Home and Community-Based Services
Person-Centered Service Planning Guidelines
For Medicaid Managed Care Organizations,
Local Departments of Social Services, and Health Homes

Rather than receiving care in an institutional setting, most people want to remain in or return to their own home or the home of a family member or close friend, even when assistance is needed due to a physical, behavioral or developmental disability to allow this possibility. It is important that systems are aligned to ensure that in providing needed long term care services and supports we do not simply change the setting but change the way people live. No one wants to avoid or leave a restrictive residential setting only to be restricted in their home. Home and community-based services (HCBS), including community-based long-term services and supports (CBLTSS), should facilitate community integration and maximize independence to the greatest extent desired by the person receiving these services. New federal requirements for developing care plans to direct the provision of authorized services and supports are intended to ensure this is both planned and executed.

No services should be planned or authorized before the care/case manager (CM) meets with the person to discuss their needs, goals, and preferences as they relate to how their services and supports should be delivered to meet identified needs. This includes a discussion of informal supports; cultural preferences; the person's strengths; the range of services and supports available to meet their needs; as well as the scope, amount, duration, and frequency of services.

The Home and Community-Based Services (HCBS) Final Rule, which can be found at https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441/subpart-G/section-441.301, requires a more fulsome discussion regarding what the person hopes to achieve in terms of community integration and independence with the provision of HCBS: a new approach to PCSP planning. This rule also establishes new standards for the settings in which persons in receipt of HCBS under 1915(c), 1915(i) and 1915(k) Waiver authorities live and receive services. In addition, the HCBS Final Rule created new conflict of interest requirements for programs and services to ensure that the entity who assesses/declares level of care (i.e., or similar measurement of level of functioning and need for care) and the entity who develops and manages the primary Person-Centered Service Plan (PCSP), cannot provide HCBS to the same individual. The Managed Care Final Rule establishes conflict-free case management for the 1115 demonstration where the Medicaid Managed Care Organization (MMCO) ensures that the person who develops an individual's primary person-centered service plan (PCPS) (or Plan of Care-POC) does not also provide other HCBS for that same individual, including having separate supervisors for these staff and other firewalls in place to safeguard individuals' rights.

In this PCSP guidance document, person (i.e., an individual receiving services and/or supports) and person's chosen representative are interchangeable, and the person should be involved in decision making as much as possible regardless of having a representative. MMCO's include Medicaid Managed Care plans (Mainstream, Health and Recovery Plans – HARP and HIV Special Needs Plans – HIV-SNP) and Managed Long-Term Care (MLTC) plans (including Partial Capitation, and Medicaid Advantage Plus – MAP). These guidelines also apply to persons receiving services under the Community First Choice Option (1915(k)), regardless of whether they are enrolled in an MMCO, a waiver or Fee for Service Medicaid. Program of All Inclusive Care for the Elderly (PACE) and Fully Integrated Duals Advantage –

Intellectual/Developmental Disability (FIDA-IDD) Plans are excluded from the provisions of this guidance as they already follow expansive, federally defined person-centered planning processes.

I. Introduction – Person-Centered Service Planning

The person comes first in the PCSP process. The person directs the planning of services and makes informed choices about the services and supports they receive, to the maximum extent possible. Federal regulations[1] require that the PCSP process be directed by the person and/or a representative they choose, and other participants they want to include.

The PCSP[2] process is for both persons in MMCO and MLTC ("enrollees"), and persons receiving services ("recipients") through Fee-For-Service (FFS) from Local Departments of Social Services (LDSS). These PCSP guidelines are based on Federal regulation 42 CFR Part 441.301, 42 CFR Part 441.540, and the Medicaid Redesign Team 1115 Demonstration Waiver Special Terms and Conditions Section V.5. Person-Centered Planning requirements for entities certified by the Office for People with Developmental Disabilities (OPWDD) are described in 14 NYCRR Part 636.

The PCSP process is required when a person needs Long Term Services and Supports (LTSS), Home and Community-Based Services (HCBS), certain State Plan Services[3], or have Special Health Care Needs[4], as directed by New York State (the State). The PCSP process guides the delivery of services and supports towards achieving outcomes in areas of the person's life that are most important to them, such as their health, relationships, work, and their home. This process incorporates development of the individual's PCSP, which addresses the physical health, behavioral health, social, and long-term support needs of the person. MMCO and LDSS are responsible for ensuring that the PCSP is developed and maintained, and services are authorized accordingly. Where primary Care Management is delegated to the Regional Resource Development Centers (RRDC) or Health Homes (HH), these entities are responsible for ensuring that the PCSP is aligned with the expectations detailed below, maintained and monitored. The PCSP must reflect the person's choices, preferences, strengths and goals, and support their inclusion in the community. The written PCSP will assist the person in achieving personally defined outcomes (i.e., outcomes the person defines for themself) in the most integrated community settings possible while contributing to the health and welfare of the person.

