Settings Rule Updates and Person Centered Service Plans

What is the Settings Rule?

- Law describing characteristics of home and community based services and providers
- Ensures participants' rights to dignity, respect, privacy, and freedom from coercion and restraint
- Focuses on day to day lives of participants and physical traits of settings in which they live, work, and spend time

Sites Impacted on A&D Waiver

- Assisted Living
- Adult Day Services
- Adult Family Care
- Structured Family Care (provider owned and controlled only)
- Supportive Employment
- Structured Day Programs

Settings Rule Timeline

- Passed by CMS in 2014
- Statewide Transition Plan approved 2022
- Transition period expires March 17, 2023

Compliance Process

- **Site Visit**
  - Assess physical site
  - Interview with staff
  - Interview with Medicaid participant
- **Desk Review**
  - Person-centered service plans
  - Leases and supporting documents for residential sites
  - IDOH waiver for Assisted Living sites
  - Staff and participant training
- **Heightened Scrutiny Process**

Compliance Issues

- **Physical accessibility**
  - Front-loading washers
  - Automatic doors
- **Lease issues**
  - Limitations on visitors
  - Referral procedures
  - Lease termination practices
  - Landlord/tenant laws
- **Privacy**
  - Privacy in bedrooms
  - Locking bedroom/bathroom doors
  - Staff entering apartment
- **Other**
  - Terms of endearments (like “sweetie” and “hon”) instead of preferred name
  - Food at any time

IC/IAC/DOH Regulations

- Amending IC and IAC to comply with Settings Rule
  - Readoption of current rules
  - Amending rules
- DOH amending licensure rules to comply with Settings Rule

Affiliated Projects

Settings Rule Grant

- Flat rate for residential and non-residential settings
- $50/Medicaid recipient
- Contingent upon March 17 compliance

Communication Projects

- “What Comes Next” after site visit
- Staff training
- Webinar for families of Adult Day participants

Ongoing Compliance Monitoring

- Every three years
- Process still under development

Person-Centered Service Plans

- Seeking to strengthen alignment between IN process and CMS requirements
- Seeking advice from New Editions and Advancing States
- Discussions with care management team pending

Glossary of Terms

- Person Centered Service Planning
- Person Centered Thinking
- Person Centered Monitoring Tool (PCMT)
- Person Centered Service Plan
- Person Centered Support Plan

Historical Context and Where We Are Now

- 1980s – "person centered planning" language becomes mainstream
- Core tenets of all person centered practices models:
  - Person directed, with support as needed
  - Clearly identifies strengths, gifts and positive attributes, as well as needs
  - Prioritizes what is important to the person, balanced with what the person needs to be healthy and safe
  - Balances choice, opportunities and control

Person Centered Planning

- Driven by the person, and must be individualized to the person
  - E.g., if you redacted the person's identifying information, could you tell one plan from another?
- Includes others chosen by the person, or their representative if the person cannot choose themselves
  - May include family, friends, or others invited by the person
  - May include members of the person's care team

Person Centered Planning

- Must include support the person needs to direct the process as much as possible
- Is timely – and occurs in a place and time that is convenient to the person and invited participants

Person Centered Planning

- Must identify what is important to the person in everyday life
  - E.g., routines, rituals, relationships, belongings, schedules, ways of maintaining control, communication preferences, etc.)
- Must identify supports needed to help the person be healthy and safe in a way that works for them
  - E.g., assistance with medication but on their schedule

Person Centered Planning

- Must be culturally relevant and responsive
  - Always ask the person and/or family how to do this!
- Must use plain language
  - No jargon
  - Limited clinical language
- The plan must identify strategies for resolving disagreements

HCBS Rights Modifications

- When someone does something that puts themselves or others at risk, we must assess the person's ability to take that risk
  - E.g., taking a walk around their neighborhood alone
- Can the person understand the upside and downside of that choice (the benefits or associated risks)?
- The plan must address support for "dignity of risk"

