NEW YORK STATE OF OPPORTUNITY. Department of Health

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**ADMINISTRATIVE DIRECTIVE**

**TRANSMITTAL**: 23 OHIP ADM-01

**TO:** Commissioners of Social Services

**DIVISION:** Office of Health Insurance Programs

**DATE:** February 17, 2023

**SUBJECT:** Person-Centered Service Plan (PCSP)

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| **SUGGESTED DISTRIBUTION:** | Director of Social Services<br>Medicaid Staff<br>Home Care Staff<br>Fair Hearing Staff<br>Local Professional Director |
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| **ATTACHMENTS:** | See Appendix for Attachment |

**FILING REFERENCES**

| Previous Ref. ADMs/INFs | Releases Cancelled | Dept. Regs. Law | Soc. Serv. & Other | Manual Ref | Misc. |
|---|---|---|---|---|---|
| 19 OHIP/ADM-01 | None | 18 NYCRR 505.14<br>18 NYCRR 505.28 | 365-a<br>365-f | None | None |

## I. PURPOSE

The purpose of this Office of Health Insurance Programs Administrative Directive (OHIP ADM) is to provide Local Departments of Social Services (LDSS) with information and guidance regarding the person-centered service plan (PCSP) in New York State.

The person requiring care (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 require that the PCSP process be directed by the person and/or a representative they choose, and other participants they want to include.

## II. BACKGROUND

This guidance expands upon direction previously given in 19 OHIP/ADM-01 and is based on Federal regulations 42 CFR 441.301, 42 CFR 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) as described in 14 NYCRR 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, or have Special Health Care Needs 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. The LDSS is 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.

## III. PROGRAM IMPLICATIONS & REQUIRED ACTIONS

To support Medicaid individuals in remaining or returning to their own home (or the home of a family member or close friend) to receive care rather than in an institutional setting, the Department of Health (Department) is ensuring that systems are aligned to provide needed long term care services and supports. This would include when assistance is needed due to a physical, behavioral, or developmental disability, and aligns with federal requirements for developing care plans.

## A. Elements of the Person-Centered Planning Process

During the PCSP process, the LDSS must:

1. Include people chosen by the person receiving services and/or their representative.
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 their representative does not agree with the PCSP, they can work with the LDSS case manager (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 may pursue additional options for recourse, 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.

## B. Assessment

### 1. Comprehensive Assessment

Before a PCSP can be developed, the person's need for community-based long term care services and supports (CBLTSS) must be determined based on a comprehensive assessment of their functional and health needs. The PCSP process requires 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 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 LDSS. While the assessment documents living arrangements, health concerns, and functional needs related to the ability to perform daily activities, the 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 LDSS 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 LDSS 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.

### 2. 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:

a) ability to give consent
b) mobility
c) bathing safety
d) ability to manage their finances
e) ability to seek and maintain employment/volunteer opportunities
f) medication management
g) chronic medical conditions and allergies
h) special dietary needs
i) behaviors that present harm to self or others
j) level of safety awareness
k) level of supervision required at home and in the community
l) fire safety and evacuation

### 3. Risk Management Plan

Following the risk assessment, a risk management plan must 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 LDSS 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.

## C. Person-Centered Service Plan Requirements

The PCSP must be individualized and understandable to the person. Federal 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 is capable of and 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.

### 1. 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:

a) 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.
b) 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.
c) clinical and support needs as identified through the comprehensive assessment of functional need.
d) individually identified goals and desired outcomes.
e) 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.
f) 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).
g) services and supports not covered that are necessary to maintain the PCSP, including identified unmet needs and steps to address them.

h) risk factors and measures in place to minimize them, including individualized backup plans and strategies.
i) plain language and descriptions that are accessible to persons with disabilities and LEP persons, consistent with 42 CFR 435.905(b) of this chapter, so both the person and their helpers can clearly understand the PCSP.
j) identify the individual and/or entity responsible for monitoring the plan.
k) informed consent of the person, in writing, and signatures of all individuals and providers responsible for its implementation.
l) services, the purchase or control of which the person elects to self-direct, if applicable.
m) measures to prevent the provision of unnecessary or inappropriate services and supports.

In addition, the PCSP must:

n) be distributed to the person and other people involved in the plan, and
o) document that any modification of the additional conditions, under federal regulations, must be supported by a specific assessed need and justified in the PSCP.

The template for a Person-Centered Service Plan is attached as Attachment I. This template is updated with additional required elements and must be used by each LDSS. An LDSS that has developed another tool that includes all elements as outlined in Attachment I may be submitted to the Department for review and consideration.

The Department 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 Department's website within the Person-Centered Planning and Practice Resource Library at https://www.health.ny.gov/health_care/medicaid/redesign/person-centered_planning/index.htm.

**2. Home and Community-Based Settings**

Per federal regulation at 42 CFR 441.301:

HCBS may only be provided in settings that meet federal standards. All recipients of Medicaid-funded HCBS must live and receive services in settings that provide informed choice, options, and integration in their community.

Recipients must also have a PCSP that documents their informed choices and options. 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.

For additional information about the definition of HCBS settings, please refer to: https://www.health.ny.gov/health_care/medicaid/redesign/home_community_based_settings.htm (p.3030)

The PCSP should indicate that the home and community-based setting includes the following required qualities:

a) 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.
b) 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.
c) The setting ensures a person's rights of privacy, dignity and respect, and freedom from coercion and restraint.
d) 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.
e) The setting facilitates the person's choice regarding services and supports, and who provides them.

### 3. 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 person'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.

### 4. 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:

a) at least once every 12 months or as often as is required by applicable regulations
b) upon reassessment of functional, behavioral, medical, and/or social needs
c) when the person's circumstances or needs change significantly;
d) 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, their representative if they have one, and whomever the person invites. The PCSP review should include a check on progress regarding the person's goals and whether they need to be reevaluated/revised.

### D. 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 covered under Medicaid fee-for-service (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.

## IV. SYSTEMS IMPLICATIONS

None

## V. EFFECTIVE DATE

This ADM is effective March 1, 2023.

**Appendix/Attachment**

**Attachment I**: Person-Centered Service Plan Template.

Also available at:
https://www.health.ny.gov/health_care/medicaid/redesign/hcbs/docs/pcp_template.pdf