MEDICAID POLICY INFORMATION SHEET

Policy Analyst: Heather Hill

Phone Number: 517-241-3999

Initial ☐ Public Comment ☒ Final ☐

Brief description of policy:

This policy describes the process related to appeals for involuntary discharges in provider owned/controlled residential settings (e.g., Adult Foster Care, Homes for the Aged, unlicensed assisted living, etc.) for individuals enrolled in one of the affected programs. This policy is in response to requirements under the Home and Community Based Services (HCBS) Final Rule released by the Centers for Medicare & Medicaid Services (CMS).

Reason for policy (problem being addressed):

To update the HCBS Medicaid Provider Manual chapter to comply 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 - Section 1915(c) of the Social Security Act and CMS 2249-F/2296-F.

Does policy have operational implications on other parts of MDHHS?

Yes - MI Choice Waiver, MI Health Link HCBS Waiver, Habilitation Supports Waiver, Managed Specialty Services & Supports Waiver.

Does policy have operational implications on other departments?

Yes, the Department of Licensing and Regulatory Affairs (LARA)/MOAHR will be involved in the appeal process if appeals are requested. MOAHR staff assisted with development of the notices and appeal request.

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: 2225-HCBS	**Date:** October 6, 2022

Comments Due: November 10, 2022
Proposed Effective Date: January 1, 2023
Direct Comments To: Heather Hill
Address:
E-Mail Address: Hillh3@michigan.gov
Phone: 517-241-3999 **Fax:**

Policy Subject: Appeals for Involuntary Discharges for Home and Community-Based Services (HCBS) Programs

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

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

Summary: This policy describes the process related to appeals for involuntary discharges or transfers in provider owned/controlled residential settings (e.g., Adult Foster Care, Homes for the Aged, unlicensed assisted living, etc.) for individuals enrolled in one of the affected programs. This policy is in response to requirements under the HCBS Final Rule released by the Centers for Medicare & Medicaid Services (CMS).

Purpose: To comply with the HCBS Final Rule.

Cost Implications: Budget neutral

Potential Hearings & Appeal Issues: There may be appeals forthcoming related to involuntary discharges or transfers.

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**

Comment001 **Revised 6/16**

Proposed Policy Draft

Michigan Department of Health and Human Services
Behavioral & Physical Health and Aging Services Administration

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

Issued: December 1, 2022 (Proposed)

Subject: Appeals for Involuntary Discharges for Home and Community-Based Services (HCBS) Programs

Effective: January 1, 2023 (Proposed)

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

This policy provides additional requirements pertaining to appeals for involuntary discharges to be added to the Home and Community Based Services Chapter of the Michigan Department of Health and Human Services (MDHHS) Medicaid Provider Manual. This policy change is required to comply with federal requirements for HCBS programs.

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 and includes requirements that individuals receiving Medicaid HCBS must be allowed protections comparable to State landlord tenant laws for residential settings that do not otherwise fall under those laws. This policy establishes the resident notification and appeals procedures related to non-emergency involuntary discharge and emergency involuntary discharge for provider owned/controlled residential settings.

As applicable, all providers of the affected programs must comply with these requirements.

Appeals for Involuntary Discharges

Non-Emergency Involuntary Discharge

(1) An individual who receives HCBS must not be involuntarily discharged by a residential setting without 30 calendar days advance written notice to the individual, the legal representative of the individual, and the placing agency stating the reasons for the non-emergency involuntary discharge. The placing agency must provide the individual and the legal representative of the individual with information in writing about the individual's rights to request a hearing which will be held in accordance with the Michigan Office of Administrative Hearings and Rules (MOAHR) Uniform Hearing Rules R 792.11001-792.11018. Individuals may only be involuntarily discharged by a residential setting for the following reasons:

(a) Behavior that poses a significant danger to the individual or others;
(b) The care needs of the individual exceed the ability of the provider; or
(c) Failure to make payment for care and services.

(2) The notice required by subsection (1) must be on the Notice of Non-Emergency Involuntary Discharge (MDHHS-5897) form and completed in its entirety by a representative from the residential setting. The Notice must include a copy of the Request to Appeal a Notice of Involuntary Discharge form (MDHHS-5899).

(3) The individual has the right to request a hearing to challenge the decision to discharge against his or her wishes. The individual or legal representative may file a request for a hearing utilizing MDHHS-5899 with the Michigan Office of Administrative Hearings and Rules (MOAHR) within 10 calendar days after receiving the notice indicated above (MDHHS-5897). If a hearing is requested, it will be held within seven calendar days after the request is received by MOAHR. The residential setting cannot discharge an individual during that time. If the individual loses the hearing, there will be no discharge until at least 30 calendar days after the individual received the notice of discharge.