II. Elements of the Person-Centered Planning Process

During the PCSP process, the MMCO, LDSS, RRDC, and HH must:

1. Include people chosen by the person receiving services, and/or their representative.

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[1] 42 CFR §441.540; 42 CFR §438.208; 1115 Demonstration; 42 CFR §441.301
[2] Including 1915(c) Waivers, Mainstream Medicaid Managed Care Plans, HIV Special Needs Plans, Health and Recovery Plans, Partial Capitation Managed Long Term Care Plans, Fully Integrated Duals Advantage Plans, and the Medicaid benefits under Medicaid Advantage Plus
[3] Including, but not limited to: Community First Choice Option (CFCO), and for Clotting Factor when covered by managed care
[4] Including, but not limited to: Children with Special Health Care needs

2. Provide necessary information and support to ensure that the person (and/or their representative) directs the process as much as possible.
3. Ensure that the person can make informed choices and decisions about their life and their goals.
4. Ensure the process is timely and occurs at times and locations convenient to the person.
5. Ensure the process reflects cultural considerations of the person and is conducted by providing information in plain language and in a way that is accessible to persons with disabilities and LEP (Limited English Proficient) persons.
6. Offer choices to the person about the services and supports they receive and from whom.
7. Ensure that the written PCSP is developed during the annual PCSP meeting and updated as needed, after reassessment, when the person's support needs or circumstances change significantly, and/or at the request of the person or their representative.
8. Ensure that the PCSP is finalized and agreed to in writing by the person, or their representative. If the person or designated representative does not agree with the PCSP, they can work with the CM and, if needed, the CM supervisor to come to a resolution and a PCSP that is satisfactory to the person or their representative. If there is no way to reach an agreement on the plan using the process described here, the person or their representative does not have to sign the plan and there are additional options for recourse that depend on the entity that oversees the HCBS, of which the person and/or their representative will be informed.
9. Ensure that the finalized PCSP is distributed to the person and any other people involved in the PCSP during the initial assessment. It must also be distributed whenever any changes are made to the original PCSP, and at reassessment prior to the end of the service authorization period.
10. Include a method for the person to request changes to the PCSP.
11. Ensure the process includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest (or conflict-free case management where applicable) guidelines for all planning participants.
12. Record the alternative HCBS settings that were considered by the person.

III. Assessment

A. Comprehensive Assessment

Before a PCSP can be developed, the person's need for CBLTSS must be determined based on a comprehensive assessment of their functional and health needs. The PCSP process requires[5] such an assessment once the request for services or supports is received. New York State uses the Community Health Assessment (CHA) in the Uniform Assessment System – New York (UAS-NY) suite to determine CBLTSS needs for all persons in need of personal care services (PCS) or consumer-directed personal assistance services (CDPAS), as well as for the elderly and/or physically disabled population seeking other CBLTSS including private duty nursing, home health care (nursing, speech, occupation and physical therapy), adult day health

[5] 42 CFR §441.535; 42 CFR §441.301(c)(3) and §441.365(e)

care, and Medicaid Assisted Living Program. Other assessments may be conducted to evaluate a person's eligibility to enroll in a 1915(c) Waiver, program, or delivery system (such as HH).

Completed CHAs are documented in the Uniform Assessment System (UAS). This assessment forms the basis of the PCSP developed by the MMCO/LDSS. While the assessment documents living arrangements, health concerns, and functional needs related to the ability to perform daily activities, the MMCO/LDSS CM must meet with the person to learn their strengths, preferences, and goals related to their receipt of CBLTSS, as well as to ensure the safety and adequacy of their environment and availability of informal supports. During this meeting, the CM will work with the person and anyone the person selects to participate to review the assessment data and identify measurable goals and desired outcomes based on the assessment tool(s) and the PCSP process. Only then may the CM identify appropriate services for the person among a range of options.

A reassessment must be conducted at intervals as directed by the State for the covered service, (e.g., for PCS/CDPAS, reassessment is conducted at least once every twelve months). A reassessment is also conducted when there is a significant change in the person's condition, or if requested by the person.

