Department of Health | Office of Mental Health | Office of Addiction Services and Supports | Office of Children and Family Services | Office for People With Developmental Disabilities

Plan of Care & Person-Centered Planning Requirements

For Health Home Care Managers (HHCM) &
Children's Home and Community Based Services (HCBS)

April 2021

Upcoming HCBS Children's Waiver Webinars

HCBS Overview	LOC/ Eligibility Determination	Waiver Enrollment	POC Development	Referral	Maintaining Waiver Enrollment / Service Delivery	Transfer / Disenroll
Children's Medicaid System Overview/ Children's Waiver Overview	CANS-NY/ Eligibility Assessment	Capacity Management	Plan of Care/Person-Centered Planning Requirements	HCBS POC Workflow and MMCP Authorization	Care Management Requirements for HCBS	Waiver Disenrollment
Health Home Care Management Basics	NODs, Fair Hearing, Critical Incident Reporting, Grievances and Complaints	Participant Rights and Protections	Service Delivery and Definitions		Service Delivery Requirements	Transferring to Adult Services (aging out) or OPWDD waiver
HCBS Provider Requirements for Designation	Children and Youth Evaluation Services (C-YES) – the Role of the Independent Entity	Conflict Free Care Management				
Medicaid Overview / Medicaid and the Children's Waiver						

Required for only Health Home Care Managers
Required for only HCBS Providers
Required for Both
Optional for Both

April 2021

Agenda

- ✓ Medicaid Programs and Services
- ✓ Person-Centered Service Planning Requirements (PCSP)
- ✓ Overview of Plan of Care (POC) / Service Planning / Treatment Planning
- ✓ POC Development & Updates
- ✓ POC Coordination
- ✓ Appendix

Medicaid Programs and Services - PCSP

April 2021

NYS Medicaid Programs and Services

- Person-Centered Service Planning (PCSP) is being instituted in NYS Medicaid Programs and Services however required specific to Home and Community Based Services (HCBS) and the HCBS Settings Final Rule

- Additionally, the Centers of Medicare and Medicaid Services (CMS) at the federal level are requiring Person-Centered Service Planning through Services, Programs, and Benefits approved by CMS

- Person-Centered Service Planning is a model for how we interact with members and members are in the center of their service planning regardless of the service, program, or type of planning document (Plan of Care, Service Plans, or Treatment Plans)

- NYS has been providing Person-Centered Service Planning Training Statewide to ensure that throughout all services, programs, and providers - Person-Centered Service Planning is implemented

Websites:

- Person-Centered Planning Comprehensive System Transformation Statewide Training Initiative

- Person-Centered Planning and Practice Resource Library

- Virtual Learning Institutes

Person-Centered Service Planning Requirements

April 2021

Person-Centered Service Planning (PCSP) Overview

- 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 child/youth.
- This process incorporates development of the child/youth's **Plan of Care (POC)** and **Service Plan**.
- Per the PCSP process, the POC and Service Plan must reflect the child/youth's choices, preferences, and goals, and support their inclusion in the community.
- During the PCSP process, the child/youth (and their parents/guardian) directs the planning of services and makes informed choices about the services and supports received, to the maximum extent possible.
- Federal regulations require that the PCSP process be directed by the individual and, if the person has a representative, includes the representative.
- **PCSP is a requirement of the CMS Home and Community Based Services (HCBS) Final Rule and the Children's Waiver**

More information can be found in the Person Centered Service Planning Guidelines

PCSP Collaboration

- The PCSP process may include an interdisciplinary team consisting of licensed professionals, other service providers, and supports, as the enrollee/recipient desires
  - Health Home requires an interdisciplinary team meeting when developing the Plan of Care and during times of CANS-NY assessments.
  - The Health Home process requires communication and collaboration with involved providers and supports.
  - Health Home care managers and HCBS provider MUST work together to ensure a comprehensive Plan of Care and that the HCBS provider's service plan is aligned
- The PCSP process can be coordinated by a care manager (CM) or HCBS provider, or care team member as long as they consider the child/youth's support system including formal and informal supports
- The formal supports must have adequate knowledge, training, and expertise regarding community living and person-centered service delivery
- Informal supports include the child/youth'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 child/youth is willing to accept services from the informal support

PCSP Assessments

Assessment

- The CM should coordinate the assessments the child/youth requires to determine functional needs and to determine the scope of individual services necessary to complete the POC.
- The PCSP process requires a face-to-face assessment of the child/youth's need, once the request for services or supports is received
  - For Health Homes this the Comprehensive Assessment along with the CANS-NY
  - For HCBS this could be an intake assessment for the identification of specific service need

Risk Assessment

- To ensure the health and safety of each child/youth, a risk assessment must be conducted during the initial comprehensive assessment and each subsequent reassessment.
- The risk assessment will evaluate potential risks to the child/youth'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 child/youth and anyone the child/youth wishes to attend.

