Definition of Person-Centered Planning

Person-centered planning is a process directed by the person with LTSS needs. It may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. PCP should also include family members, legal guardians, friends, caregivers, and others the person or his/her representative wishes to include. PCP should involve the individuals receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs (medical and HCBS), and desired outcomes. The role of agency workers (e.g., options counselors, support brokers, social workers and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs, and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

Preferences may include, for example, the following concepts related to the person's experience and necessary supports:

- Family and friends
- Housing
- Employment
- Community integration
- Behavioral health
- Culture
- Social activities
- Recreation
- Vocational training
- Relationships
- Language and health literacy
- Other community living choices

PCP assists the person to construct and articulate a vision for the future, consider various paths, engage in decision-making and problem solving, monitor progress, and make needed adjustments to goals and HCBS in a timely manner. It highlights individual responsibility including taking appropriate risks (e.g. back-up staff, emergency planning). It also helps the team working with the individual to know the person better.

Person-Centered Planning Process

PCP must be implemented in a manner that supports the person, makes him or her central to the process, and recognizes the person as the expert on goals and needs. In order for this to occur there are certain process elements, consistent with statutory or regulatory provisions. These include:

1. The person or representative must have control over who is included in the planning process, as well as the authority to request meetings and revise the plan (and any related budget) whenever necessary.
2. The process is timely and occurs at times and locations of convenience to the person, his/her representative, family members, and others.
3. Necessary information and support is provided to ensure the person and/or representative is central to the process, and understands the information. This includes the provision of auxiliary aids and services when needed for effective communication.
4. A strengths-based approach to identifying the positive attributes of the person must be used, including an assessment of the person's strengths and needs. The person should be able to choose the specific PCP format or tool used for the PCP.
5. Personal preferences must be used to develop goals, and to meet the person's HCBS needs.
6. The person's cultural preferences must be acknowledged in the PCP process, and policies/practices should be consistent with the HHS Office on Minority Health Standards National Standards on Culturally and Linguistically Appropriate Services (CLAS) http://www.minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15.
7. The PCP process must provide meaningful access to participants and/or their representatives with limited English proficiency (LEP), including low literacy materials and interpreters.
8. People under guardianship or other legal assignment of individual rights, or who are being considered as candidates for these arrangements, should have the opportunity in the PCP process to address any concerns.
9. There must be mechanisms for solving conflict or disagreement within the process, including clear conflict of interest guidelines.
10. People must be offered information on the full range of HCBS available to support achievement of personally identified goals.
11. The person or representative must be central in determining what available HCBS are appropriate and will be used.
12. The person must be able to choose between providers or provider entities - including the option of SD services - when choice is available.
13. The PCP must be reviewed at least every twelve months or sooner, when the person's functional needs change, circumstances change, quality of life goals change, or at the person's request. There must be a clear process for individuals to request updates. The accountable entity must respond to such requests in a timely manner that does not jeopardize the person's health and safety.
14. PCP should not be constrained by any pre-conceived limits on the person's ability to make choices.
15. Employment and housing in integrated settings must be explored, and planning should be consistent with the individual's goals and preferences,

including where the individual resides, and who they live with.

Elements of the Person-Centered Plan

The person-centered service plan must identify the services and supports that are necessary to meet the person's identified needs, preferences, and quality of life goals. To the extent that PCPs are consistent with statutory and regulatory provisions, the PCP must have the following attributes:

1. Reflect that the setting where the person resides is chosen by the individual. The chosen setting must be integrated in and support full access 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 HCBS.
2. The plan must be prepared in person-first singular language and be understandable by the person and/or representative.
3. In order to be strengths-based, the positive attributes of the person must be considered and documented at the beginning of the plan.
4. The plan must identify risks, while considering the person's right to assume some degree of personal risk, and include measures available to reduce risks or identify alternate ways to achieve personal goals.
5. Goals must be documented in the person's and/or representative's own words, with clarity regarding the amount, duration, and scope of HCBS that will be provided to assist the person. Goals will consider the quality of life concepts important to the person.
6. The plan must describe the services and supports that will be necessary and specify what HCBS are to be provided through various resources including natural supports, to meet the goals in the PCP.
7. The specific person or persons, and/or provider agency or other entity providing services and supports must be documented.
8. The plan must assure the health and safety of the person.
9. Non-paid supports and items needed to achieve the goals must be documented.
10. The plan must include the signatures of everyone with responsibility for its implementation including the person and/or representative, his or her case manager, the support broker/agent (where applicable), and a timeline for review. The plan should be discussed with family/friends/caregivers designated by the individual so that they fully understand it and their role(s).
11. Any effort to restrict the right of a person to realize preferences or goals must be justified by a specific and individualized assessed safety need and documented in the PCP. The following requirements must be documented in the PCP when a safety need warrants such a restriction:
    a. The specific and individualized assessed safety need.
    b. The positive interventions and supports used prior to any modifications or additions to the PCP regarding safety needs.

