Person Centered Service Planning Guidelines
For Managed Care Organizations
and Local Departments of Social Services

I. Introduction

These guidelines are intended to provide information regarding the requirements for the Person Centered Service Planning (PCSP) process for enrollees in Medicaid Managed Care[1] (MMC), and individuals receiving services (recipients) through fee for service from Local Departments of Social Services (LDSS). Please note that these PCSP guidelines are based on the following 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.4. Person Centered Planning requirements for entities certified by the Office for People With Developmental Disabilities (OPWDD) are described in 14 NYCRR Part 636.

PCSP is a process required when enrollees/recipients are in need of Long Term Services and Supports (LTSS); Home and Community Based Services (HCBS); certain State Plan Services[2], or have Special Health Care Needs[3], as directed by the state. The PCSP process guides the delivery of services and supports towards achieving outcomes in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home.) This process incorporates development of the enrollee/recipient's Plan of Care (POC), which addresses: physical health; behavioral health; social; and long-term support needs. Medicaid Managed Care Plans (MMCPs) and LDSS are responsible for ensuring that the POC is developed and services are authorized in accordance with the POC. The PCSP process and POC must reflect the person's choices, preferences, and goals, and support his or her inclusion in the community. The process and resulting written POC will assist the enrollee/recipient in achieving personally defined outcomes (outcomes the consumer defines for his or herself) in the most integrated community settings possible while contributing to the health and welfare of the person.

During the PCSP process, the enrollee/recipient directs the planning of services and makes informed choices[4] about the services and supports received, to the maximum extent possible. Federal regulations[5] require that the PCSP process be directed by the individual and, if the person has a representative, includes the representative. The enrollee/recipient also has the right to choose additional participants to contribute to the process.

II. Person Centered Service Planning Process

A. Elements of Person Centered Service Planning

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[1] 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, Program of All-inclusive Care for the Elderly Plans, the Medicaid benefits under Medicaid Advantage, and Medicaid Advantage Plus

[2] Including, but not limited to: Community First Choice Option (CFCO), and for Clotting Factor when covered by managed care

[3] Including, but not limited to: Children with Special Health Care needs

[4] choices individuals have the information and support to make for themselves

[5] 42 CFR Part 441.540; 42 CRF Part 438.208; 1115 Demonstration; 42 CRF Part 441.301

During the PCSP process, the MMCP or LDSS must ensure that the process:

1. Includes people chosen by the enrollee/recipient, or the enrollee/recipient's representative;
2. Provides necessary information and support to ensure that the enrollee/recipient (and/or their representative) directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;
3. Is timely and occurs at times and locations of convenience to the enrollee/recipient;
4. Reflects cultural considerations of the enrollee/recipient and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons with limited English proficiency;
5. Offers informed choices to the enrollee/recipient regarding the services and supports they receive and from whom;
6. Ensures that the written plan of care (POC) is developed during the annual PCSP meeting, and updated as needed after re-assessment when the enrollee/recipient's support needs or circumstances change significantly;
7. Ensures that the POC is finalized and agreed to in writing by the enrollee/recipient, or the enrollee/recipient's representative[6]. Signature is not required when there is a provider order change. If the enrollee/recipient or designated representative is not in agreement with the POC, the enrollee/recipient has dispute/appeal and fair hearing rights as for any service determination. The LDSS and MCO will follow the normal processes for dispute resolution/appeals;
8. Ensures that the finalized POC is distributed to the enrollee/recipient and other people involved in the POC, during the initial assessment process. It must also be distributed whenever any changes are made to the original plan of care, and at reassessment prior to the service authorization period ending;
9. Includes a method for the enrollee/recipient to request updates to the POC; and
10. Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.