HCBS Rights Modifications

- Facilities/leadership/staff cannot make unilateral decisions about restricting someone's rights
- The facility must assess the person's ability to make the decision if it's considered risky
  - If upon admission, a facility is informed of a risk, they may act on that information while assessing and developing their approach
- If the person cannot understand the risk or cannot make the decision safely, the facility may implement a restriction

HCBS Rights Modifications

- The proposed restriction must be proportionate to the risk
  - E.g., it's not okay to restrict someone's right to go outside alone ever again simply because they fell one time
- The person's plan must reflect the specific restriction and the assessed rationale
  - In IN, this will be documented in the person-centered support plan
- There must be a plan and a timeline for attempting to restore the right to the person
- The plan must reflect alternatives tried – rights may not be modified without documenting an alternative approach

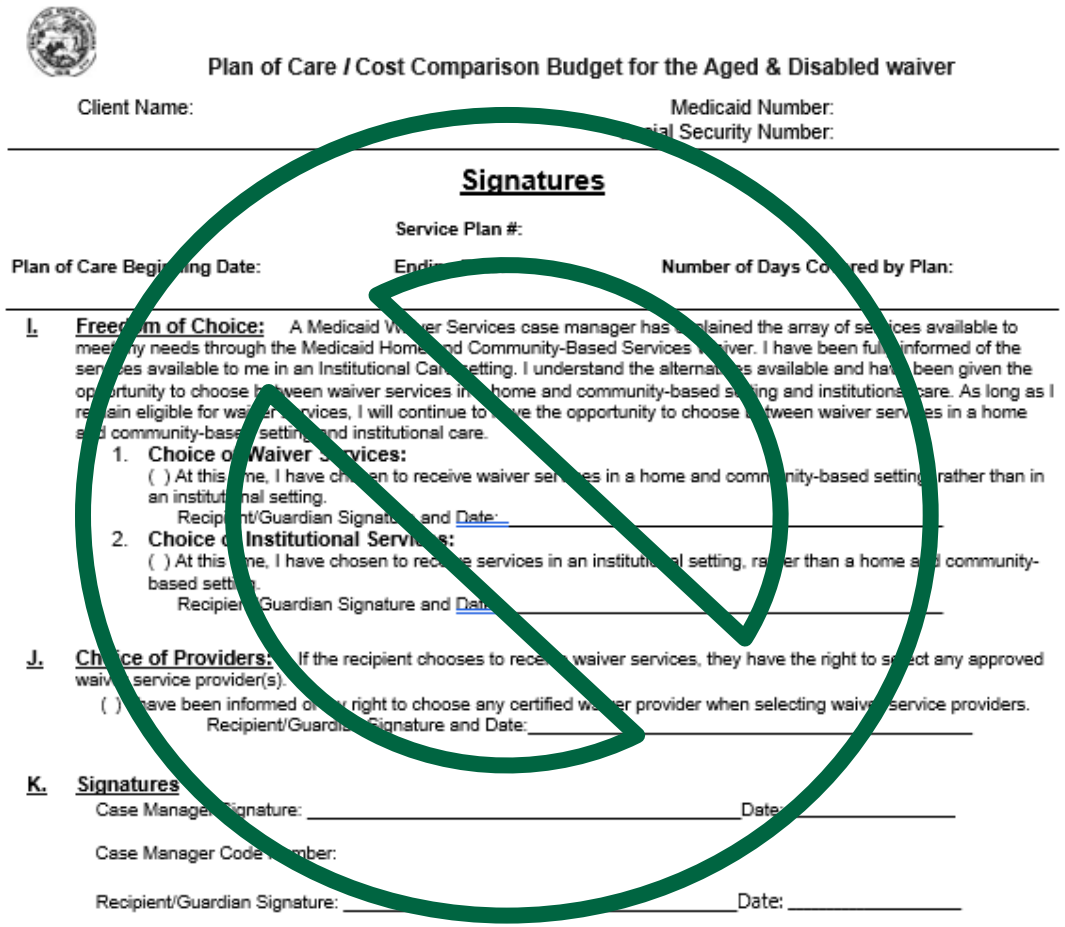
HCBS Rights Modifications

- **The plan must reflect informed consent:** the person has been made fully aware of the concern and the restrictions being suggested, and the person must consent to the restriction
- If the person does not agree:
  - Look to the plan to identify what to do if there are disagreements
  - Develop a detailed plan for helping the person:
    - Understand the risk and the associated issues, and
    - Have the opportunity to engage in their chosen "risk" with support
      - E.g., taking a walk, using the stove

