Focus Group: Modifications and Restrictions
Cannon Health Building, Room 132
September 11, 2018

Welcome:

Introductions: Tell us your name and your connection to the modifications and restrictions process.

Purpose: To inform the State on how to best improve the modifications and restrictions process and preserve individual rights/preferences their settings.

Ground Rules:

- No right or wrong answers, just different points of view. We welcome comments for multiple perspectives.
- You don't need to agree with others, but you must listen respectfully as others share their views.
- We ask that you please turn off cell phones or put them on silent. If you cannot and must answer a call please do so quietly and rejoin us as quickly as you can.
- My role as the moderator will be to guide the discussion.
- Talk to each other.

The Settings Rule

Any modifications must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:

1. Identify a specific and individualized assessed need.
2. Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
3. Document less intrusive methods of meeting the need that have been tried but did not work.
4. Include a clear description of the condition that is directly proportionate to the specific assessed need.
5. Include regular collection and review of data to measure the ongoing effectiveness of the modification.
6. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
7. Include the informed consent of the individual.
8. Include an assurance that interventions and supports will cause no harm to the individual.

Controls on personal freedoms and access to the community cannot be imposed on a class or group of individuals. Restrictions or modifications that would not be permitted under the HCBS settings regulations cannot be implemented as "house rules" in any setting, regardless of the population served and must not be used for the convenience of staff.

Questions

1. What are we already doing successfully when modifications and restrictions need to be implemented? Specifically, what is working with:
    - the Human Rights review process?
    - the informed consent of the individual process?
    - how other individuals receiving services are able to circumvent the restriction?

2. What areas do we need to improve in? Specifically, what do we need to improve with:
    - the Human Rights review process?
    - the informed consent of the individual process?
    - how other individuals receiving services are able to circumvent the restriction?

3. What are the top 2-4 challenges in being able to implement modifications and restrictions successfully?

What other questions, concerns, or suggestions do you have for us?

1. What kind of training or guidance would you like to see from the State?
2. How can we better communicate with you?

Comments and CMS Responses regarding Modifications and Restrictions

Federal Register / Vol. 79, No. 11 / Thursday, January 16, 2014 / Rules and Regulations

Modifications based on assessed needs of an individual:

Comment: Several commenters strongly agreed with the proposed language requiring that should a provider choose to modify conditions, changes must be supported by documentation in the person's service plan. Another commenter expressed support of CMS' efforts to allow necessary flexibility to address individual circumstances in provider based settings, but urged CMS to allow flexibility in interpretation of the language, ''specific assessed'' need. Two commenters also expressed concern over this language, noting that in some instances residents may require services based on overall condition rather than a specific assessed need and suggested revision to this subsection of the rule.
Response: We acknowledge and appreciate support of the requirement that any modification of the conditions for provider-owned or controlled residential settings must be supported by a specific assessed need and documented in the person-centered service plan. **However, we disagree that such modification would be acceptable based on a condition that does not also result in a specific assessed need of an individual. Allowing for modifications based on a condition that is not also supported by a specific assessed need and documented in the person-centered service plan could result in decisions being made based on global assertions as opposed to individual need, and thus be contrary to the purpose of this section of the rule.** Therefore, we have not made the requested changes.

Comment: Comments supported the proposed language. We choose to address here similar comments on several sections of the proposed rule. Some commenters were concerned that in taking care to protect freedoms, the regulation did not provide for reducing risk due to certain kinds of disabilities.. Dementia was mentioned most often, with many examples of why some believe individual freedoms may need to be curtailed to prevent wandering, injury with cooking equipment and so on.
Response: Based on the comments received, we conclude that additional language is needed to ensure that reducing risk for individuals receiving Medicaid HCBS does not involve abridgement of their independence, freedom, and choice either generally or at the spontaneous decision of persons providing services and supports. **Restricting independence or access to resources is appropriate only to reduce specific risks, and only when considered carefully in the person-centered service plan. The person-centered planning process required in this regulation will engage the individual and others involved in the planning process as fully as possible in making these difficult but necessary decisions.** As comments indicated, there may be a need for immediate action in emergent or changing circumstances—that is the purpose of backup strategies. In thinking through risk, the planning team will identify temporary measures to be used if needed, and then update the plan when needs have stabilized. Back-up strategies are to be individualized to the unique mix of risks, strengths, and supports represented by each waiver participant We will articulate this in the final rule by amending the language at § 441.301(c)(2)(vi) to read: ''Reflect risk factors and measures in place to minimize them, including individualized backup plans and strategies when needed.'' We have also added at § 441.301(c)(2)(xiii) that any modification of the additional conditions must be supported by a specific assessed need and justified in the person-centered service plan, and specified what must be documented in the person-centered service plan in these instances.

