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Person-Centered Service Planning

Home and Community-Based Services Final Rule Implementation

Presented by: Center For Long Term Care Finance and Supports Policy Bureau

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July 2023

Agenda

1. Person-Centered Service Planning (PCSP) in Context – Goal of HCBS Final Rule, Applicability
2. What's new with PCSP?
3. Summary of PCSP Requirements
4. Overview of Roles and Responsibilities in PCSP Process and new Template
5. PCSP & Settings
6. Role of PCSP in Ongoing Monitoring and Quality Assurance

	Institutional Care	Managed Care	Integrative Supports	Community Supports
Organizing Principle	System Centered Based on Targeted Population	Coordinated Services and Outcome Centered based on targeted population	Person-Centered – Based on unique qualities of each Individual	Citizen/community centered Based on the individual rights and for the betterment of community
Individual-Professional Relationship	Expert-Patient. Professional directed & power over	Provider-Consumer Professional responds to consumer need & power- over	Facilitator/Broker-self-directed individual (individual designs with others & power shared.	Resource-Autonomous Citizen. Community supporting with professional auxiliary & power collective.
Individual-Service Experience	Functionally specific and pre-set services & programs based assessed deficiencies. Push-Model Driven	Habilitation pathways or treatment protocols determined by clinical assessments. Coordinated care – pull driven.	Individualized supports, circles of support, peer-supported, wrap-around services. Person driven- supports negotiated.	Self or co-directed. Home & community located Community-driven (allocation).
Organizational Culture, Coordination Mechanism – How Power Shows Up	.Bureaucratic or paternalistic culture Hierarchy, command & control	Rules-based, clinically dominated culture. Managed care entities & care management	Affiliation, appreciation -based culture. Network, facilitated dialog & mutual adaptation (person-centered planning)	Inclusive, diverse culture. Seeing from the whole – through a process of collective sense making & innovation cycles
Outcomes for Individuals	Placement. Personal Care, face to face service Activity & supervised housing	Appropriate service levels. Reduced service costs Consumer satisfaction	Individualized supports leading to own home, relationships & meaningful activity	Citizenship, full inclusion & participation in the community in typical settings Life of distinction (assumption of valued roles

Goal of HCBS Final Rule:
What matters to me; not what matters for me

- The HCBS Settings Rule was created to ensure that every person receiving Medicaid-funded HCBS has full access to the benefits of community living.
- Provides freedom to make choices and to control the decisions that impact their lives, including controlling personal resources; being treated with privacy, dignity, respect, and freedom from coercion and restraint.
- Includes, even when living and/or receiving services in provider owned or controlled settings, deciding what and when to eat; having visitors; being able to lock doors; and having the protections of a lease or other legally enforceable agreement.
- The rule requires a person-centered process for receipt of HCBS, which means that the individuals receiving services direct the planning process and the plan reflects their own preferences and goals they have set for themselves.

HCBS Final Rule and Managed Care

Requirement to conduct Person-Centered Planning are included throughout the relevant sections of the Medicaid Managed Care Model Contracts, including but not limited to:

- Medicaid Managed Care/HIV Special Needs Plan/ Health And Recovery Plan Model Contract: Section 10.35; Appendix S
- Managed Long Term Care Partial Capitation Contract: Article V, Section J
- Medicaid Advantage Plus (MAP): Section 10.13

Covered Services which are classified as HCBS include:

- LTSS – personal care, consumer directed personal assistance services, ADHC, Long-term Home health care, private duty nursing
- MLTC benefits: SADC, Home delivered meals, environmental modification
- Children's HCBS – community habilitation, day habilitation, prevocational services, supported employment, planned and crisis respite, adaptive and assistive equipment, environmental modifications, vehicle modifications, caregiver/family supports, community self advocacy training and supports, non-medical transportation, palliative care (express therapy, pain and symptom management, bereavement service, massage therapy).
- BH HCBS (HARP) – habilitation, educational support services, pre-vocational services, transitional employment, intensive supported employment support, ongoing supported employment support, non-medical transportation

The Person Comes First in Person Centered Planning

Person-Centered Thinking is a way of thinking that helps create the means and resources for a person to live a life that they value.

Person-Centered Planning is a way to assist people needing HCBS services and supports to construct and describe what they want and need to bring purpose and meaning to their life.

Person-Centered Practice is the alignment of service resources that give people access to the full benefits of community living and ensure they receive services in a way that may help them achieve individual goals.