B. Risk Assessment

To ensure the health and safety of the person so they may enjoy the full benefits of community life, a risk assessment must be conducted during the initial PCSP meeting and each subsequent meeting based on initial assessment/reassessment. The risk assessment will evaluate potential risks to the person's health and welfare as well as the ability to calculate and manage risks in an appropriate manner so that the person may set goals and maintain and/or expand their life experiences. The risk assessment must be completed with the person and anyone the person wishes to attend, including any designated representative. Safeguards and positive interventions for the person's health and safety must be balanced with the person's strengths and needs. Areas for evaluation may include:

1. ability to give consent
2. mobility
3. bathing safety
4. ability to manage their finances
5. ability to seek and maintain employment/volunteer opportunities
6. medication management
7. chronic medical conditions and allergies
8. special dietary needs
9. behaviors that present harm to self or others
10. level of safety awareness
11. level of supervision required at home and in the community
12. fire safety and evacuation

C. Risk Management Plan

Following the risk assessment, a risk management plan will be developed as part of the PCSP. If risk is identified, the positive interventions and safeguards used to mitigate or eliminate the risk are to be written in the risk management plan. The CM must take into consideration the person's rights, needs, and preferences, as well as the benefits and impact of the risk management on the person. The risk management plan should include ways to empower the person to improve their ability to make informed decisions through education and self-advocacy

skills. Possible resources and environmental adaptations that can allow the person to take acceptable risks while reducing potential hazards must also be included.

The risk management plan must include a safeguarding section. This safeguarding section must identify the supports needed to keep the person safe from harm and actions to be taken when the health or welfare of the person is at risk. Information in this section includes, but is not limited to, a description of the supervision and oversight that may be required in such areas as fire safety, medication management, allergies, activities to promote the person's inclusion in the community, diet, behavioral concerns, financial transactions, and other vulnerabilities at home and in the community.

IV. Person-Centered Service Plan Requirements

It is important that the PCSP will be individualized and understandable to the person. Federal regulations[6] describe the minimum requirements for a PCSP to be developed. These regulations state that this process results in a written PCSP with individually identified goals and preferences. These goals and preferences can relate to community participation, employment, control of one's personal resources, health care and wellness, or education. Every PCSP should reflect the services and supports (formal and informal), identify all providers, and indicate whether a person chooses to self-direct their services. The PCSP will identify the specific services and the service providers used to meet stated goals, as well as their frequency, amount, and duration.

A. Elements of the Person-Centered Service Plan

The written PCSP, based on the comprehensive assessment of the person and related to the provision of services and supports to address identified needs, will include or reflect the following:

(1) the person's choice in selecting the setting where they live. The State must ensure that the setting chosen by the person is integrated in, and supports full access to the greater community, includes opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community like everyone else,

(2) the person's strengths and preferences – what they're good at and like related to their services and supports to facilitate autonomy and community integration,

(3) clinical and support needs as identified through the comprehensive assessment of functional need,

(4) individually identified goals and desired outcomes,

(5) services and supports (paid and unpaid) that will help the person achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports are unpaid supports that are voluntarily provided to and accepted by the person in lieu of Medicaid-funded HCBS,

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[6] 42 CFR §441.540; 42 CFR §438.208; 1115 Demonstration; 42 CFR §441.301

(6) all authorized covered services (including CBLTSS and HCBS) that will be delivered and their scope (description that determines which activities constitute billable activities), amount (units or hours), and frequency (number of times per week, days of the week, and hours during the day),

(7) services and supports not covered by the MMCO or FFS that are necessary to maintain the PCSP, including identified unmet needs and steps to address them.

(8) risk factors and measures in place to minimize them, including individualized backup plans and strategies,

(9) plain language and descriptions that are accessible to persons with disabilities and LEP persons, consistent with § 435.905(b) of this chapter, so both the person and their helpers can clearly understand the PCSP,

(10) identify the individual and/or entity responsible for monitoring the plan,

(11) informed consent of the person in writing, and signatures of all individuals and providers responsible for its implementation,

(12) services, the purchase or control of which the person elects to self-direct, if applicable

(13) measures to prevent the provision of unnecessary or inappropriate services and supports,

In addition, the PCSP must:

(1) be distributed to the person and other people involved in the plan, and

(2) document that 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 PSCP (see Section B for full details).

As part of the PCSP process, the CM will confirm that the person's residential setting meets the HCBS settings rule. The attached **Person-Centered Service Plan (PCSP) Template** is required to be used for this activity.