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 child/youth'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 child/youth's family member, friend or other responsible adult.

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 (safety plan or crisis plan).
  - 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.

- The risk management plan must include a safeguarding section.
  - This safeguarding section must identify the supports needed to keep the child/youth safe from harm and actions to be taken when the health or welfare of the enrollee/recipient is at risk.

Care Management Requirements

Conflict of Interest Standard

- Federal regulations require that the POC development function of care/case management must be separate from the service delivery function (specific for HCBS).
- Providers of HCBS for the child/youth, or those who have an interest in or are employed by a provider of HCBS for the child/youth must not provide case management or develop the POC without fire walls in place (called Conflict Free). HCBS and Care Management must be separate lines of business.
- 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 HCBS
- Within the Children's Services of Health Home care management and HCBS Conflict Free is allowable.

More information can be found in the Conflict Free Care Management Policy

Overview of POC

Distinction between the Plan of Care (POC) and Service Plan

POC:

- This document is used to guide day to day care management and overview of the needs and services of the member.
- The POC documents the child/youth's current goals, preferences, interventions, and timeframes.
- This must be written in plain language and in a manner that is accessible to individuals with disabilities and persons with limited English proficiency and should reflect the cultural considerations of the child/youth.

HCBS Service Plan:

- Once the child/youth's needs are identified and the child/youth/family identifies the service and HCBS provider of choice, then the HCBS provider must document the approach for service provision on a HCBS Service Plan.
- The purpose of the Service Plan is to outline the child/youth's service(s), goals, and objectives.
- The HCBS Service Plan determines the focus of the service(s), while also documenting the **scope, duration,** and **frequency** to which each service will be provided.
- If the child/youth is referred to more than one HCBS provider, then each HCBS provider will have their own Service Plan for the services they will provide to the child/youth.

Distinction between HH POC and HCBS POC

HH POC:

- Children/youth enrolled in HHSC but **not** HCBS have a HH POC completed by the HHCM.

HCBS POC:

- Children/youth enrolled in HHSC **and** HCBS will have a HCBS POC completed by the HHCM.
- Children/youth receiving HCBS but are **not** enrolled in HHSC will have a HCBS POC completed by C-YES and or their Medicaid Managed Care Plan.

POC Requirements

- Federal regulations describe the minimum requirements for POC developed through the person-centered service planning process:
  - The PCSP process results in a written POC with individually identified goals and preferences, which 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 the child/youth chooses to self-direct their services.
  - The POC will identify the specific services and the service providers used to meet stated goals, as well as their frequency, scope, and duration for HCBS.
  - Most importantly, the POC will be individualized and understandable to the child/youth/family

Please note that the POC must comply with other state guidance that applies to specific services such as Health Homes.

Individualized and Understandable

POC:

- The CM completes a collaborative assessment with the child/youth/family to determine strengths and needs
- The child/youth/family determine the needs they would like to address first
- The care manager shares information and education of services that may address the identified needs
- The POC outlines all the identified needs and those specifically the child/youth/family want to address, and the services chosen
  - For HCBS, adding Frequency, Scope, and Duration is later added from the HCBS provider
- Child/youth/family and CM come to agreement regarding the review of the POC and the ability to update and change the POC and specific services

Service Plan:

- The HCBS provider verifies with the child/youth/family the needs and the service chosen
- The HCBS provider shares information and education of the services, option of how the service may be provided
- The child/youth/family and HCBS provider come to agreement regarding how the services will be provided - the Frequency, Scope, and Duration to address the particular need
- Agreement is also made to re-visit the Frequency, Scope, and Duration and goal outcomes throughout service delivery

POC Development

- To develop a POC, the care manager must meet with the child/youth/family and their identified care team to discuss the needs of the child/youth, using person-centered planning guideline/principles.
- The POC development is based upon the assessment of needs which is determined through the interaction with the child/youth, their family, and identified supports as well as through the multi-disciplinary team meeting/information, CANS-NY, Health Home Comprehensive Assessment, and/or HCBS/LOC Eligibility Determination.
- The POC will change and evolve over time as the child/youth meets their goals or there is a need for new services/supports.
- The POC must be signed by the child/youth, if age appropriate (able to understand and contribute to their own POC) and/or the parent, guardian, or legally authorized representative.