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PCSP Process

Authorizers of HCBS (Medicaid Managed Care (MMC) and MLTC Plans and Local Districts of Social Services (LDSS), Regional Resource Development Centers (RRDCs), or Health Homes (HH)) must:

- Provide all information and support to make sure the person directs the process whenever possible
- Include people chosen by the person receiving services and their representative in the planning process
- Make sure the person can make informed decisions about their life and goals
- Ensure a timely and convenient process, including a convenient location for the person
- Reflect cultural considerations and be in a language suitable to the person, and
- Offer the person choices about their services and from whom they receive them

PCSP Process, Continued

Authorizers must also:

- Ensure the person-centered service plan (PCSP) is written and updated as needed (whenever there is a significant change in condition, upon reassessment interval, or upon request by individual)
- Include a method for the person to request changes to the PCSP
- Ensure the process includes strategies for resolving conflict
- Record the alternative HCBS settings that were considered by the person
- Ensure the PCSP is finalized and signed upon agreement
- Ensure the finalized PCSP is distributed to any persons involved, including the individual served and service providers, and redistributed whenever changes are made

PCSPs Must Identify:

- Strengths
- Preferences
- Needs (Clinical and Supportive)
- Desired Outcomes/Goals

Differences In Plan Templates

Plan of Care Template

In accordance with Person Centered Service Planning Guidelines

Summary Page

Authorization Period_____ Date Issued_____

Enrollee Name		Date of Birth	
Address			
Phone Number		Preferred Language	
Email Address			

If you have a question or a problem regarding your services, call your care manager below,

_____[Care Manager Name]_____ **at (xxx) xxx-xxxx**

Description of Services

Use this area to identify current services received by the enrollee. [Duplicate boxes below as needed].

Name of Service			
Scope/Description of Service			
Unit and Frequency of Service		Provider	
Duration/Authorization Period		Contact Information	
Assessment Identifying Need		Authorizing Entity	
Desired Outcome/Goals			

Name of Service	

Person-Centered Service Plan Template

In accordance with Person-Centered Service Planning Guidelines

Authorization Period_____ Date Issued_____

Name		Date of Birth	
Address			
Phone Number		Preferred Language	
Email Address			

If you have a question or a problem regarding your services, call your Care/Case Manager:

_____[Care/Case Manager name]_____ **at (xxx) xxx-xxxx**

Preferences and Strengths:

Use this section to describe the person's preferences and strengths.

Preferences:

Ask the person about the things they like and dislike. Input their responses as well as any other known preferences of the person. Include any preferences they may have for the delivery of their services.

Strengths:

Ask the person about the things they're good at. Input their responses as well as any other known strengths of the person.

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Roles & Responsibilities

- MMCO ("plans") and LDSS ("districts") are responsible for ensuring that the primary PCSP is *developed and maintained*, and services are authorized accordingly.
- There is also an expectation that plans and districts coordinate with service providers to ensure that the PCSP remains up-to-date and comprehensively documents the individual's experience.
- 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.
- The respective roles of the MMCO 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.

PCSP and Settings

Settings are:

- Where someone in receipt of Medicaid-funded HCBS lives, even if the services received only occur outside of the home
- Where someone receives HCBS in the community, such as an Adult Day Health Care Program or Social Adult Day Care (for MLTC enrollees)
- Community locations such as a park, library or commercial for-profit or not-for-profit space where HCBS may be provided
- Sometimes owned or controlled by a provider, which may be obvious, such as a certified setting operated by an OPWDD provider or less obvious where the landlord of the supported housing unit the HCBS recipient lives in controls who provides HCBS in the building
- Provider owned or controlled settings have additional standards that must be met to comply with the HCBS Final Rule

Five Inalienable Standards For All Settings

HCBS recipients must both live and receive services in settings that:

- Are integrated in and support full access to the greater community; and selected by the individual from among options
- Ensure an individual's rights of privacy, dignity and respect
- Assure freedom from coercion and restraint
- Optimize autonomy and independence in making life choices
- Facilitate choice about services and who provides them

Additional standards for residential settings that are provider owned or controlled

- Individuals in residential units have legally enforceable agreements giving them the same protections and responsibilities as any tenant living in that jurisdiction
- Privacy in sleeping or living unit
- Units have lockable entrance doors
- The individual and appropriate staff have keys/codes to doors
- Choice of roommates in shared units
- Freedom to furnish and decorate sleeping or living units

Additional Standards For Residential And Non-Residential Settings (Provider-Owned or Controlled)

- Freedom and support to control one's own schedule and activities
  - Community Integration and Corrective Action Plan (CAP)
- Access to food and visitors at any time
- The setting is physically accessible to the individual (*not modifiable)

Person Centered Service Plan and Settings

Residential Setting and Supports:
Use this section to confirm that the individuals residential setting meets the HCBS settings rule.

