

Michigan Department of Health and Human Services;
Behavioral Health and Developmental Disabilities

UPDATE ON PERSON-CENTERED PLANNING GUIDELINE CHANGES

ELLEN SUGRUE HYMAN

Self-Determination Coordinator

MILLIE SHEPHERD

HCBS Specialist

New Federal Rule

HOME AND COMMUNITY BASED RULE

Published in the Federal Register on January 16, 2014

Title:

Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice (Section 1915(k) of the Act) and Home and Community-Based Services (HCBS) Waivers (Section 1915(c) of the Act)

Implementing Michigan's Person-Centered Planning Policy

- MDHHS has revised the Person-Centered Planning Policy to include both the spirit, and the PCP requirements of the HCBS Final Rule
- The policy has been rewritten using plain language guidelines
- CMS requires immediate Compliance. PCP policy is not part of Transition Plan

CMS Intent of the HCBS Final Rule

- To ensure that individuals receiving long-term services and supports through home and community based service (HCBS) programs under the **1915(c), 1915(i) and 1915(k)** Medicaid authorities have full access to the benefits of community living and the opportunity to receive services in the most integrated setting appropriate
- To enhance the quality of HCBS and provide protections to participants

Intent of the HCBS Final Rule

- Ensure that individuals have full access and freedom of movement within their homes and in their communities.
- Improve individuals access to the community
- Support individuals in making decisions about their lives

HCBS Final Rule PCP Requirements

- The setting is **chosen by the individual and is integrated in, and supports full access to the greater community**
- Individuals have opportunities to **seek employment and work in competitive integrated settings**
- Individuals are encouraged and supported in **engaging in community life, controlling personal resources, and receiving services in the community to the same degree of access as individuals not receiving Medicaid HCBS**

Modifications to the Requirements of the Rule

In order to be considered home and community based settings and providers must meet guidelines as identified by CMS. Any modification must be outlined in the individual's person centered plan.

Health or safety needs are the only acceptable justifications for restricting individual rights and freedoms and must follow these guidelines:

- **Identify a specific and individualized assessed safety or health related need**
- **Positive interventions and supports used prior to modification**
- **Less intrusive methods tried**

Modifications continued

- Describe the condition that is directly proportionate to the specified need
- Regular collection and review of data to review effectiveness
- Established time limits for periodic review to determine if modification is still needed
- Informed consent of the individual
- Assure interventions and supports will cause no harm

Person Centered Planning

Written plan reflects –

- Individual's strengths and preferences
- Clinical and support needs
- Includes goals and desired outcomes
- Providers of services/supports, including unpaid supports provided voluntarily in lieu of waiver or state plan HCBS
- Risk factors and measures in place to minimize risk
- Individualized backup plans and strategies when needed
- Individuals important in supporting individual
- Individuals responsible for monitoring plan

Person Centered Planning

Written plan reflects (continued) -

- Plain language and understandable to the individual
- Informed consent of the individual in writing
- Includes purchase/control of self-directed services
- Exclude unnecessary or inappropriate services and supports
- Modification of the additional conditions as previously discussed in the home and community-based setting requirements
- Must be reviewed, and revised upon reassessment of functional need as required every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

Cultural Considerations

- A person's cultural background is recognized and valued in the PCP process. Cultural background may include language, religion, values, beliefs, customs, dietary choices and other things chosen by the person. Linguistic needs, including ASL interpretation, are also recognized, valued and accommodated.

Strategies for Solving Disagreements

- Includes strategies for solving conflict or disagreement within the process including clear conflict of interest guidelines for all planning participants

Development and Documentation of Goals and Outcomes

- Goals must be documented in the person's and/or representative's own words, with clarity regarding the amount, duration, and scope of HCBS that will be provided to assist the person
- Goals will consider the quality of life concepts important to the person
- The plan must be prepared in person-first singular language and be understandable by the person and/or representative

Community Inclusion and Integration

- The [PIHP/CMHSP] must ensure that the setting chosen by the individual is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in 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 Medicaid HCBS. (ACA)
- Employment and housing in integrated settings must be explored, and planning should be consistent with the individual's goals and preferences, including where the individual resides, and who they live with. (HCB)

Documentation of Individual Strengths

- The PCP approach identifies the person's strengths, goals, preferences, needs (medical and HCBS) and desired outcomes. In order to be strengths-based, the positive attributes of the person must be considered and documented at the beginning of the plan.
- Strengths-based approach to identifying positive attributes of the person must be used , including an assessment of the persons strengths and needs.

Documentation of Preferences

- Preferences may include: family and friends, housing, employment, community integration, behavioral health, culture, social activities, recreation, vocational training, relationships, language and health literacy and other community living choice.
- Personal preferences must be used to develop goals and to meet the person's HCBS needs.

Assessment

Assessments may be used to inform the PCP process, but is not a substitute for the process. Functional assessments must be undertaken using a person-centered approach. The functional assessment and the PCP process together should be used as a basis for identifying goals, risks, and needs; authorizing services, utilization management and review. No assessment scale or tool should be utilized to set a dollar figure or budget that limits the person-centered planning process.

Information Provided on Services and Supports

People must be offered information on the full range of HCBS available to support achievement of personally-identified goals. The person or representative must be central in determining what available HCBS are appropriate and will be used.

Plan Reflects Paid and Unpaid Supports and Services

- The PCP process often results in quality of life goals that exceed the ability of any set of program-specific services and supports to fully met them
- Therefore, the PCP process must not be limited by program specific functional assessments
- The plan must describe the services and supports that will be necessary and specify what HCBS are to be provided through various resources including natural supports, to meet the goals in the PCP
- The specific person or persons, and/or provider agency or other entity providing services and supports must be documented
- Non-paid supports and items needed to achieve the goals must be documented

Documentation of Choice Where to Live

The chosen setting must be integrated in and support full access to the greater community, including opportunities to seek employment and work in 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 HCBS

Wellness and Well-Being

- Issues of wellness, well-being, health and primary care coordination support needed for the person to live the way he or she want to live are discussed and plans to address them are developed.
- People are allowed the dignity of risk to make health choices just like anyone else in the community (such as, but not limited to, smoking, drinking soda pop, eating candy or other sweets)
- If the person chooses, issues of wellness and well-being can be addressed outside of the PCP meeting
- PCP highlights personal responsibility including taking appropriate risks. The plan must identify risks and risk factors and measures in place to minimize them, while considering the person's right to assume some degree of personal risk
- The plan must assure the health and safety of the person. When necessary, an emergency and/or back-up plan must be documented and encompass a range of circumstances (e.g. weather, housing, support staff)

Documentation of Restrictions on a Person's Rights and Freedom

Any effort to restrict the right of a person to realize preferences or goals must be justified by a specific and individualized assessed safety need and documented in the PCP.

Independent Facilitation

- Language on Independent Facilitation Expanded
- Based on IF Workgroup Recommendations (chaired by Jill Gerrie, The Arc Michigan)

CMS Website – the URL

CMS has a website with all of their materials, guidance, and the toolkit. They update this webpage as new materials are developed so watch the site regularly.

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html>

Contact Information

Person Centered Planning

Ellen Sugrue Hyman

Self-Determination Coordinator

Michigan Department of Health and Human Services

Behavioral Health and Developmental Disabilities Administration

HymanE@Michigan.gov

For communications related to the final rule please contact:

Michigan Department of Health and Human Services

Behavioral Health and Developmental Disabilities Administration

Home and Community Based Services

HCBS Transition Team

HCBS@Michigan.gov