More information is in the HCBS POC Workflow

POC Development (cont.)

- The POC must indicate all of the services a child/youth receives. Examples of services that should be indicated in a child/youth's POC, if applicable, include:
  - All physical and/or mental health providers, and the scope and goals of treatment
  - HCBS waiver providers and services, and the scope and goals of services
  - Non-Medicaid services utilized by the child/youth to help meet their physical mental and social health needs
  - Children and Family Treatment and Support Services (CFTSS) providers and services the member receives, and the scope and goal of services

PCSP and the Final Rule

April 2021

HCBS Settings Requirements

- HCBS settings must have certain qualities based on the needs of the child/youth as indicated in their person centered POC
- The POC should indicate that the HCBS setting includes the following required qualities:
  - Setting is integrated in and supports full access of children/youth 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.
  - Setting is selected by the child/youth/family 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 POC and are based on the child/youth's needs, preferences, and, for residential settings, resources available for room and board.
  - Setting ensures the child/youth's rights of privacy, dignity and respect, and freedom from coercion and restraint.

HCBS Settings Requirements (cont.)

- 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.
- Setting facilitates child/youth choice regarding services and supports, and who provides them.
- 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.

- **HCBS Providers should have policies in place to ensure PCSP and HCBS Setting principles are adhered to**; employees should be trained in how to incorporate PCSP into service planning and delivery

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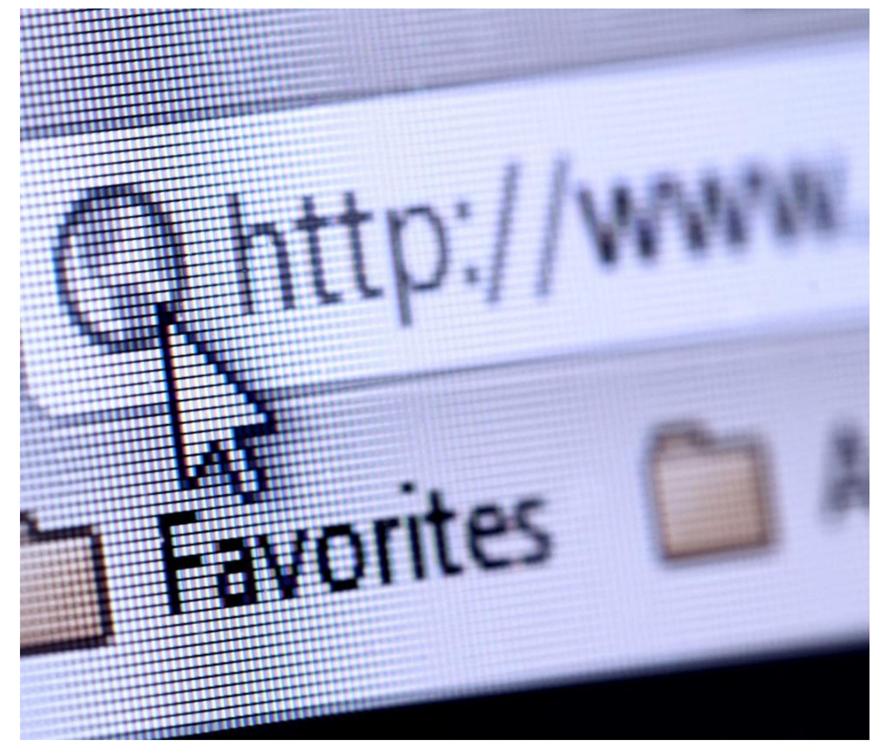
Appendix