FAQs concerning Medicaid Beneficiaries in Home and Community-Based Settings who Exhibit Unsafe Wandering or Exit-Seeking Behavior
December 15, 2016

Q2: Can provider-controlled settings with Memory Care Units with controlled-egress comply with the new Medicaid HCBS settings rule? If so, what are the requirements for such settings?

A2: **Yes, but only if controlled-egress is addressed as a modification of the rules defining home and community-based settings**, with the state ensuring that the provider complies with the requirements of 42 C.F.R. 441.301(c)(4)(F), 441.530(a)(vi)(F) and 441.710(a)(vi)(F). Any setting using controlled-egress should assess an individual that exhibits wandering (and the underlying conditions, diseases or disorders) and document the individual's choices about and need for safety measures in his or her person-centered care plan. The plan should document the individual's preferences and opportunities for engagement within the setting's community and within the broader community.

Settings with controlled-egress should be able to demonstrate how they can make individual determinations of unsafe exit-seeking risk and make individual accommodations for those who are not at risk. Should a person choose a setting with controlled-egress, the setting must develop person-centered care plans that honor autonomy as well as minimize safety risks for each person, consistent with his or her plan goals. For example, spouses or partners who are not at risk for exit-seeking and who reside in the same setting should have the ability to come and go by having the code to an electronically controlled exit. Technological solutions, such as unobtrusive electronic pendants that alert staff when an individual is exiting, may be used for those at risk, but may not be necessary for others who have not shown a risk of unsafe exit-seeking. Importantly, such restrictions may not be developed or used for non-person-centered purposes, such as punishment or staff convenience.

In situations where a setting uses controlled-egress on an individual basis to support individuals who wander or exit-seek unsafely, consistent with our regulations, the person-centered plan must document the individual's:

- Understanding of the setting's safety features, including any controlled-egress,
- Choices for prevention of unsafe wandering or exit-seeking
- Consent from the individual and caregivers/representatives to controlled-egress goals for care
- Services, supports, and environmental design that will enable the individual to participate in desired activities and support their mobility
- Options that were explored before any modifications occurred to the person-centered plan

Regulations require the person-centered plan to be reviewed at least annually with the Medicaid beneficiary and his or her representative, to determine whether it needs revision. If a secured memory unit is no longer necessary to meet the individual's needs, the individual must be afforded the appropriate services in that setting to integrate into the community and exercise greater autonomy as well as being offered the option of a setting that does not have controlled egress.

To assure fidelity in complying with the regulations defining home and community-based settings, Memory Care Units should attempt to implement as many options as possible that are outlined within this guidance regarding staffing, activities and environmental design to assure optimal community integration for HCBS beneficiaries.

Note that the regulations provide that Medicaid beneficiaries receiving services in home and community-based settings must be free from coercion and restraint. Consistent with this, home and

community-based settings should not restrict a participant within a setting, unless such restriction is documented in the person-centered plan, all less restrictive interventions have been exhausted, and such restriction is reassessed over time.

HCBS FINAL REGULATIONS QUESTIONS AND ANSWERS REGARDING HOME AND COMMUNITY- BASED SETTINGS

Q3: How can modifications to the home and community-based settings requirements be appropriately used in the person-centered service planning process?

A3: **The modifications section of the rule is a tool allowing providers to serve individuals with the most complex needs in integrated community settings to ensure that the setting supports the health and wellbeing of the individual beneficiary and those of people around them.** For example, providers in many states serve individuals with severe pica behavior (compulsive eating of non-food items), for whom the physical environment may need to be tightly controlled to prevent the occurrence of individual behavior that can cause severe injury or death. In addition, some community providers support individuals with a history of sexual predation where line-of-sight supervision and limits on interaction with certain members of the community may need to be imposed. Other community providers serve individuals with dementia for whom measures must be taken to account for safety needs in a person-centered manner, including concerns related to wandering. With the HCBS rule's emphasis on full community integration and control of personal resources and activities, the restrictions needed to provide individuals with these kinds of behaviors or other complex needs, alternatives to institutional placement could otherwise violate the HCBS requirements.

However, CMS emphasizes that it is essential that the modifications process be used with strict adherence to its very specific requirements. The modifications process must:

- be highly individualized
- document that positive interventions had been used prior to the modifications
- document that less-intrusive methods did not successfully meet the individual's assessed needs.
- describe how the modification is directly proportionate to the specific assessed need
- include regular data collection have established time limits for periodic reviews
- include informed consent, and
- be assured to not cause harm.

Controls on personal freedoms and access to the community cannot be imposed on a class or group of individuals. Restrictions or modifications that would not be permitted under the HCBS settings regulations cannot be implemented as "house rules" in any setting, regardless of the population served and must not be used for the convenience of staff. In the case of individuals for whom modifications are included in the person-centered plan in accordance with the requirements described above, it is equally important to ensure robustness in the person- centered planning process by honoring other preferences the individual has outside of the specific risk targeted by the modification, and to review such restrictions frequently to ensure they are administered consistent with current health and safety needs and are still necessary.