c. Documentation of less intrusive methods of meeting the safety needs that have been tried, but were not successful.
d. A clear description of the condition that is directly proportionate to the specific assessed safety need.
e. A regular collection and review of data to measure the ongoing effectiveness of the safety modification.
f. Established time limits for periodic reviews to determine if the safety modification is still necessary or can be terminated.
g. Informed consent of the person to the proposed safety modification; and
h. An assurance that the modification itself will not cause harm to the person.

12. The plan must identify the person(s) and/or entity responsible for monitoring its implementation.
13. The plan must identify needed services, and prevent unnecessary or inappropriate services and supports.
14. An emergency back-up plan must be documented that encompasses a range of circumstances (e.g. weather, housing, staff).
15. The plan must address elements of SD (e.g. fiscal intermediary, support broker/agent, alternative services) whenever a self-directed service delivery system is chosen.
16. All persons directly involved in the planning process must receive a copy of the plan or portion of the plan, as determined by the participant or representative.

Person-Centered Planning Implementation

Implementing the person-centered plan requires monitoring progress to achieve identified goals, so that appropriate action is taken when necessary. This includes mechanisms to ensure all HCBS - paid and unpaid - are delivered, that the plan is reviewed according to the established timeline; there is a feedback mechanism for the person or representative to report on progress, issues and problems; and that changes can be made in an expedient manner.

People receiving HCBS must be fully involved in the process to update their service plans based on their needs and preferences on an ongoing and regular basis, no less often than annually, based on the time the plan was created or last revisited.

Successful implementation for systems or accountable entities (e.g. state or local programs) requires policy, mission/vision statements, and operations documents at the federal, state, local, and person-level (for self-direction) aligned to incorporate PCP standards, and that staff involved in the PCP process have a consistent understanding of the process and implementation. In order for PCP principles to be fully realized leadership, administrative, and other staff are strongly encouraged to receive competency-based training in PCP. A process for monitoring PCP should be implemented at the federal, state, and local levels and incorporated as an integral component of quality improvement activities across HCBS programs.

For people using HCBS, this includes active engagement in the planning and service delivery process involving a number of support professionals. The person's input informs the quality

of services and supports when he/she takes an active role in the PCP process by:

- Providing accurate information for eligibility and service planning.
- Actively identifying and engaging providers, case managers, family members, friends, direct support workers, support brokers, medical professionals, and others.
- Approving and signing only a plan that is developed and accepted by everyone involved.
- Participating fully after the approved plan is implemented (e.g., appearing timely for meetings and appointments, reviewing the plan regularly).
- Providing regular feedback on the HCBS provided.

Definition of Self-Direction

SD means a consumer-controlled method of selecting and using services and supports that allow the person maximum control over his or her HCBS including the amount, duration, and

scope of services and supports as well as choice of provider(s). Often, in addition to the typical range of HCBS, self-directed delivery systems permit the person to purchase alternative goods and supports (where authorized by statute or regulation) that may not be available in traditional HCBS service delivery systems. Alternatively, some services available in traditional services delivery (e.g. respite care, day programs, criminal background checks, drug and alcohol screens, training) may not be available in a self-directed service delivery model. There are also various administrative arrangements that apply specifically to SD. For example, the person may act as the "employer of record" with the necessary supports to perform that function, and/or have a significant and meaningful role in the supervision of direct service worker(s). Some people may use a representative to direct their HCBS, and family members or legal guardians may have a role to assist people under guardianship, or un-emancipated minors. People who are self-directing their services should be given as much responsibility as they desire to hire, train, supervise, schedule, determine duties, and dismiss the providers or direct service workers whom they employ directly, or for whom they may share employment responsibilities with an agency. Many people use the services of a support broker or agent to assist them in these and other duties, with the support broker/agent included as distinct service in the person's PCP.