B. Person Centered Planning Roles

The PCSP process may include an interdisciplinary team consisting of licensed professionals, other service providers, and supports, as the enrollee/recipient desires. A care/case manager (CM) is identified to coordinate the PCSP process. The CM may be an individual from a Health Home Care Management Agency, LDSS, or MMCP, depending on the enrollee/recipient's need and circumstances. (See Section VI. B.) As part of the process, the CM must consider the enrollee/recipient's support system including formal and informal supports. The formal supports in the interdisciplinary team involved in the planning and decision-making process must have adequate knowledge, training, and expertise regarding community living and person centered service delivery.

[6] Acceptable methods of agreement with the POC from the enrollee or designated representative are: 1) wet signature on the POC, either in person or mailed or 2) wet signature on a separate page with language indicating agreement with the current POC, either in person or mailed. All attempts to obtain signature should be documented on the POC by the care/case manager.

Informal supports include the enrollee/recipient's relatives, friends, significant others, neighbors, roommates, and other people from the community. Informal supports are determined to be available when such a person is willing to *voluntarily* provide the identified services and the enrollee is willing to accept services from the informal support. If the informal support is not willing or is unable to provide the identified services, or the enrollee/recipient is not willing to accept services from the informal support, the needed services will be provided by other formal supports. These do not include services or supports that are within the typical range of activities that a parent or legally responsible individual would perform on behalf of a child without a disability or chronic illness of the same age.

III. Assessment

A. Comprehensive Assessment

The PCSP process requires[7] a face-to-face assessment of the enrollee/recipient's need, once the request for services or supports is received. States must conduct a face-to-face assessment of the individual's needs, strengths, preferences, and goals for the services and supports. The plan or LDSS is responsible for arranging this assessment of the enrollee/recipient. A Nurse or a Social Worker will conduct this face-to-face assessment using the Uniform Assessment System (UAS). The results of this assessment will document the enrollee/recipient's functional need for Long-Term Services and Supports (LTSS) as well as help inform the person centered plan of care (POC).

Depending on individual circumstances, there may be competing needs for various service assessments. The CM should coordinate the assessments an enrollee/recipient requires to determine functional needs and to determine the scope of individual services necessary to complete the POC. For each enrollee/recipient determined eligible for an HCBS benefit, the State must provide for an independent assessment of needs in order to establish a plan of care (POC). **The results of the assessment(s) will inform the development of the POC.**

A CM who has been trained to perform person centered planning in accordance with state requirements will meet with each enrollee/recipient to assist with identifying strengths and needs. Together they will review all assessment data and identify measurable goals and desired outcomes based on the assessment tool(s) and the person centered planning process.

An assessment of the enrollee/recipient's functional, medical, environmental, and social needs must be conducted:

1) Upon request from an enrollee/recipient newly in need of LTSS/HCBS or identified as having Special Health Care Needs;
2) Upon request for a new LTSS or HCBS; and

[7] 42 CFR 441.720; 42 CFR 441.535; 42 CFR 441.300

3) For a new MMC enrollee in receipt of LTSS/HCBS or identified as having Special Health Care Needs, upon enrollment in the MMCP.

A re-assessment must be conducted at intervals as directed by the State for the covered service, e.g. for LTSS, reassessment is conducted at least once every twelve months. Reassessments are also conducted upon a significant change in the enrollee/recipient's condition, or if requested by the enrollee/recipients. (See Section V.)

B. Risk Assessment

To ensure the health and safety of each enrollee/recipient, a risk assessment must be conducted during the initial comprehensive assessment and each subsequent re-assessment. The risk assessment will evaluate potential risks to the enrollee/recipient's health and welfare as well as the ability to calculate and manage risks in an appropriate manner. The risk assessment must be completed with the enrollee/recipient and anyone the enrollee/recipient wishes to attend. Safeguards and positive interventions for the enrollee/recipient's health and safety must be developed based on the enrollee/recipient's strengths and needs. Areas for evaluation include, but are not limited to:

1. fire safety and evacuation;
2. chronic medical conditions and allergies;
3. special dietary needs;
4. medication management;
5. level of supervision required at home and in the community;
6. ability to manage finances;
7. ability to give consent;
8. ability to travel independently;
9. level of safety awareness;
10. bathing safety;
11. mobility;
12. behaviors that present harm to self or others; and
13. natural disaster preparation.