(4) The individual has an opportunity to review any proposed placement prior to a discharge.

Emergency Involuntary Discharge

(1) An individual who receives HCBS can receive an emergency involuntary discharge in the following situations:

(a) Substantial risk to the individual due to the inability of the residential setting to meet the individual's needs or ensure the safety and well-being of other residents of the residential setting;
(b) Substantial risk, or occurrence of self-destructive behavior; or
(c) Substantial risk, or occurrence of destruction of property.

(2) Before discharging an individual for an emergency involuntary discharge, the residential setting must consult with the placing agency regarding the proposed emergency involuntary discharge to determine if additional services and supports can be provided to avoid the need for an emergency involuntary discharge.

(3) The residential setting must notify in writing the individual, the individual's legal representative, the placing agency and the adult foster care licensing consultant not less than 24 hours before the discharge. This notice must be on the Notice of Emergency Involuntary Discharge (MDHHS-5898) form and completed in its entirety by a representative from the residential setting. The notice must include a copy of the Request to Appeal a Notice of Involuntary Discharge form (MDHHS-5899)

(4) The individual or legal representative has the right to request a hearing to challenge the decision to discharge against his or her wishes. The placing agency must provide the individual and the legal representative of the individual with information in writing about the individual's rights to request a hearing which will be held in accordance with the Michigan

Office of Administrative Hearings and Rules (MOAHR) Uniform Hearing Rules R 792.11001-792.11018. The individual or legal representative may file a request for a hearing (MDHHS-5899) with MOAHR within 10 calendar days after receiving this notice (MDHHS-5898). If a hearing is requested, it will be held within seven calendar days after the request is received by MOAHR.

(5) The individual cannot be discharged until an appropriate setting is found that meets the individual's needs.

(6) If the individual requests a hearing with MOAHR challenging the emergency involuntary discharge and MOAHR finds the individual was improperly discharged, the individual has the right to elect to return to the first available bed in the residential setting.

HOME AND COMMUNITY BASED SERVICES (HCBS) RECIPIENTS (RESIDENTS)
NOTICE OF NON-EMERGENCY INVOLUNTARY DISCHARGE

Michigan Department of Health and Human Services

Date and Time Delivered to Resident	Date and Time Delivered to the Legal Representative (if applicable)	Date and Time Delivered to the Placing Agency

Resident Name	Guardian/Legal Representative	
Facility Name	Placing Agency	
Facility Contact Person	Contact Person Title	
Facility Address	Contact Person's Phone Number	
City	State	Zip Code

THIS NOTICE IS TO ADVISE YOU THAT YOU WILL BE DISCHARGED

Effective date of discharge (minimum 30 days from this notice)

Reason for Non-Emergency Involuntary Discharge

- ☐ Behavior that poses a significant danger to the resident or others;
- ☐ The care needs of the resident exceed the ability of the provider;
- ☐ Failure to make payment for care and services.

Explanation of Reason Above

You have the right to request a hearing to challenge the decision to discharge you against your wishes. If you think you should not have to leave this facility, you may file a request for a hearing with the Michigan Office of Administrative Hearing and Rules (MOAHR) within 10 calendar days after receiving this notice.

If you request a hearing, it will be held not sooner than 7 calendar days with a decision rendered within 14 calendar days after the filing of the hearing request. You will not be discharged during that time. If the judge decides that the proposed discharge is proper, you will not be discharged until at least 30 calendar days after you receive the original notice of discharge.

A form to request a hearing shall be provided to you by the facility at the time of this notice.

You have the right to review any proposed placement prior to your discharge.

If you decide to appeal, mail the request for hearing form to:

Michigan Office of Administrative Hearing and Rules (MOAHR)
PO Box 30763
Lansing, MI 48909

Or you may fax your appeal to:

Fax: 517-763-0146

Before the hearing you or your representative will be able to see any of the facility's records pertaining to you. At the hearing you may speak for yourself; hire an attorney at your expense; or use a relative, friend or other person of your choice. You or your representative will be able to have witnesses at the hearing to speak on your behalf.

The facility is required to send a copy of this notice to your guardian or legal representative (if applicable) and your placing agency.

