation to access places of interest in the greater community.

An activity is meaningful when it is based upon the beneficiary's interests and meets the following standards:

- It is not defined by others and may not be dependent upon the preferences of others.
- It is an opportunity to engage with the greater community in ways the beneficiary prefers.

The community integration goal will include the following:

- Areas of interest or activities the beneficiary enjoys doing or would like to do.
- The level of support needed or desired by the beneficiary and the basis of the need for that support (IPOS modification, the beneficiary's preference, etc.).
- When appropriate or necessary (as determined through the person-centered planning), the community integration goal will outline how the CMHSP and/or setting provider will ensure the beneficiary has a minimum of twice weekly meaningful community access. These outings will be consistent with the information in the IPOS related to interests and desires for community involvement.
- Community integration activities do not have to be facilitated by the CMHSP or setting provider when there is natural support or other means to meet the beneficiary's goals. This information should be identified in the IPOS.
- When a beneficiary has the ability to come and go from the setting as they choose without support, has access to the greater community, and prefers to engage in activities without the support of the CMHSP or setting, this will be

clearly documented in the IPOS. Additional planning related to community integration is not required.

The PIHP/CMHSP will monitor the community integration goal for all beneficiaries. This will occur through regular review of activity/outing logs. Reviews will assess the following:

- The identified support level continues to be appropriate.
- The need to develop more robust support consistent with changes in the beneficiary's needs or desires.
- Regular access to meaningful activities (no less than twice weekly) occurs.
- Meaningful activities are based upon the beneficiary's desires and are consistent with HCBS requirements.

iv. Qualities of an HCBS Compliant IPOS

The IPOS must be written in plain language that is easily understood by the beneficiary and is written at a reading level consistent with the beneficiary's ability. It should be free from clinical jargon to the extent possible and be understandable by beneficiaries and those with limited English proficiency in accordance with federal law. It should reflect a robust discussion of the beneficiary's goals, interests and desires and include goals and objectives to indicate such. The IPOS is signed (or otherwise agreed to) by the beneficiary regardless of guardianship status.

IV. Characteristics of a Home and Community-Based Setting

Beneficiaries receiving Medicaid HCBS shall enjoy the same rights, protections and assurances in all living arrangements as those not receiving Medicaid HCBS. A beneficiary's private home is presumed to be compliant with home and community-based requirements. All home and community-based services and supports provided to Medicaid beneficiaries must be provided in compliance with the HCBS Final Rule regardless of the type of setting in which they are provided.

A. Residential Settings

Requirements for residential settings apply to provider-owned or -controlled settings.

i. Meals

Beneficiaries 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 beneficiary must have access to food and drink that they prefer when they choose.

ii. Visitors

Beneficiaries must be allowed to have visitors of their choosing at any time and have the right to visit privately.

iii. Lockable Doors

Residential settings must have bedroom and bathroom doors that are lockable by the beneficiary, 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.

iv. Freedom to Furnish and Decorate Room

Beneficiaries 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.

v. Choice of Roommate

Beneficiaries must have their choice of roommate if possible. In some circumstances, there may only be limited beds available at the residence so if the beneficiary chooses that setting, they may also be choosing that bed without the ability to choose the roommate. The beneficiary retains the right to request a new roommate or private room as availability allows.

vi. Freedom to Control Schedule, Activities and Resources

Beneficiaries must have freedom to control their own schedules, activities and resources to the extent they desire. This freedom should be supported and facilitated by the provider. If they choose to receive assistance, that should be provided as needed and desired by the beneficiary. Beneficiaries must be made aware of their right to decline to participate in any therapy or scheduled activity without fear of reprisal from the setting.

vii. Privacy

Beneficiaries must have privacy in their unit. This includes physical privacy as well as keeping any of the beneficiary's confidential information private. Beneficiaries must be allowed to close and lock their bedroom door as they wish for privacy. Protected health information and other confidential personal information must be stored in a locked area of the setting with access granted only to those who need it. Consistent with the right to privacy the use of video cameras is prohibited in HCBS

settings receiving Medicaid funding through Behavioral Health services and supports.