Settings Rule in CaMSS:

Freedom of Choice:

- The form is expected to be explained and filled out initially and annually, and anytime there is a transition in settings type for all Individuals receiving AD, TBI and MFP waiver services.
- Document completion of the form in the service plan.
- The form does not need to be uploaded to CaMSS, but needs to be retained in the Individual's file.
- We are working on an updated Person Centered Support Plan which will include a signature for choice of providers.



Plan of Care / Cost Comparison Budget for the Aged & Disabled waiver

Client Name: Medicaid Number:

Social Security Number:

Signatures

Service Plan #:

Plan of Care Beginning Date: Ending Date: Number of Days Covered by Plan:

I. Freedom of Choice: A Medicaid Waiver Services case manager has explained the array of services available to meet my needs through the Medicaid Home and Community-Based Services Waiver. I have been fully informed of the services available to me in an Institutional Care setting. I understand the alternatives available and have been given the opportunity to choose between waiver services in a home and community-based setting and institutional care. As long as I remain eligible for waiver services, I will continue to have the opportunity to choose between waiver services in a home and community-based setting and institutional care.

1. **Choice of Waiver Services:**
   ( ) At this time, I have chosen to receive waiver services in a home and community-based setting, rather than in an institutional setting.
   Recipient/Guardian Signature and Date: _____
2. **Choice of Institutional Services:**
   ( ) At this time, I have chosen to receive services in an institutional setting, rather than a home and community-based setting.
   Recipient/Guardian Signature and Date: _____

J. Choice of Providers: If the recipient chooses to receive waiver services, they have the right to select any approved waiver service provider(s).
( ) I have been informed of my right to choose any certified waiver provider when selecting waiver service providers.
Recipient/Guardian Signature and Date: _____

K. Signatures

Case Manager Signature: _____ Date: _____

Case Manager Code Number:

Recipient/Guardian Signature: _____ Date: _____

- Old Form: No Longer in Use

STATEMENT FOR FREEDOM OF CHOICE
State Form 46016 (R8 / 4-02) / HCBS 0003

☐ Aged and Disabled ☐ Autism ☐ MFC ☐ TBI ☐ AL ☐ AFC ☐ DD ☐ SupSrv ☐ ICF / MR

A Medicaid Waiver Services case manager has explained the array of services available to meet my needs through the Medicaid Home and Community-Based Services Waiver.

SECTION I: CHOICE BETWEEN INSTITUTIONAL PLACEMENT AND HCBS WAIVER SERVICES

NOTE:This section should only be completed for individuals that are choosing institutional placement. Those recipients that are choosing waiver services will sign the Freedom of Choice statement on the HCBS Plan of Care / Cost Comparison Budget form.

SERVICES AVAILABLE

☐ NF / I ☐ NF / S ☐ Hospital ☐ ICF / MR ☐ NF/TBI ☐ NF/ AL ☐ NF/AFC

I have been fully informed of the services available to me in an institutional setting. I understand the alternatives available and have been given the opportunity to choose between waiver services in home and community-based settings and institutional care.

I understand that in order to be eligible for Medicaid Waiver Services, the costs of waiver services in home and community-based settings must comply with waiver programmatic cost-effectiveness.

As long as I remain eligible for waiver services, I will continue to have the opportunity to choose between waiver services in home and community-based settings and institutional care.

CHOICE OF SERVICE

☐ At this time, I have chosen to receive waiver services in home and community-based settings, rather than services in an institutional setting.

