GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Office of the Senior Deputy Director/Medicaid Director **Transmittal # 15-37**

TO: Elderly and Persons with Physical Disabilities (EPD) Waiver Providers

FROM: Claudia Schlosberg, J.D.
Senior Deputy Director and State Medicaid Director

DATE: October 7, 2015

SUBJECT: **Implementation of Person-Centered Planning**

I. Federal Requirement Regarding Person-Centered Planning

Per the federal 1915(c) Home and Community-Based Services (HCBS) Waivers Final Rule, published January 2014, service planning for participants in Medicaid HCBS programs under section 1915(c) and 1915(i) of the Act must be developed through a person-centered planning process that addresses health and long-term services and support needs in a manner that reflects individual preferences and goals. The rule is available at www.federalregister.gov/articles/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider.

The rules require that the person-centered planning process is directed by the individual with long-term support needs, and may include a representative that the individual has freely chosen and others chosen by the individual to contribute to the process. The rule describes the minimum requirements for person-centered plans developed through this process, including that the process results in a person-centered plan with individually identified goals and preferences, including those related community participation, employment, income and savings, health care and wellness, education and others.

This planning process, and the resulting person-centered service plan, will assist the individual in achieving personally defined outcomes in the most integrated community setting, ensure delivery of services in a manner that reflects personal preferences and choices, and contribute to the assurance of health and welfare.

II. Department of Health Care Finance and Person-Centered Planning

In order to comply with federal requirements regarding person-centered planning, the Department of Health Care Finance (DHCF) has hosted a number of trainings on PCP which were open to DHCF staff, EPD providers, and DHCF contractors. These trainings are required of EPD case managers. DHCF also convened a workgroup including EPD waiver providers (case management and home health services), District agency partners, and DHCF staff to develop a DHCF-specific PCP template.

As of November 1, 2015, all case managers will be required to use this PCP template[1] (available at http://dhcf.dc.gov/page/dhcf-our-providers) to develop person-centered plans for

- Newly enrolled EPD beneficiaries and
- EPD beneficiaries requiring Medicaid recertification due February 1, accounting for case manager activities due 90 days in advance of Medicaid expiration (i.e., November 1).

The process for developing PCPs will replace the previous process of developing Individual Service Plans (ISPs).

III. Developing the Person-Centered Plan

Under the process for EPD enrollment launched June 1, 2015, the Aging and Disability Resource Center (ADRC) is charged with working with EPD applicants to complete the EPD Waiver Program application package, select three EPD Case Management Agencies, submit the Level of Care for approval, submit the application package to the Economic Security Administration (ESA) for review of financial eligibility, and if found eligible, transition the individual to his/her selected case management agency.

From this point, case managers must engage in the following steps towards developing person-centered plans for EPD waiver beneficiaries.

1. Each case management service provider must conduct a comprehensive intake within forty-eight (48) hours of receiving the waiver referral and prior to the development of the PCP. Due to implementation of the PCP, the following areas are no longer required; completion of all other forms will continue to be required of case managers as a component of the individual's assessment in preparation for development of the PCP.
    a. Current/Anticipated Risks (*Note*: this will continue to be required as part of the quarterly report)
    b. Supportive/Community Resources Section (*Note*: this will continue to be required as part of the quarterly report)
    c. Individual Service Plan
    d. ISP Documentation of Agreement

[1] Note that individuals enrolled in the 1915(i) State Plan Amendment Adult Day Health Program (ADHP) also must have PCPs, which will be developed by the Aging and Disability Resource Center (ADRC), monitored by the ADHP provider selected by the beneficiary, and reviewed and updated by the ADRC at least every twelve months or when the person's functional needs change, circumstances change, quality of life goals change, or at the person's request.