B. Home and Community-Based Settings[7] [8]

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[7]The State is working with CMS to finalize the Statewide Transition Plan (STP), which has initial approval, to come into compliance with the HCBS Final Rule. For definition of HCBS Settings, please refer to https://www.health.ny.gov/health_care/medicaid/redesign/home_community_based_settings.htm p.3030

[8]Home and community-based (HCBS) settings do not include the following:

1. a nursing facility
2. an institution for mental diseases
3. an intermediate care facility for persons with intellectual disabilities
4. a hospital providing long-term care services, or
5. any other locations that have qualities of an institutional setting

All recipients of Medicaid-funded HCBS must live and receive services in settings that provide informed choice, options, and integration in their community, per federal regulation at 42 CFR 441.301. Recipients must also have a PCSP that documents their informed choices and options, and which meets the federal PCSP process requirements at 42 CFR 441.301. Any modification of the additional conditions that apply to residential or non-residential settings that are provider-owned and/or controlled must be supported by a specific assessed need and justified in the PCSP.

HCBS may only be provided in settings that meet the federal standards outlined in 42 CFR Part 441.301. Per the rule, home and community-based settings must have certain qualities, based on the needs of the person as indicated in their PCSP. The PCSP should indicate that the home and community-based setting includes the following required qualities:

1. The setting is integrated in and supports full access of the person receiving HCBS to the greater community, including opportunities to engage in community life, control personal finances, seek employment and work in competitive and integrated settings, and receive services in the community to the same degree of access as persons not receiving Medicaid HCBS.
2. The setting is selected by the person 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 PCSP and are based on the person's needs, preferences, and, for residential settings, resources available for room and board.
3. The setting ensures a person's rights of privacy, dignity and respect, and freedom from coercion and restraint.
4. The setting 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.
5. The setting facilitates the person’s choice regarding services and supports, and who provides them.

For enrollees/recipients receiving HCBS through 1915(c), CFCO (1915(k)), and MMCO (1115 Demonstration Waiver), modifications to the additional provider-owned and controlled standards, for settings where a HCBS provider owns and operates the person’s residential or non-residential setting, must be made on a case-by-case basis within an enrollee’s/recipient’s PCSP, rather than imposing blanket restrictions on settings. It is permissible for programs to afford individuals these standards at all times, without the ability to modify them, as a way to address compliance.

Such modifications for residential settings include:

i. a change in status of written, legal agreements/leases to live in the current setting;
ii. privacy in sleeping or living unit;
iii. lockable entrance doors with only persons served and appropriate staff keeping keys/key codes;

iv. reasonable choice of roommate(s); and
v. freedom to furnish/decorate

For both residential and non-residential settings such modifications include:

i. freedom and support to control one's own schedule and activities; and
ii. the ability to access food and receive visitors of the person's choosing at any time.

To modify any of the above additional provider-owned and controlled standards the following requirements must be documented in the PCSP:

(i) Identify a specific and individualized assessed need
(ii) Document the positive interventions and supports used prior to any modifications to the PCSP
(iii) Document less intrusive methods of meeting the need that have been tried but did not work
(iv) Include a clear description of the condition that is directly proportionate to the specific assessed need
(v) Include a regular collection and review of data to measure the ongoing effectiveness of the modification
(vi) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated
(vii) Include informed consent of the person
(viii) Include an assurance that the interventions and supports will cause no harm to the individual

C. Backup Plan

The backup plan is a contingency plan put in place to ensure that needed assistance will be provided if the regular services and supports in the enrollee's/recipient's PCSP are temporarily unavailable. The backup care plan may include electronic devices, relief care, providers, and other individuals, services, or settings and must also be included in the PCSP. Individuals available to provide temporary assistance include informal caregivers such as the person's family member, friend or another responsible adult.

D. Person-Centered Service Plan Review

The effectiveness of the PCSP is closely monitored through reassessment and care/case management. To expand on what has been stated above, the PCSP must be reviewed and revised:

1) at least once every 12 months or as often as is required by 42 CFR §441.301, 1115 Demonstration Section V.4 and 42 CFR §441.540;
2) upon reassessment of functional, behavioral, medical, and/or social needs;
3) when the person's circumstances or needs change significantly; and/or
4) at the request of the person or their representative.

The required annual PCSP review must occur in a face-to-face meeting that includes minimally, the person/enrollee/recipient, their representative if they have one, and whomever the person invites. The PCSP review should include a check on progress regarding enrollee's/recipient's goals and whether they need to be reevaluated/revised.