Signature of Facility Representative	Date

cc

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

HOME AND COMMUNITY BASED SERVICES (HCBS) RECIPIENTS
NOTICE OF EMERGENCY INVOLUNTARY DISCHARGE

Michigan Department of Health and Human Services

Date and Time Delivered to Resident	Date and Time Delivered to the Legal Representative (if applicable)
Date and Time Delivered to the Placing Agency	Date of Consultation*

Resident Name	Guardian/Legal Representative	
Facility Name	Placing Agency	
Facility Contact Person	Contact Person Title	
Facilty Address	Contact Person's Phone Number	
City	State	Zip Code

THIS NOTICE IS TO ADVISE YOU THAT YOU WILL BE DISCHARGED

Effective date of discharge (minimum 24 hours from this notice):

Reason for Emergency Involuntary Discharge:

- ☐ Substantial risk to the client due to the inability of the facility to meet the client's needs or assure the safety and wellbeing or the other residents of the facility;
- ☐ Substantial risk, or occurrence of self-destructive behavior;
- ☐ Substantial risk, or occurrence of destruction of property.

Explain the reason for discharge above including the specific nature of the substantial risk:

Explain the alternatives to discharge that have been attempted by the facility:

Provide the location the client will be discharged to, if known:

*Date of consultation with the placing agency to determine if additional service and supports can be provided to avoid the need for an emergency involuntary discharge.

You have the right to request a hearing to challenge the decision to discharge you against your wishes. If you think you should not have to leave this facility, you may file a request for a hearing with the Michigan Office of Administrative Hearings and Rules (MOAHR) within 10 calendar days after receiving this notice.

If you request a hearing, it will be held within 7 calendar days after your request. If you are successful at the hearing, you have the right to elect to return to the first available bed in the facility.

You cannot be discharged until an appropriate setting is found that meets your needs.

A form to request a hearing shall be provided to you by the facility at the time of this Notice.

If you decide to appeal, mail the form to request a hearing to:

Michigan Office of Administrative Hearings and Rules
PO Box 30763
Lansing, MI 48909

Or you may fax your appeal to:

Fax: 517-763-0146

Before the hearing you or your representative will be able to see any of the facility's records pertaining to you. At the hearing you may speak for yourself, hire an attorney at your expense or use a relative, friend or other person of your choice. You or your representative will be able to have witnesses at the hearing to speak on your behalf.

The facility is required to send a copy of this notice to your guardian or legal representative (if applicable) and your placing agency.

Signature of Facility Representative	Date

cc:

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

HOME AND COMMUNITY BASED SERVICES (HCBS) RECIPIENT (RESIDENT) HEARING REQUEST TO APPEAL A NOTICE OF INVOLUNTARY DISCHARGE

Michigan Department of Health and Human Services

This form is to request a hearing due to a Notice of Involuntary Discharge for HCBS recipients (residents) only. This request must be sent to the Michigan Office of Administrative Hearings and Rules (MOAHR) within 10 calendar days of the Notice of Involuntary Discharge. If you have questions, please call 800-648-3397.

SECTION 1

Type or Print

Resident Requesting Hearing		
Address Where Resident Wants Hearing Correspondence Mailed To		
City	State	Zip Code
Resident/Guardian/DPOA Daytime Telephone Number		
Facility Name	Facility Representative	
Facility Street Address		
City	State	Zip Code
Telephone Number	Date when Notice of Involuntary Discharge was received	
Signature of Person Requesting Appeal (typing your name acts as an electronic signature) **x**		**Date**

Relationship to Resident

☐ Resident ☐ Durable Power of Attorney for Resident ☐ Guardian

SECTION 2 - Has the Resident chosen someone to represent them at the hearing?

Has someone agreed to represent the Resident at the hearing?

☐ No

☐ Yes, If Yes, have the representative complete and sign Section 3 on the next page)

SECTION 3 – Authorized Hearing Representative Information

Name of Representative	Representative Telephone Number	Date Signed
Representative Address (No. & Street, Apt. No.)		
City	State	Zip Code
Representative Signature		Date

INSTRUCTIONS

A hearing is an impartial review of a decision made by the Michigan Department of Health and Human Services or one of its contracted providers that a resident believes is wrong.

General Instructions

- Read **ALL** instructions before completing the attached form.
- Complete the form completely (even if the Resident has a guardian or is a minor).
- Attach a copy of the notice or letter from the Agency that told the Resident about the change that is being appealed.
- Please make a copy for your records.
- Questions can be answered by calling toll free: **877-833-0870**.
- After the form is completed, mail or fax to:

MICHIGAN OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
PO BOX 30763
LANSING MI 48909
Fax: 517-763-0146

- The Resident may speak for themselves; hire an attorney at their expense; or use a relative, friend or other person of their choice.
  - This person can be anyone the Resident chooses but he/she must be at least 18 years of age.
  - The Resident MUST give this person written permission to represent them.
  - The Resident may give written permission by checking **YES** in **SECTION 2 and having the person who is representing them complete SECTION 3. The Resident MUST still complete and sign SECTION 1.**
  - The Resident's guardian or conservator may represent them. **A copy of the court order naming the guardian must be included with this request.**

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.