e. Waiver Costs and Services

2. Prior to developing the PCP, the PCP preparer must
   a. Work with the individual to select and invite contributors chosen by the person, and representatives of the person's interdisciplinary team, as possible, to participate in development of the PCP.
   b. Select a time and location that is convenient for the person and any other individuals that person wants included in the planning.
   c. Download a copy of the PCP, available at http://dhcf.dc.gov/page/dhcf-our-providers Note that DHCF expects PCP preparers to complete the PCP electronically.
   d. Highlight fillable fields within the document by selecting the *Highlight Existing Fields* toggle button located in the top right corner in Adobe Acrobat.
   e. Populate the *Person's Name, Medicaid ID, PCP Preparer, and Participants' Names* on the first page of the template, which will auto-populate the relevant fields under Section 9—PCP Plan Agreement.
   f. Save data entered into this fillable PDF template by selecting *File Save As* and give the file a unique name.
   g. Print a copy of the final page of the PCP, Section 9—PCP Plan Agreement. Until this PCP template is automated, the preparer must print this page of the template and have it available for signature at the time of the PCP team meeting. The preparer must scan and upload a copy of the signed Section 9 with the completed PCP, and is required to maintain Section 9 in his/her files; such files will be subject to inspection and audit by DHCF.

3. For individuals enrolled in the EPD waiver, each PCP preparer must complete and upload the PCP into Casenet within ten (10) business days of conducting the comprehensive intake. Upon meeting with the individual and his/her selected contributors at a time and location of the individual's choosing, explain the goal behind development of the PCP. It might be helpful to outline the *Important Considerations in Developing the Person-Centered Plan* (see Section V of this transmittal) with the individual and his/her PCP team.
   a. **Section 1—Personal Information**: This section contains basic demographic information regarding the individual. Please note, information provided under *Person's Name, Preferred Name, Medicaid ID,* and *Medicaid Certification Period* will auto-populate throughout the PCP template, including Section 9-PCP Plan Agreement.
   b. **Section 2—PCP Preparer Information**: This section contains information on the preparer of the PCP. Please note, information provided under *PCP Preparer* will auto-populate to Section 9-PCP Plan Agreement.
   c. **Section 3—Participants**: This section contains the names and associated information of those parties invited by the individual to participate in development of the PCP. Please note, information provided under *Name* will auto-populate to Section 9-PCP

Plan Agreement. The preparer also should note the individual's level of capacity in developing the PCP, and what supports, if any, are necessary.

d. **Section 4—About Me**: This section contains a series of questions to be answered by the individual, which will help document the person's gifts, abilities, talents, and skills. If an individual chooses not to answer a specific question, this must be documented in the PCP.

e. **Section 5—Goals**: This section contains information on goals the individual would like to accomplish. These goals should be achievable within 12 months, and should be framed as "I will" statements. At minimum, each completed PCP must detail one (1) goal. If more than one (1) goal is identified, click on the "Add Goal" button to create space for documenting additional goals. The plus/minus buttons for *Key Step* and *Name/Responsibility* can be used to add/delete Key Steps and Names/Responsibilities.
    i. Example*: I will attend activities at my local church twice a week.*
    ii. Example*: I will go for a daily walk in my neighborhood.*

f. **Section 6—Goal Summary**: This section contains a summary of each goal outlined in Section 5, along with information on the key steps and responsible party, the provider the individual is being referred to, the target date for accomplishing the goal, and the plan of action if progress is lacking towards achieving the goal. Information from Section 5 will auto-populate into Section 6 (i.e., Goal, Key Steps, Responsible Party, & Target Date). Fields for *Done*, *Achieved Date*, and *Plan of action if progress is lacking* must be completed by the preparer with the individual and his/her PCP team.

g. **Section 7—Risk Factors**: This section contains information on potential risks and how each identified risk will be addressed by the individual and his/her PCP Team. At minimum, each completed PCP must detail one (1) area of risk. Click on the "Add Risk" button to create space for documenting additional risks. The preparer must also note if the individual has an advance directive and plans for future healthcare decisions.
    i. Example*: Falling; My PCP team and I will address this risk by fastening loose rugs, removing clutter from my floor/stairs, and by installing stair railings and grab bars in the bathroom.*
    ii. Example*: Overuse of benzodiazepines; My PCP team and I will monitor my use of benzodiazepines, and if necessary explore using psychotherapy approaches and antidepressants as treatment for my anxiety, and explore using behavioral interventions for my insomnia.*