V. Health Home Care Management (HHCM)

HHCM is a service model for persons enrolled in Medicaid with complex chronic medical and/or behavioral health needs. Persons who receive services from OPWDD will be referred to Care Coordination Organization/Health Homes (CCO/HH).

For recipients in FFS, a HH must partner with the LDSS with the emphasis on coordination among the two entities. The HH develops and maintains a PCSP that integrates physical and behavioral health services and includes CBLTSS and HCBS, as appropriate to the person's needs. The LDSS continues to be responsible for authorizing the LTSS and HCBS (unless otherwise directed by the State) for FFS recipients enrolled in HH.

HH services are covered by mainstream MMCO, HIV Special Needs Plans (SNP), and Health and Recovery Plans (HARP), as well as MLTC Partial Capitation and Medicaid Advantage Plans. Eligible persons enrolled in an MMCO may also be enrolled in a HH. If a person is in an MMCO and HH or CCO/HH, the HH care manager is the primary provider of care management and the MMCO does not duplicate the service. The MMCO is responsible for arranging for LTSS and HCBS assessments and authorizing the needed services. The MMCO must communicate the outcome and coordinate the service authorization options with the HHCM and the person. The HH develops and maintains a PCSP that integrates physical and behavioral health services and includes LTSS and HCBS, social care needs and social determinants of health, as appropriate to the person's needs.

It is expected that the MMCO care manager will coordinate with the HH care manager to ensure that one comprehensive PCSP is completed, and authorization of services is not delayed due to administrative barriers. Both care managers are part of the PCSP team. The MMCO is responsible for regular monitoring, as to whether the services in the PCSP are being delivered as authorized in the PCSP and whether those delivered services meet the needs of the enrollee/recipient. An MMCO contracting with a designated HH to provide HH services must develop plan-specific agreements with an HH for the services and may use the Department's Administrative Health Home Services Agreement (ASA) with the HH. This link is provided below.

The Department of Health´s Office of Health Insurance Programs (OHIP) is requiring MLTC Plans to ensure access to any HH on a statewide basis. HHCM services are carved out of the MLTC benefit package. The State requires a collaborative, team approach to service coordination between the HH and the MLTC Plan. The MLTC Plan and the HH must clearly define their respective roles to develop a comprehensive, integrated, PCSP.

The assigned MLTC Plan care coordinator and the HH care manager will assure that duplication of care management service does not occur, and that any in-plan services recommended on the care plan are authorized by the MLTC Plan. MLTC Plans are responsible for coordination with the HH but are not responsible for HH management or performance of any services outside the scope of the MLTC Plan benefit package.

The respective roles of the MLTC Plan and the HH must also be formalized by entering into a Statewide Administrative Health Home Services Agreement (ASA) using the template that has been developed by the Department. It will be the joint responsibility of both parties to determine which care manager will serve as the lead care manager for each person. This decision will be

based on the primary needs of the person and must be documented on the Care Planning and Coordination form (see link to form below).

An ASA template has been developed for the HH and MLTC Plans to delineate their respective care management roles when both are serving recipients, to ensure that services are not duplicated. The ASA template allocates a primary role for the coordination of long-term care services to the MLTC Plan, and a primary role for the coordination of behavioral health care and other services and supports that are outside of the MLTC benefit package to the HH.

While the ASA template provided by the Department may not be altered, a description of the in-plan and out-of-plan services and the respective responsibilities of the MLTC Plan and the HH should be included as Appendix A to the ASA. A suggested template for Appendix A has also been developed by the Department.

This form should be completed in conjunction with each reassessment to ensure continuity of care and reflect the long-term care expertise of the MLTC Plan and the behavioral health expertise of the HH.

The ASA template, Care Planning and Coordination form as well as a suggested care planning and coordination tool can be found at:
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/managed_care.htm

Note: This guidance and the required **PCSP Template** is effective upon posting. Should an entity to which this guidance and template applies have existing PCS planning tools that cover all elements within the required **PCSP Template**, it is acceptable for them to be used. The entity in charge of monitoring your organization will monitor activities to verify implementation of changes required by this guidance and is where questions should be directed. DOH offers free provider training on person-centered thinking, planning, and practice. These trainings are strongly recommended and important to demonstrate moving toward regulatory compliance. Additional resources on person-centered planning, practice and training opportunities can be found on the DOH website at https://www.health.ny.gov/health_care/medicaid/redesign/person-centered_planning/index.htm and within the Person-Centered Planning and Practice Resource Library at https://www.health.ny.gov/health_care/medicaid/redesign/person-centered_planning/index.htm.