Payment of SD HCBS could be through the provision of vouchers, direct cash payments, or use of a fiscal agent or fiscal intermediary to assist in paying for services and making certain all necessary payroll functions, including the payment of taxes, are performed. Fiscal agents/intermediaries may also provide regular service and payment summaries to the person receiving HCBS, and issue payment to providers, direct service workers, and support brokers/agents through electronic or paper methods. In some self-directed models, fiscal agency fees are based on a monthly or utilization basis, and are included in the person's HCBS budget. Self-directed models exist in both traditional fee for service and managed care delivery systems.

Required Elements of Self-Direction

HCBS programs that provide SD must incorporate the following elements, to the extent they are consistent with statutory and regulatory provisions:

1. SD service delivery models must meet the PCP standards described in this document.
2. SD, when offered within programs, should be available to all individuals regardless of age, disability, diagnosis, functional limitations, cognitive status, sex, sexual orientation, race, ethnicity, physical characteristics, national origin, religion, and other such factors.
3. When representatives are required, they must be freely chosen when circumstances permit.
4. HCBS consumers must have access to information and counseling and information on self-direction through a variety of sources as needed or desired, so they can make an informed decision when choosing a SD service delivery model.
5. Case managers and administrative staff should have training in SD. This includes training, for example, on recruitment and education of direct service workers, budget processing, how the PCP relates to the SD budget, needed alternative supports, housing search, etc.
6. When a person chooses SD, an assessment of the supports needed to be successful should be conducted. People who choose SD must have access, for example, to culturally-linguistically sensitive information, training in issues specific to self-direction, financial/fiscal management services, and support brokers/agents, to assist them in the successful management of their HCBS.
7. In addition, the following information and support should be provided:
    a. PCP and how it is applied through SD.
    b. Use of and access to the grievance process.
    c. Individual rights, including appeal rights.
    d. Reassessment and review schedules for PCP, budgeting, etc.
8. The SD PCP must specify the following:
    a. The HCBS the individual will be responsible for self-directing.
    b. The methods by which the person will plan, direct or control services, including whether authority will be exercised over the employment of service providers and/or authority over expenditures from the individualized budget.
    c. Appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in SD, and assure the continued appropriateness of the PCP and budget based upon the resources and support needs of the person.
    d. The process for facilitating voluntary (and involuntary) transition from self-direction to a traditional service delivery model or other arrangement (e.g. institutional setting). There must be procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods or provider types.
    e. Financial/fiscal management supports to be provided.
    f. Support broker/agent services, irrespective of payment method (fee for service,

managed care). If there is no support broker/agent required or chosen, the person must have training in acting as his/her own support broker.

g. If the PCP includes the employer authority to select, manage, or dismiss providers, it must specify the authority to be exercised by the person, any limits to the authority, and the parties responsible for functions outside the authority of the person.

9. If the PCP includes budget authority (which identifies the dollar value of the HCBS under the control and direction of the person), the SD PCP must meet the following requirements:
    a. Outline the method(s) for calculating the dollar values and/or categories in the budget, based on reliable costs and service utilization.
    b. Define a flexible and easily accessible process for making timely adjustments in dollar values to reflect changes in the person's SD PCP, particularly to support health and safety.
    c. Provide for a regular procedure to evaluate expenditures under the budget, including those outlined in the SD PCP.
10. The SD planning process must be conducted in a manner and language understandable to the person and his/her representative(s). Individuals and/or their representatives must be provided with auxiliary aids and services if necessary for effective