h. **Section 8—Specific Services Recommended**: This section contains information on the services (both Medicaid and non-Medicaid) recommended that will help the individual achieve the goals outlined in Sections 5 and 6. The recommended services should include community and natural resources, as well as those services paid for by Medicaid and/or the District of Columbia. For recommended Community Resources, the PCP preparer must provide detail on the scope and nature of this resource in the "Notes" section. In addition, any added detail regarding the individual's preferences on how/when/where the recommended services should be delivered must be detailed

under the "Notes" section. Section 8 will be approved by DHCF and/or its designee only if the services recommended clearly relate to the goals and objectives outlined in the PCP.

i. **Section 9—PCP Plan Agreement**: This section contains signatures by the individual and the PCP Team both agreeing to and attesting to the entirety of the PCP. Until this PCP template is automated, the preparer must print this page of the template and have it available for signature at the time of the PCP team meeting. The case manager must scan and upload a copy of the signed Section 9 with the completed PCP, and is required to maintain Section 9 in his/her files; such files will be subject to inspection and audit by DHCF.

4. Each PCP preparer must upload the completed PCP to the "Member Information" folder of an individual's file in Casenet within ten (10) business days of conducting the comprehensive intake (i.e., twelve (12) days from receiving the waiver referral).
    a. If PCA services are recommended in the PCP, the preparer must task Delmarva in Casenet in order for the required face to face assessment (Level of Need) to be conducted.
    b. If other services are recommended in the PCP, the preparer must task Qualis to issue Prior Authorizations for all Waiver services identified in Person-Centered Plan (other than Case Management and PCA services).

5. DHCF expects case managers to share the PCP with other EPD providers, as appropriate, either via a task within Casenet or by other secure means. PCP documents are located on the recipient case tree in Casenet under the "Member Information" folder of an individual's file. A task should be sent to the direct care provider using the recipient task. This task must be sent to the direct care provider agency work queue, which will allow the provider agency access to review the case tree and all uploaded documents.

6. Case managers are expected to review and update the PCP with the individual at least every twelve months or when the person's functional needs change, circumstances change, quality of life goals change, or at the person's request.

7. For recertification, case managers must import the required documents for EPD Waiver recertification into Casenet for the ESA financial assessment, which includes:
    a. Beneficiary Freedom of Choice, Rights/Responsibilities form
    b. 1209-Wform
    c. 1728 form to be signed by DC Medicaid Physician
    d. LTC Application
    e. Proof of residency (i.e. utility bill, driver license, or bank statement)
    f. Proof of income and other supporting documentation (i.e. bank statements, Social Security allocation letters, annuity letters)

g. Proof of assets (i.e. stocks and bonds, mortgage statement, property tax information, life insurance policy)
h. Proof of Guardianship, and
i. Proof of Power of Attorney

IV. Aligning the PCP and Medicaid Recertification Dates

In an effort to align the PCP and Medicaid recertification dates, DHCF expects that case managers develop PCPs which will align with an individual's Medicaid start and end dates. To that end, DHCF is authorizing the validity of a current ISP for a period not to exceed eighteen (18) months to align the new PCP with the person's Medicaid renewal date. For a visual description of this alignment, see Attachment 1 on Page 9 of this transmittal.

V. Important Considerations in Developing the Person-Centered Plan

The following are important considerations to remember, both for the case manager, the individual beneficiary, and the entire PCP team, as the PCP is being developed, implemented, and monitored.

- Person Directed: The individual controls the planning process.
- Capacity Building: Planning focuses on an individual's gifts, abilities, talent, and skills, rather than deficits.
- Person-Centered: The focus is continually on the individual with whom the plan is being developed, and not on fitting the person into available services and supports in a standard program.
- Outcome-Based: The plan focuses on increasing the experiences identified as valuable by the individual during the planning process.
- Presumed Competence: All individuals are presumed to have the capacity to actively participate in the planning process.
- Information and Guidance: The planning process must address the individual's need for information, guidance, and support.
- Participation of Allies: For most individuals, person-centered planning relies on the participation of allies chosen by the individual, based on whom they feel is important to be there to support them.
- Health and Welfare: The planning process addresses the health and welfare needs of the individual, as well as strategies identified by the individual to maintain his/her life in the community setting of his/her choice.
- Documentation: The planning results should be documented in ways that are meaningful to the individual and useful to people with responsibilities for implementing the plan.