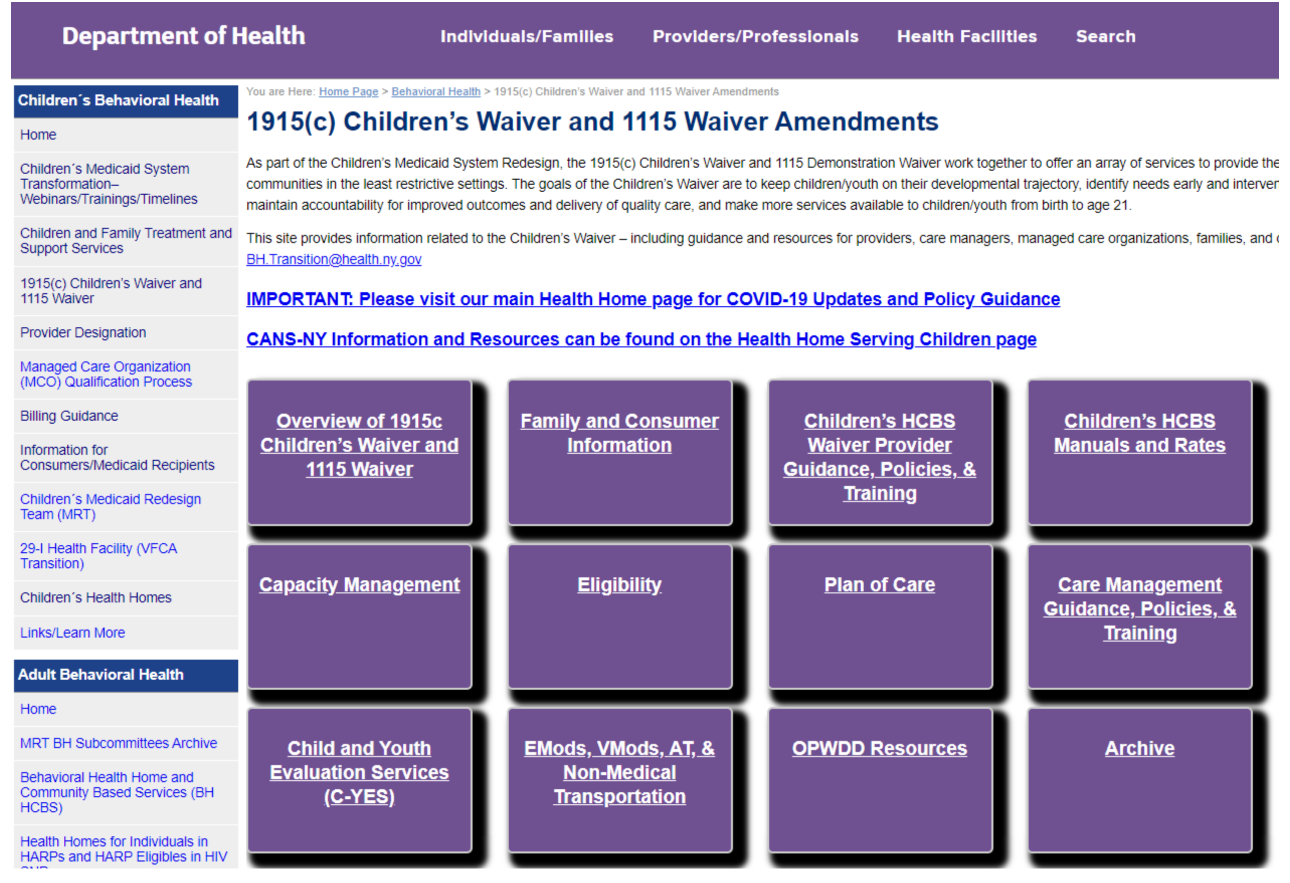
Resources and Questions

- HHCMs and HH CMAs should first talk with their Lead Health Home regarding questions and issues they may have
- Questions, comments or feedback on Health Homes Serving Children to: hhsc@health.ny.gov or contact the Health Home Program at the Department of Health at 518.473.5569
- Specific Questions/Comments regarding Transition services BH.Transition@health.ny.gov
- Questions specific to the HCBS Settings Final Rule can be sent to ChildrensWaiverHCBSFinalRule@health.ny.gov
- Subscribe to the HH Listserv http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/listserv.htm



NYS DOH Website

Find guidance, policies, forms, webinars, and more on the NYS DOH 1915c Children's Waiver webpage located at, https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/1115_waiver_amend.htm



Resources: Person-Centered Training

To learn more, visit: https://www.cvent.com/c/calendar/a80427e7-4d30-4cfe-864b-a4080b07e48e

Resources: Forms

Children's HCBS Authorization and Care Manager Notification Form

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/childrens_hcbs_authorization_cm_notification_form_fillable.pdf

Resources: Policies

Person Centered Service Planning Guidelines
https://www.health.ny.gov/health_care/medicaid/redesign/cfco/docs/2018-12-19_pcsp_guidelines.pdf