Once the enrollee/recipient's risk assessment is completed, a risk management plan (described in section IV. D.) will be developed as part of the POC, incorporating areas of risk and the positive interventions and safeguards used to manage the identified risk.

IV. Plan of Care Requirements

Federal regulations describe the minimum requirements for plans of care (POC) developed through the person centered service planning process. These regulations state that this process results in a written POC with individually identified goals and preferences. These goals and preferences may relate to community participation, employment, income and savings, health care and wellness, or education. Every POC should reflect the services and supports (formal and informal), identify all providers, and indicate whether an enrollee/recipient chooses to self-direct his or her services. The POC will identify the specific services and the service providers used to meet stated goals, as well as their frequency, amount, and duration. Most importantly, the POC will be individualized and understandable to the enrollee/recipient. Please note that the POC must comply with other state guidance that applies to specific services such as Health Homes.

A. Elements of the Plan of Care

The written POC based on the comprehensive assessment of the enrollee/recipient will include:

1. personal and health care goals and desired outcomes identified by the enrollee/recipient;
2. enrollee/recipient's strengths and preferences;
3. types of all authorized covered services (including LTSS 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);
4. services and supports not covered by the MMC plan or FFS that are necessary to maintain the POC;
5. informal services and supports that will assist the enrollee/recipient to achieve the identified goals including type, scope and frequency;
6. providers of each service and support;
7. clinical and support needs as identified through the assessment of functional need;
8. timeframes for completion of the expected outcomes;
9. back-up plan for when services and supports are temporarily unavailable;
10. identification of care manager responsible for monitoring the plan and business hours and after-hours emergency contact information for that care manager;
11. identification of unmet service needs and strategies to address them;
12. the setting in which the enrollee/recipient resides; and
13. risk factors and measures in place to minimize them.

B. Home and Community-Based Settings[8]

HCBS may only be provided in settings that meet the federal standards outlined in 42 CFR Part 441.301. [9] Home and community-based settings must have certain qualities, based on the needs of the enrollee/recipient as indicated in their person centered POC. The POC should indicate that the home and community-based setting includes the following required qualities:

1. Setting is integrated in and supports full access of enrollees/recipients receiving 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.
2. Setting is selected by the enrollee/recipient 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

[8] The State is CMS working with to finalize the State Transition Plan. For definition of HCBS Settings, please refer to https://www.health.ny.gov/health_care/medicaid/redesign/home_community_based_settings.htm p.3030

[9] HCB settings standards do not apply to PACE

person centered POC and are based on the enrollee/recipient's needs, preferences, and, for residential settings, resources available for room and board.

3. Setting ensures an enrollee/recipient's rights of privacy, dignity and respect, and freedom from coercion and restraint.
4. 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. Setting facilitates enrollee/recipient choice regarding services and supports, and who provides them.
6. For special populations receiving services under 42 CFR 441 Subparts G, and K modifications should made on a case-by-case basis to the additional home and community-based settings standards within an enrollee's person centered plan. Such modifications may relate to a change in: status of written, legal agreements to live in the current setting; privacy; lockable entrance doors with only individuals served and appropriate staff keeping keys/key codes; choice of roommate(s); freedom to furnish/decorate within legal agreements; control of own schedules and activities, and the ability to access food and receive visitors of the enrollee's choosing at any time.

Home and community-based settings do not include the following:

1. A nursing facility;
2. An institution for mental diseases;
3. An intermediate care facility for individuals with intellectual disabilities;
4. A hospital providing long-term care services; or
5. Any other locations that have qualities of an institutional setting.