VI. Requirements for Person Centered Planning

The case manager must commit to making services fit persons, rather than making persons fit services, and enable a PCP process, directed by the person with long-term services and support needs (or a representative they choose), that meets the following requirements:

1. Occurs at a time and location that is convenient for the person and any other individuals that person wants included in the planning;
2. Includes face-to-face discussions with the person whose plan is being developed, other contributors chosen and invited by the person, and representatives of the person's interdisciplinary team, as available;
3. Incorporates feedback of members of the person's interdisciplinary team and other key individuals if and when they are unable to participate in the face to face PCP meeting;
4. Ensures that information shared with the person is aligned to his or her acknowledged cultural preferences and communicated in a manner that ensures the person and/or his or her representative understands the information. Communication must be consistent with the policies/practices of the US Health and Human Services 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. If needed, auxiliary aids and services should be provided;
5. Provides meaningful access to persons and/or their representatives with limited English proficiency (LEP), including low literacy materials and interpreters;
6. Uses a strengths-based approach to identifying the positive attributes of the person, including an assessment of the person's strengths, preferences, and needs;
7. Embraces the personal preferences of the individual to develop goals and to meet the person's needs;
8. Explores employment and housing in integrated settings, where planning is consistent with the individual's goals and preferences, including where the individual resides and who they live with; and
9. Ensures that persons under guardianship or other legal assignment of individual rights, or who are being considered as candidates for these arrangements, have the opportunity to address any concerns related to the person-centered Individual Service Planning process.

VII. Important Reminders

The PCP preparer must ensure that the PCP highlights the person's strengths and that it aligns with the person's articulated health and quality of life goals, service and support needs, and preferences. Specifically, the PCP must:

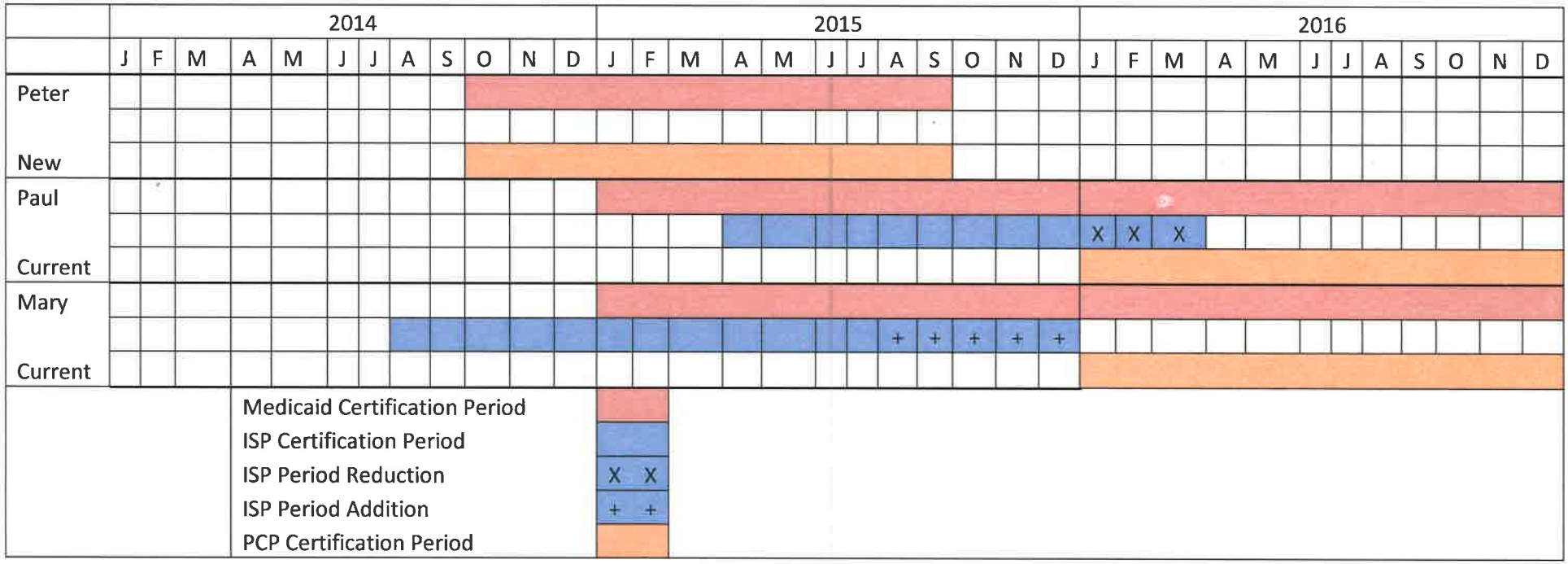
1. Document the person's strengths and positive attributes at the beginning of the plan;
2. Document the goals of the person and/or representative in his or her own words, which tie to the specific amount, duration, and scope of services that will be provided;
3. Document the person's preferences related to end of life planning, as appropriate;