    communication. The SD process must provide meaningful access to people and/or their representatives who have limited English proficiency.
11. SD program entities must explicitly outline and make transparent to all stakeholders enrollment requirements such as limitations based on geography, demographic factors, residential arrangements, etc.
12. People must have the flexibility to choose the needed services and supports that best meet their needs and preferences within the context of a PCP process that includes the development of an agreed upon, multi-lateral, and approved funding allocation/budget amount for the projected SD HCBS.
13. People must have the flexibility to choose how funds will be used based on the HCBS identified in the PCP, consistent with the requirements of the funding authority, in a transparent manner, including (where appropriate), the ability to move funds categorically as needed.
14. People must have the flexibility to expeditiously and seamlessly change their service plans and budget allocations, based on different needs and preferences, with an assurance of health and safety.
15. People must be able to choose their paid and unpaid direct care workers and/or medical support staff, may include family and friends based on administrative policies, so long as they meet agreed upon guidelines and qualifications for the position, and are willing to perform the duties.
16. People must be allowed to direct the training of their workers in a manner consistent with applicable program requirements, and receive financial support to accomplish critical training needs as appropriate and available.
17. People must be provided with opportunities to participate in defining quality,

such as the determination of worker qualifications and training, personal goal setting, and performance measures.

18. People must be supported in taking risks associated with pursuing their goals. There must be a back-up plan for assumed risks, and for a variety of emergency situations.
19. People must have the opportunity, as identified in the PCP and budget, to allocate or set aside funds for emergency needs (e.g., more costly emergency back-up workers, alternative emergency housing) to the extent authorized by applicable law and regulations.
20. People must have the opportunity, as identified in their PCP and budget, to allocate or set aside funds for, and where authorized, specialized purchases made timely such as necessary home or vehicle modifications to support independence and avoid unnecessary institutionalization.
21. People who need assistance with decision-making and do not have an authorized representative must have the option to choose an informal representative to assist them in selecting or managing services and supports, and/or have a person authorized to make personal or health decisions for them. People must also have access to one-on- one assistance as needed or requested with selecting or changing their informal representative.
22. The finalized SD PCP must be signed by the person or his/her legal representative, and a written copy of the plan and budget should be provided to all relevant parties.

Regulatory Requirements for Home and Community-Based Settings:

For 1915(c) home and community-based waivers and, for 1915(i) State plan home and community-based services, home and community-based settings must have all of the following qualities defined at §441.301(c)(4) and §441.710 respectively, 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:

- 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.
- 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.
- Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
- 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. \
- Facilitates individual choice regarding services and supports, and who provides them.
- In a provider-owned or controlled residential setting, in addition to the qualities specified above, the following additional conditions must be met:

1. 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.
2. Each individual has privacy in their sleeping or living unit:
    a. Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
    b. Individuals sharing units have a choice of roommates in that setting.
    c. Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
3. Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.
4. Individuals are able to have visitors of their choosing at any time.
5. The setting is physically accessible to the individual.
6. Any modification of the additional conditions specified in items 1 through 4 above, 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:
    • Identify a specific and individualized assessed need.
    • Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
    • Document less intrusive methods of meeting the need that have been tried but did not work.
    • Include a clear description of the condition that is directly proportionate to the specific assessed need.
    • Include regular collection and review of data to measure the ongoing effectiveness of the modification.
    • Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
    • Include the informed consent of the individual.
    • Include an assurance that interventions and supports will cause no harm to the individual.

Settings That are Not Home and Community-Based:

For 1915(c) home and community-based waivers, settings that are not home and community-based are defined at §441.301(c)(5) as follows:

- A nursing facility;
- An institution for mental diseases;
- An intermediate care facility for individuals with intellectual disabilities;
- A hospital; or
- Any other locations that have qualities of an institutional setting, as determined by the Secretary.

For 1915(i) State plan home and community-based services, settings that are not home and community-based are defined at §441.710(a)(2) as follows:

- A nursing facility;
- An institution for mental diseases;
- An intermediate care facility for individuals with intellectual disabilities;
- A hospital; or
- Any other locations that have qualities of an institutional setting, as determined by the Secretary.

Settings that are Presumed to have the Qualities of an Institution:

For 1915(c) home and community-based waivers, section 441.301(c)(5)(v) specifies that the following settings are presumed to have the qualities of an institution:

- any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment,

- any setting that is located in a building on the grounds of, or immediately adjacent to, a public institution, or

- any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.

For 1915(i) State plan home and community-based services, section 441.710(a)(2)(v) specifies that the following settings are presumed to have the qualities of an institution:

- any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment,

- any setting that is located in a building on the grounds of, or immediately adjacent to, a public institution, or

- any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.