Is the residence integrated in and does it support full access to the greater community?	Yes ☐	No ☐
Was the residence selected from among options by the person?	Yes ☐	No ☐
Does the residence ensure the person's rights of privacy, dignity and respect, and freedom from coercion and restraint?	Yes ☐	No ☐
Does the residence optimize the person's autonomy and independence in making life choices?	Yes ☐	No ☐
Does the residence facilitate the person's choice about services and who provides them?	Yes ☐	No ☐
Is the residence physically accessible to the person?	Yes ☐	No ☐
Can the person control personal resources?	Yes ☐	No ☐
Did the person participate in the person-centered planning process, leading the process whenever possible?	Yes ☐	No ☐
Did the person choose where they live now?	Yes ☐	No ☐
Can the person easily move around their home and other places where services are received?	Yes ☐	No ☐
Can the person participate in the activities such as work, volunteer, attend school, etc., when they like inside and outside of their home? If not, is there a modification noted	Yes ☐	No ☐

Person Centered Service Plan and Settings, continued

Person-Centered Service Plan Template

In accordance with Person-Centered Service Planning Guidelines

properly below (see Residential and Non-Residential Modifications Section below)? (Note: modifications are only applicable for provider-owned or controlled residential or non-residential settings, not private homes) Yes ☐ No ☐	
Can the person visit friends and family if/when they want? If not, is there a modification noted properly below? Yes ☐ No ☐	Yes ☐ No ☐
Can the person enjoy food and snacks that they like whenever they want? If not, is there a modification noted properly below? Yes ☐ No ☐	Yes ☐ No ☐
For provider-owned or controlled residential settings, is there a lease/occupancy agreement/etc. in place that gives the person the same rights and protections afforded to anyone in that jurisdiction, i.e., no rules are in the written agreement that would not be in a common lease, including the ability to furnish and decorate sleeping or living unit? If not, is there a modification noted properly below? Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐
For provider-owned or controlled residential settings, does the person have privacy in their sleeping or living unit, choice regarding roommate(s), and do only the person and necessary staff have a key/key card/code to their sleeping and/or living unit? If not, is there a modification noted properly below? If not, is there a modification noted properly below? Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐
Use the space provided below for additional comments if the answer to any of the questions above is "No".	

Modifications to Person-Centered Plans

Any modification to the standards on slides 15 and 16 must be:

- Supported by a specific assessed need
- Justified in the PCSP and must:
  - Follow positive interventions and supports used prior to any modifications
  - Use less intrusive methods of meeting the need that were tried and did not work
  - Come with a clear description of the condition that is directly proportionate to the specified need

Modifying A PCSP On A Case-by-Case Basis

Modifications to the additional standards must be:

- Directed by and with the informed consent of the individual being supported
- Subject to regular collection and review of data measuring the ongoing effectiveness of the intervention(s) used
- Reviewed periodically within defined time limits to determine if the modification is still necessary
- Developed to assure that interventions and supports will cause no harm

Modification Example

Jaime requires assistance with managing access to snack foods due to their tendency to eat frequently, which raises Jaime's blood sugar levels. ADHC or SADC staff tried counseling Jaime but were not successful. With Jaime's informed consent (or that of Jamie's representative) staff will support Jaime with accessing the snack cabinet for at least the next 6 months and will document this information in Jaime's PCSP to make sure that it is working well. The modification will be reviewed periodically to determine if it is still needed.

Modifications Can Be Used When An HCBS Recipient:

- Lives in a provider-owned or controlled setting, e.g., group homes and select supportive housing units that have house rules and are not run like private homes
- Receives services in a setting that is provider-owned or controlled, where their ability to control their own schedule, activities, or access to food or visitors may need to be modified to better support them, e.g., Adult Day Health Care Program, Social Adult Day Care, Structured Day
- When a member lives 24 hours a day with an unrelated paid caregiver receiving HCBS funding (these are provider-owned or controlled settings under the Rule)

Modifications Cannot Be Used In Private Homes

People living in private homes are presumed to have more control over their food, visitors, activities and when they come and go. Modifications should not be necessary in these environments.

However, when PCSP are developed, maintained and monitored; and when reviewing PCSP during routine or focused surveillance activities, plan, district or state staff should ensure that HCBS recipients living in private homes realize the inalienable rights required in all appropriate settings, as well as this kind of control of their environment.