☐ At this time, I have chosen to receive services in an institutional setting, rather than waiver services in home and community-based settings.

SIGNATURES

Signature of recipient	Date signed (month, day, year)
Signature of: (check one) ☐ Family ☐ Guardian ☐ Witness	Date signed (month, day, year)
Signature of Case Manager	Date signed (month, day, year)

SECTION II: CHOICE BETWEEN HCBS WAIVER SERVICES AND MEDICAID MANAGED CARE

NOTE:This section should only be completed if a "Targeted" HCBS waiver applicant is currently on a Medicaid Managed Care program or if an HCBS waiver recipient wants transfer to a Medicaid Managed Care program (if eligible). An individual can not be on a HCBS waiver program and a Medicaid Managed Care program.

CHOICE OF PROGRAM

(To be completed after all eligibility determinations have been made.)

I have been fully informed of the array of services available under the HCBS Waiver program and the Medicaid Managed Care program.

☐ At this time, I have chosen to receive HCBS Waiver services, rather than Medicaid Managed Care services.

☐ At this time, I have chosen to receive Medicaid Managed Care services, rather than HCBS Waiver services.

SIGNATURES

Signature of recipient	Date signed (month, day, year)
Signature of: (check one) ☐ Family ☐ Guardian ☐ Witness	Date signed (month, day, year)
Signature of Case Manager	Date signed (month, day, year)

DISTRIBUTION: ☐ Original - Waiver Case File ☐ Copy - Recipient ☐ Copy - AAA Case File ☐ Copy - BDDS Case File *(Autism, ICF/MR Only)*

- Current Form: Use This One

STATEMENT FOR FREEDOM OF CHOICE

State Form 46016 (R8 / 4-02) / HCBS 0003

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SECTION I: CHOICE BETWEEN INSTITUTIONAL PLACEMENT AND HCBS WAIVER SERVICES

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SERVICES AVAILABLE

☐ NF / I ☐ NF / S ☐ Hospital ☐ ICF / MR ☐ NF/TBI ☐ NF/ AL ☐ NF/AFC

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As long as I remain eligible for waiver services, I will continue to have the opportunity to choose between waiver services in home and community-based settings and institutional ca[illegible].

CHOICE OF SERVICE

☐ At this time, I have chosen to receive waiver services in home and community-based settings, rather than services in an institutional setting.

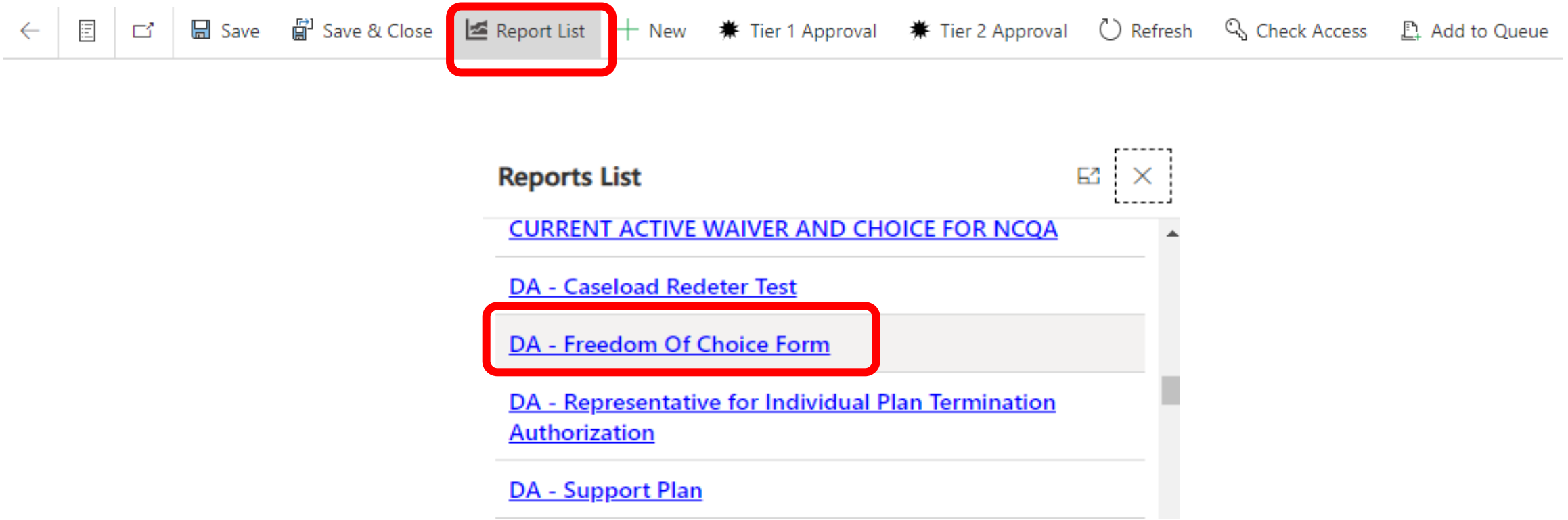
☐ At this time, I have chosen to receive services in an institutional setting, rather than waiver services in home and community-based settings.