C. Back Up Plan

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

D. Risk Management Plan

Following the risk assessment, a risk management plan will be developed as part of the POC. 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 care/case manager must take into consideration the enrollee/recipient's rights, needs, and preferences, as well as the benefits and impact of the risk management on the enrollee/recipient. The risk management plan should include ways to empower enrollees/recipients to improve their ability to make informed decisions through education and self-advocacy skills. Possible resources and environmental adaptations that can allow the enrollee/recipient to take acceptable risks while reducing potential hazards must be included, as well.

The risk management plan must include a safeguarding section. This safeguarding section must identify the supports needed to keep the enrollee/recipient safe from harm

and actions to be taken when the health or welfare of the enrollee/recipient 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, community inclusion activities, diet, behavioral concerns, financial transactions, and other vulnerabilities at home and in the community.

V. Person Centered Service Plan (PCSP) Review

The effectiveness of the POC is closely monitored through reassessment and care/case management. The POC must be reviewed and revised:

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

Review and revision of the POC may occur more frequently as warranted by the enrollee/recipients' condition.

The required annual POC review must occur in a face-to-face meeting that includes minimally, the enrollee/recipient, the enrollee/recipient's representative if they have one, whomever the enrollee/recipient invites, and an interdisciplinary team. As part of the POC review, a determination is made on whether the enrollee/recipient's goals are being met or whether the goals need to be reevaluated/revised.

VI. Care/Case Management Requirements

A. Conflict of Interest Standard

Federal regulations[10] require that the POC development function of care/case management must be separate from the service delivery function. Individuals conducting the comprehensive assessment and person centered POC for an enrollee/recipient are not:

a) A parent or spouse of the enrollee/recipient, or to any paid caregiver of the enrollee/recipient;
b) Financially responsible for the enrollee/recipient;
c) Empowered to make financial or health-related decisions on behalf of the enrollee/recipient;
d) Individuals who would benefit financially from the provision of assessed needs and services; and

[10] 42 CFR Part 438.58; 42 CFR Part 441.301; 42 CFR Part 441.555; 42 CFR Part 441.730

e) Providers of Home and Community-Based Services (HCBS) for the enrollee/recipient, or those who have an interest in or are employed by a provider of HCBS for the enrollee/recipient.

Providers of HCBS for the enrollee/recipient, or those who have an interest in or are employed by a provider of HCBS for the enrollee/recipient must not provide case management or develop the POC. The State invokes the Conflict of Interest Exception when the only willing and qualified entity performing assessments of functional need and/or developing the person centered POC also provide Home and Community-Based Services. Where it is demonstrated that that the only willing and qualified entity to provide case management and/or develop POCs in a geographic area also provides HCBS, the PCSP process must include conflict of interest protections. This may include the separation within a provider entity of assessor, care/case manager, and provider functions.

As is required by 42 CFR 438, effective April 1, 2018, any service coordinator or service coordination provider agency will be restricted from providing any other waiver services including 1915(c) unless it is demonstrated that the provider meets the exemption standards for rural and /or cultural accommodation. Under no circumstances can a direct service provider determine eligibility for a service.

In the FFS environment, the Local Department of Social Services (LDSS) will ensure that there is separation between the function as case manager or assessor and the other functions the same individual performs at the LDSS or agency/provider. Firewalls ensure that the individual conducting the functional needs assessment and/or developing the person centered POC is independent of those who are providing the services. Accordingly, the case manager or assessor will not provide services as a direct care worker for the enrollee/recipient; nor have a majority ownership stake in the provider agency.

The Health Home model provides care management for FFS and managed care enrollees. Under the 1115 MRT Waiver, when a service provider is an approved Health Home provider and also a HCBS provider, this entity may conduct person centered service planning, care coordination, and provision of HCBS as long as firewalls are constructed between the service planning, care coordination, and service provision. As directed by the State, Health Home Care Managers (HHCM) and State Designated Entities (SDEs) may determine eligibility for certain HCBS through State required assessments. HHCMs and SDEs are restricted from assessing a person for whom they have financial interest or other existing relationship that would present conflict of interest.

