

## HCBS Waiver Final Rule Language for Person-Centered Planning and Plan Development

(c) A waiver request under this subpart must include the following—

**(1) *Person-centered planning process.*** The individual will lead the person-centered planning process where possible. The individual's representative should have a participatory role, as needed and as defined by the individual, unless State law confers decision-making authority to the legal representative. All references to individuals include the role of the individual's representative. In addition to being led by the individual receiving services and supports, the person-centered planning process:

(i) Includes people chosen by the individual.

(ii) Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.

(iii) Is timely and occurs at times and locations of convenience to the individual.

(iv) Reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with [§ 435.905\(b\)](#) of this chapter.

(v) Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.

(vi) Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and [qualified entity](#) to provide case management and/or develop person-centered service plans in a geographic [area](#) also provides HCBS. In these cases, the State must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by [CMS](#). Individuals must be provided with a clear and accessible alternative dispute resolution process.

(vii) Offers informed choices to the individual regarding the services and supports they receive and from whom.

(viii) Includes a method for the individual to request updates to the plan as needed.

(ix) Records the alternative home and community-based settings that were considered by the individual.

**(2) *The Person-Centered Service Plan.*** The person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the individual, and the scope of services and supports available under the State's 1915(c) HCBS waiver, the written plan must:

- (i)** Reflect that the setting in which the individual resides is chosen by the individual. The State 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.
- (ii)** Reflect the individual's strengths and preferences.
- (iii)** Reflect clinical and support needs as identified through an assessment of functional need.
- (iv)** Include individually identified goals and desired outcomes.
- (v)** Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports are unpaid supports that are provided voluntarily to the individual in lieu of 1915(c) HCBS waiver services and supports.
- (vi)** Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.
- (vii)** Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with [§ 435.905\(b\)](#) of this chapter.
- (viii)** Identify the individual and/or entity responsible for monitoring the plan.
- (ix)** Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.
- (x)** Be distributed to the individual and other people involved in the plan.
- (xi)** Include those services, the purpose or control of which the individual elects to self-direct.
- (xii)** Prevent the provision of unnecessary or inappropriate services and supports.
- (xiii)** Document that any modification of the additional conditions, under paragraph (c)(4)(vi)(A) through (D) of this section, 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:
- (A)** Identify a specific and individualized assessed need.
  - (B)** Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
  - (C)** Document less intrusive methods of meeting the need that have been tried but did not work.

**(D)** Include a clear description of the condition that is directly proportionate to the specific assessed need.

**(E)** Include a regular collection and review of data to measure the ongoing effectiveness of the modification.

**(F)** Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

**(G)** Include informed consent of the individual.

**(H)** Include an assurance that interventions and supports will cause no harm to the individual.

**(3) Review of the Person-Centered Service Plan.** The person-centered service plan must be reviewed, and revised upon reassessment of functional need as required by [§ 441.365\(e\)](#), at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.

**(4) Home and Community-Based Settings.** Home and community-based settings must have all of the following qualities, and such other qualities as the [Secretary](#) determines to be appropriate, based on the needs of the individual as indicated in their person-centered service plan:

**(i)** The setting 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.

**(ii)** The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.

**(iii)** Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and [restraint](#).

**(iv)** Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

**(v)** Facilitates individual choice regarding services and supports, and who provides them.

**(vi)** In a provider-owned or controlled residential setting, in addition to the qualities at [§ 441.301\(c\)\(4\)\(i\)](#) through (v), the following additional conditions must be met:

**(A)** The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that

tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

**(B)** Each individual has privacy in their sleeping or living unit:

**(1)** Units have entrance doors lockable by the individual, with only appropriate [staff](#) having keys to doors.

**(2)** Individuals sharing units have a choice of roommates in that setting.

**(3)** Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

**(C)** Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.

**(D)** Individuals are able to have visitors of their choosing at any time.

**(E)** The setting is physically accessible to the individual.

**(F)** Any modification of the additional conditions, under [§ 441.301\(c\)\(4\)\(vi\)\(A\)](#) through (D), 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.