viii. Accessibility

Each setting must be physically accessible to the beneficiaries residing there so the beneficiaries may function as independently as they wish. Beneficiaries must be able to move around in the setting without physical barriers getting in their way. This is especially true for beneficiaries utilizing wheelchairs or those who require walking aids. Furniture must be placed in such a way that beneficiaries can easily move around it, with pathways large enough for a wheelchair, scooter or walking aids to navigate easily if beneficiaries with these types of mobility aids reside in the setting.

ix. Eviction and Appeals

Beneficiaries 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 beneficiary and that the lease or agreement provides protections that address eviction processes and appeals similar to that of landlord/tenant laws.

x. 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. House rules may not be added to a lease, resident care agreement or other document.

xi. Control of Personal Resource

The HCBS Final Rule requires that beneficiaries be able to control their personal resources. Settings may not require beneficiaries to give them control of their personal resources.

xii. Setting-Wide Restrictions

A setting-wide restriction is a requirement or removal of a right that is not based upon a beneficiary's health or safety needs but is a function of living or receiving services in the setting. Restrictions or modifications of a beneficiary’s right consistent with the HCBS Final Rule may not be implemented unless the HCBS modification requirements have been met in full and are in the beneficiaries’ IPOS.

xiii. Freedom of Movement

Beneficiaries must have the ability to move freely within the setting and into the greater community as desired. Any restrictions upon this freedom of movement must be authorized by the individual IPOS consistent with the HCBS modification requirements identified in the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter of the MDHHS Medicaid Provider Manual.

Included in the ability to move freely is the ability to move within or outside of the setting without this movement being monitored or restricted through the use of delayed egress door/window systems or alarms of any kind. This does not include the use of security systems utilized to keep beneficiaries within the home safe.

B. Requirements for Non-Residential Settings

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

i. Skill-Building Assistance

Skill-building assistance must provide opportunities for beneficiaries to develop or learn skills to successfully engage in meaningful activities in the community, such as school, work or volunteering. This service assists beneficiaries with increasing self-sufficiency and can be a pathway that leads to competitive integrated employment.

ii. Community Living Supports

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

Refer to the Home and Community-Based Services chapter of the MDHHS Medicaid Provider Manual for further detail regarding characteristics of a home and community-based setting.

V. Settings Not Compliant with the HCBS Final Rule Requirements

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

- Nursing facilities
- Institutions for mental disease

- Intermediate care facilities for beneficiaries with intellectual disabilities
- Hospitals
- Other locations that have characteristics of an institution (e.g., Child Caring Institutions)

VI. Reverse Integration

According to the HCBS Final Rule, reverse integration does not make a setting home and community based. Reverse integration is when the setting brings providers into the setting from the community instead of taking the beneficiary 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 beneficiaries receiving services. Beneficiaries must also have the option to go out into the community and participate with providers of their choice.

VII. Heightened Scrutiny

The State of Michigan and CMS have a process for “heightened scrutiny” which consists of an additional review of settings that appear to be non-compliant with the HCBS Final Rule including those that may appear to be isolating or to have setting-wide restrictions on the freedoms of Medicaid beneficiaries.

MDHHS is responsible for determining if a setting qualifies for the “heightened scrutiny” process or can be found compliant with the HCBS Final rule.

VIII. 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 made after the setting is built and has been operational with residents or beneficiaries receiving services in order for the evaluating entity to have a full understanding of the beneficiary’s experience while participating with the setting.

Effective March 17, 2023, all settings/providers must be fully compliant with the HCBS Final Rule in order to render HCBS to Medicaid beneficiaries.

New residential providers must demonstrate all of the characteristics of the HCB requirements in order to be eligible to provide HCBS to Medicaid beneficiaries.

IX. 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 the MDHHS Medicaid Provider Manual for specific requirements unique to that program.

X. HCBS Training Requirements

All HCBS service providers must attend and participate in MDHHS-developed HCBS training initially or upon hire and annually thereafter.

- All case managers and/or supports coordinators will attend the required HCBS Case Manager training developed by MDHHS and implemented by the PIHP HCBS Regional Leads. Compliance will be monitored through MDHHS' annual site review.
- All Setting Service Providers, including program management and direct service professionals, must attend the required direct service provider training developed by MDHHS and implemented by the PIHP HCBS Regional Leads initially or upon hire and annually thereafter as determined by MDHHS. Compliance will be monitored through MDHHS' annual site review.