Any agency in New York State that is not a Health Home may not provide both HCBS and care management unless the State has demonstrated that they are the only willing and qualified entity to provide case management and/or develop person centered service plans in a geographic area or the State has demonstrated that the provider is the only qualified provider due to its unique ability to deliver culturally or linguistically competent care to the enrollee/recipient.

Enrollees/recipients receiving services must be provided with a clear and accessible alternative dispute resolution process. In all cases, enrollees/recipients will be made aware of appeals processes and due process protections to ensure their needs are met in the fairest manner possible.

B. Health Home Care Management

Health Home (HH) is a care management (CM) service model for individuals enrolled in Medicaid with complex chronic medical and/or behavioral health needs. Individuals who receive services from the Office for People with Developmental Disabilities (OPWDD) will be referred to Care Coordination Organization/Health Homes (CCO/HH)

For recipients in Fee For Service (FFS), Health Homes must partner with the LDSS with the emphasis on coordination among the two entities. The Health Home develops and maintains a POC that integrates physical and behavioral health services and includes LTSS and HCBS, as appropriate to the enrollee'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.

Health Home services are covered by mainstream Medicaid Managed Care Plans (MMCP), HIV Special Needs Plans and Health and Recovery Plans (HARP). Eligible persons enrolled in MMCPs may also be enrolled in a HH. If an enrollee is in a MMCP and HH or CCO/HH, the HH care manager is the primary provider of care management and the MMCP does not duplicate the service. The MMCP is responsible for arranging for LTSS and HCBS assessments, and authorizing the needed services in accordance with State direction for the covered benefit(s). The MMCP must communicate the outcome and coordinate the service authorization options with the HHCM and the member. The Health Home develops and maintains a POC that integrates physical and behavioral health services and includes LTSS and HCBS, as appropriate to the enrollee's needs.

It is expected that the MMCP care manager will coordinate with the HH care manager to ensure that one comprehensive POC is completed, and authorization of services is not delayed due to administrative barriers. Both care managers are part of the PCSP team. The MMCP is responsible for monitoring, on a regular basis, whether the services in the POC are being delivered as authorized in the POC and whether those delivered services meet the needs of the enrollee. MMCPs contracting with designated HHs to provide HH services must develop plan specific agreements with Health Homes for HH 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 Health Homes on a statewide basis. HH care management services are carved out of the MLTC benefit package. The State requires a collaborative, team approach to service coordination between the Health Home and the Managed Long Term Care Plan. The MLTC Plan and the HH must clearly define their respective roles in order to develop a comprehensive, integrated, person-centered care plan.

The assigned MLTC Plan care coordinator and the Health Home 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 Health Home but are not responsible for Health Home management or performance or any services outside the scope of the MLTC Plan

benefit package. Please note, the assessment part of the PCSP process continues to be conducted by the MLTC Plan nurse.

The respective roles of the MLTC Plan and the Health Home 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 enrollee. This decision will be based on the primary needs of the enrollee and must be documented on the Care Planning and Coordination form (see link to form below).

An ASA template has been developed for HH and Managed LongTerm Care Plans (MLTC) to delineate their respective care management roles when both are serving recipients, to ensure that services are not duplicated. The template ASA 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 Health Home.

While the template ASA 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 Health Home 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 Health Home.

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

This guidance is effective upon posting, XXXX, 2019. The Managed Care Plan in charge of monitoring your organization will commence monitoring activities to verify implementation of changes required by the HCBS Final Rule beginning as early as January 1, 2020. Beginning in 2019 DOH is sponsoring free provider trainings on person-centered thinking, planning, and practice. These training are strongly recommended in order to demonstrate movement towards regulatory compliance. More information can be found by emailing NYDOHPCPTraining@pcgus.com.