Health Home Plan of Care Policy
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/docs/hh0008_plan_of_care_policy.pdf

HCBS POC Workflow
https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/childrens_hcbs_poc_workflow.pdf

Conflict Free Case Management Policy (February 2020)
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/docs/hh0012_conflict_free_care_management_policy.pdf

Department of Health Complaints

- Enrollees and providers may file a complaint regarding managed care plans to DOH
  - 1-800-206-8125
  - managedcarecomplaint@health.ny.gov
- When filing:
  - Identify plan and enrollee
  - Provide all documents from/to plan
  - Medical record not necessary

- Issues not within DOH jurisdiction may be referred

- DOH is unable to arbitrate or resolve contractual disputes in the absence of a specific governing law

- File Prompt Pay complaints with Department of Financial Services: https://www.dfs.ny.gov/insurance/provlhow.htm

Referral Form Instructions

- The Children and Youth Evaluation Service (C-YES) accepts referrals from individuals and providers including a parent, wider family member, doctor, therapist, school guidance counselor, CBOs and others:

- Individuals and families should call C-YES so that we can send you a Referral Form and a pre-paid return envelope in the mail right away! You can mail back the form in the envelope at no cost to you. Call C-YES at 1-833-333-CYES (1-833-333-2937). TTY: 1-888-329-1541

- Providers and Organizations with secure email protocols can download the Referral Form below. Return the form to: CYESREFERRAL@MAXIMUS.COM. Be sure to include the child/youth's name and contact information.

- C-YES Referral Form

POC Coordination

Responsible Entities

MMCP	HHCM	C-YES	HCBS Provider

Milestone event	Responsible entity			
	Enrolled in MMCP		FFS Medicaid	
	Enrolled in HH	Opt-out of HH, Served by C-YES	Enrolled in HH	Opt-out of HH, Servedby C-YES
HCBS Provider referral	HHCM	C-YES	HHCM	C-YES
Notifies MMCP and HHCM of First Appointment	HCBS Provider	HCBS Provider	N/A	N/A
On-going POC updates	HHCM	MMCP	HHCM	C-YES
Request Authorization for Services	HCBS Provider	HCBS Provider	N/A	N/A
Major life event requiring POC update	HHCM	MMCP	HHCM	C-YES
Monitoring access to care	MMCP	MMCP	HHCM	C-YES
Annual reassessment	HHCM	C-YES	HHCM	C-YES

Coordination between C-YES & HHCM

For HCBS children/youth who are enrolled in Health Home:

- Care management of the HCBS POC will be conducted by Health Homes.
- The HHCM meets with the child/youth and family and identified care team, discussing strengths and needs using the person-centered planning guideline principles.
- The POC will be developed using information from the HCBS/LOC Eligibility Determination, and a person-centered discussion that identifies personal goals and how specific HCBS may support the child/youth in achieving those goals.
- This development must occur within **60 days** of HH enrollment.
- The HHCM will ensure that the POC is reviewed and updated every 6 months, or after a significant life event.

Coordination between C-YES & MMCP

For HCBS children/youth who are enrolled in an MMCP and not in Health Home:

- C-YES must develop an HCBS POC within **30 days** of the HCBS referral, using information from the HCBS/LOC Eligibility Determination, and the person-centered discussion.
- C-YES then must send the POC to the MMCP within **15 days** of its development.
- The MMCP is required to update the HCBS POC with the child/family using the information provided by the HCBS providers from the Children's HCBS Authorization and Care Manager Notification Form and related service authorization determinations.
- The MMCP will meet with the child/youth/family to maintain and update the POC every 6 months or as needed.
- C-YES will determine annual HCBS/LOC Eligibility and conduct an annual review and will coordinate with the MMCP to update the HCBS POC, with signatures based upon the HCBS/LOC reassessment.

Coordination between C-YES & Fee-for-Service Medicaid

For HCBS children/youth who are in Fee-for-Service Medicaid and not in Health Home:

- C-YES must develop a HCBS POC using information from the HCBS/LOC Eligibility Determination, and a person-centered discussion that identifies personal goals and how specific HCBS may support the child/youth in achieving those goals.

- C-YES will develop an HCBS POC with frequency, scope, and duration, and update the HCBS POC using the information provided by the HCBS providers from the Children's HCBS Authorization and Care Manager Notification Form.

- C-YES will conduct person-centered meetings with the child/youth and family at least quarterly or upon significant change and update the POC as necessary.