SIGNATURES

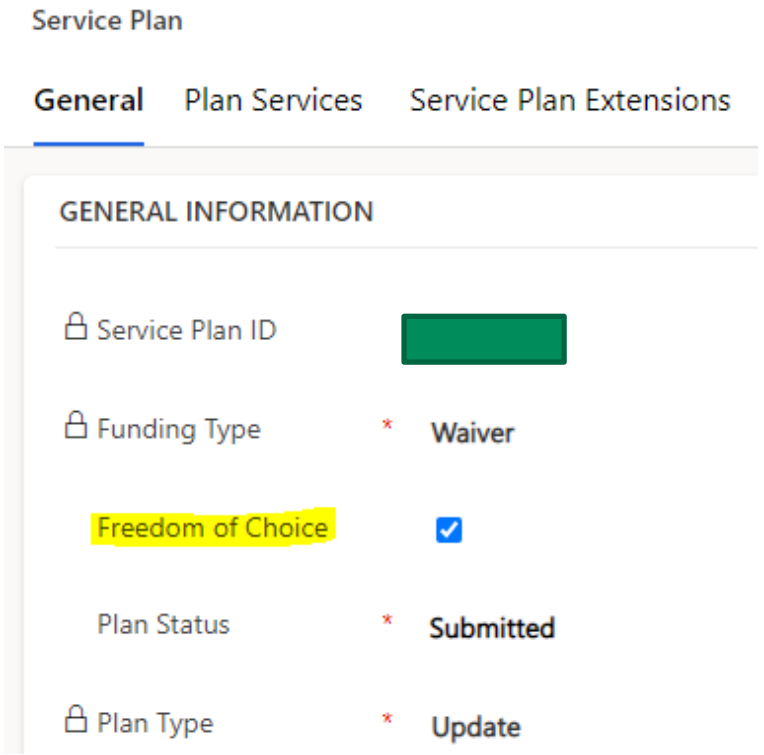
Signature of recipient Required	Date signed *(month, day, year)*
Signature of: *(check one)* ☐ Family ☐ Guardian ☐ Witness If Applicable	Date signed *(month, day, year)*
Signature of Case Manager Required	Date signed *(month, day, year)*

Reports: General Reports under DA

In Any Service Plan Record:



Documenting Freedom of Choice:



PCMT

Added:

Name on the PCMT form
New questions 14-18
- Does the staff treat the residents with dignity and respect?
- Is the individual able to choose where they eat without restrictions?
- Is the individual able to choose what they want to eat?
- Does the individual know how to file a complaint?

Removed:

Check boxes for questions 1-18:
- Settings Type
- Important To Important For
- Person Centered Discovery Tools
- Intervention

Anticipated effective date in CaMSS: March 26th:

Questions and Answer Time