Person-Centered Service Plan and Modifications

Person-Centered Service Plan Template
In accordance with Person-Centered Service Planning Guidelines

Residential and Non-Residential Modifications (applies when a HCBS provider owns or controls the Residential or Non-Residential setting):

Fill out these boxes for special populations receiving HCB services under 42 CFR 441 Subparts G, K, or self-directed 1905(a) State plan services, including the Consumer Directed Personal Assistance Program (CDPAP). Such residential modifications described here may relate to a change in status of written, legal agreements to live in the current setting; privacy; sleeping/living unit having lockable entrance doors with only the person and appropriate staff keeping keys; choice of roommate(s); freedom to furnish/decorate within legal agreements; and for both residential and non-residential settings, control of schedules, activities, and access to food at all times; or the ability to receive visitors of the person's choosing at any time. [Duplicate modifications box if needed for multiple modifications]. ☐ I, _____, understand the information below and agree to the use of the modification(s) required to address my assessed risks and needs. I know that I can change my mind and will tell my Care/Case Manager if I do.
Modification:
Specific Individualized Assessed Need (Note: a diagnosed disability is not a specific assessed need):
Positive Interventions and Supports used Before this Modification:
Diagnosis/Condition Related to the Modification:
Method for Collection and Review of Data for Effectiveness:
Timeframes/Limits for Review and Determination of Need for Modification:
Assurance that the Modification Will Cause No Harm:

PCSP Follows The Person

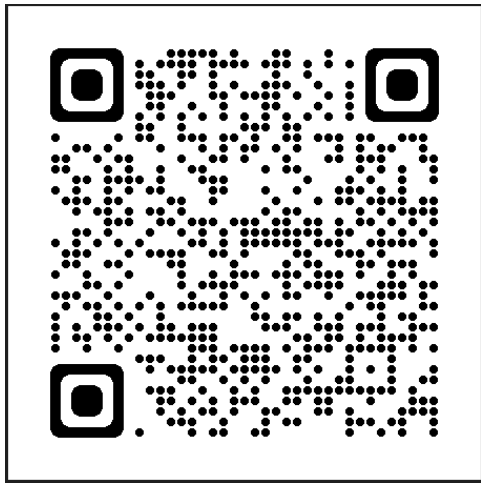
- The revised template focuses more specifically on the person and includes all the required standards/modifications. Strengths and Preferences are addressed first, allowing the person to talk about themselves, and build a trusting, meaningful relationship with the Care Manager.
- The template must be written, and easily accessible and understandable to all of those involved in the PCSP.
- The person and representative must receive a copy of the signed PCSP.
- Ideally, the document will be updated with notes from the all service providers involved in carrying it out. This will ensure that all parties are aware of modifications to the additional standards and that documentation is maintained for ongoing monitoring and quality assurance.

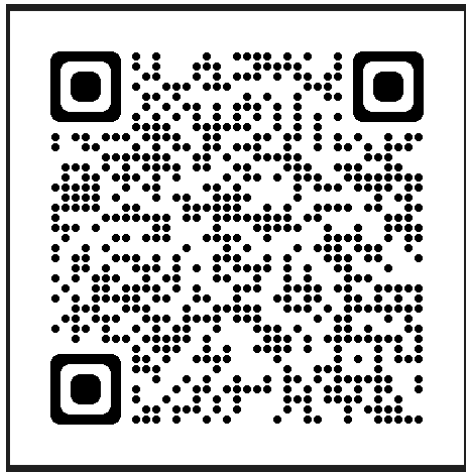
PCSP and Private Settings

- In May 2019, CMS made it clear that states' responsibility to oversee compliant settings extends beyond provider-owned or controlled settings to private homes and permitted states to presume that recipients' homes and those of relatives, friends or neighbors were compliant.
- Now CMS is expecting states to commit to ongoing monitoring of private homes in a more direct manner. NYS is working with agencies/programs overseeing HCBS and with CMS to better understand the purpose of the Rule and then develop a plan to comply within NYS resources.
- In the meantime, NYS is revising the NYS STP as requested by CMS to provide additional detail about our member and/or provider settings and their compliance status.

HCBS Final Rule Guidance and PCSP Template

- PCSP Template
- PCSP Guidance





Applicable Waivers

- 1915(c) NHTD, Children's Waiver, TBI, OPWDD Comprehensive Waiver
- 1915(k) Community First Choice Option
- 1115

The Person-Centered Plan requirements are included in Section 2402(a) of the Affordable Care Act

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Questions?

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