4. Be in a language and dialect and at the literacy level needed to be understandable for the person and/or his or her representative;
5. Specify the other contributors chosen and invited by the person to engage in the PCP and in monitoring the execution of the PCP;
6. Include consideration of and any resulting goals for employment, education and community participation;
7. Identify necessary services and supports, to be provided through Medicaid and non-Medicaid services, including supports from the person's family, friends, faith-based entities, recreation centers, or other available community resources;
8. Prevent duplicative, unnecessary or inappropriate services by identifying the necessary services chosen by the person;
9. Identify the specific persons and/or health care providers and/or other entities providing services and supports;
10. Develop, in partnership with the person, a risk mitigation plan (along with a back-up emergency plan); the plan must consider the person's right to assume some level of responsibility for the identified risk and solutions to mitigate them;
11. Assure the health and safety of the person;
12. Document the following (if a person's needs related to health and safety warrants restrictions on the person's environment):
    a. The explicit and individualized assessed safety need;
    b. Positive interventions used in the past to address the same or similar safety risk;
    c. Explanation of the condition directly related to the specified safety need;
    d. Description of plan modifications addressing the safety risk, and the results of routine collection of data measuring the effectiveness of the modification;
    e. Documentation that the person and/or representative understands and consents to the proposed modification;
    f. Time limit determined to evaluate if safety modification is still necessary or can be terminated; and
    g. Assurance that the modification will not cause harm to the person.
13. Address components of self-direction if the person has chosen a self-directed delivery system;
14. Assure the person's needs will be addressed in the case of a District-wide emergency, such as a black-out or District-wide electronic system failure;
15. Receive final approval and signature of the completed person-centered Individual Service Plan (PCP) from those who participated in its planning and development, with mandatory signatures of the person and the case manager.
16. All contributors chosen and invited by the person to participate in the PCP process must receive a copy of the completed PCP (or a component of the plan, as determined by the person).

If you have any questions, please contact Trina Dutta, Special Projects Officer, Office of the Senior Deputy Director/Medicaid Director, 202-719-6632, trina.dutta@dc.gov OR Mary Devasia, Acting Director, Long Term Care Administration, 202-442-5931, mary.devasia2@dc.gov.

Attachment 1

Aligning the PCP and Medicaid Recertification Dates



1. Peter is a new EPD beneficiary. Therefore, Peter's PCP certification period should align with his Medicaid certification period from the point that his PCP is developed.
2. Paul is a current EPD beneficiary. Because his Medicaid and ISP certification periods do not match, his new PCP should be developed in order to align with his Medicaid certification period. Therefore, Paul's current ISP should be shortened by three months, and his PCP should be developed such that the PCP certification period will align with his Medicaid certification period moving forward.
3. Mary is a current EPD beneficiary. Because her Medicaid and ISP certification periods do not match, her new PCP should be developed in order to align with his Medicaid certification period. Therefore, Mary's current ISP should be extended by five months, and her PCP should be developed such that the PCP certification period will align with her Medicaid certification period moving forward.