



# Person-Centered Planning

Disabled and Elderly Health Programs Group  
Center for Medicaid and CHIP Services



# Regulatory Requirement

- Required for both the 1915(c) and the 1915(i)
- For the 1915(c)
  - Requirements for the person-centered planning process can be found at 441.301(c)(1)(ix)
  - Requirements for the person-centered service plan can be found at 441.301(c)(2)(xiii A through H)
  - Requirements for review of the person-centered plan can be found at 441.301(c)(3)

# Regulatory Requirements

- For the 1915(i)
  - Requirements for the person-centered process and plan can be found at 441.725(a) and (b)
- The process and plan requirements are the same for both authorities.

# Process and Plan

- Each individual will be engaged in a person-centered planning process, which will lead to the development of their person-centered service plan.

# Person-Centered Planning Process

## *Leading*

- The individual will lead the person-centered planning process where possible.
- The process should provide necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.

# Person-Centered Planning Process

## *Leading*

- The individual's representative should have a participatory role, as needed and as defined by the individual, unless State law confers decision-making authority to the legal representative.
  - All references to individuals include the role of the individual's representative.
- The planning process should only include people chosen by the individual.

# Person-Centered Planning Process *Requirements*

The person-centered planning process should be characterized by the following:

- Is timely and occur at times and locations of convenience to the individual.
- Reflects cultural considerations of the individuals.
- Is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.

# Person-Centered Planning Process

## *Conflict Resolution*

- The person-centered planning process should include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.

# Person-Centered Planning Process

## *Conflict-of-Interest*

- Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan.
- Exceptions to this will only be granted when the State demonstrates that the only willing and qualified entity to provide case management or develop person-centered service plans in a geographic area also provides HCBS.

# Person-Centered Planning Process

## *Conflict-of-Interest*

- In these cases the State must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS.
- Individuals must be provided with a clear and accessible alternative dispute resolution process.

# Person-Centered Planning Process

## *Informed Choices & Updates*

The planning process must:

- Offer informed choices to the individual regarding the services and supports they receive and from whom.
- Record the alternative home and community-based settings that were considered by the individual.
- Include a method for the individual to request updates to the plan as needed.

# Person-Centered Service Plan

- The person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and support.
- The written plan must reflect that the setting in which the individual resides is chosen by the individual.

# Person-Centered Service Plan

## *Community Access*

- The State must ensure that the setting chosen by the individual 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
  - Receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.

# Person-Centered Service Plan *Requirements*

The person-centered service plan must:

- Reflect the individual's strengths and preferences.
- Reflect clinical and support needs as identified through an assessment of functional need.
- Include individually identified goals and desired outcomes.
- Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.

# Person-Centered Service Plan

## *Services & Supports*

The person-centered service plan must:

- Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and providers of those services and supports, including natural supports.
  - Natural supports are unpaid supports that are provided voluntarily to the individual voluntarily in lieu of 1915(c) HCBS waiver services and supports.

# Person-Centered Service Plan

## *Services & Supports*

The person-centered service plan must:

- Include those services, the purpose or control of which the individual elects to self-direct.
- Prevent the provision of unnecessary or inappropriate services and supports.

# Person-Centered Service Plan

## *Understandability*

- The person-centered service plan must be understandable to the individual receiving services and supports, and the individuals important in supporting him or her.
- At a minimum, for the written plan to be understandable, it must be written in plain language, and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.

# Person-Centered Service Plan

## *Monitoring, Finalizing, & Distributing*

The person-centered service plan must:

- Identify the individual and/or entity responsible for monitoring the plan.
- Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individual and providers responsible for its implementation.
- Be distributed to the individual and other people involved in the plan.

# Person-Centered Service Plan *Modifications*

- Any modifications of these conditions must be supported by a specific assessed need and justified in the person-centered service plan.

# Person-Centered Service Plan *Modifications*

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.
- Include a clear description of the condition that is directly proportionate to the specific assessed need.

# Person-Centered Service Plan *Modifications*

The following requirements must be documented in the person-centered service plan:

- Include a 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 informed consent of the individual.
- Include an assurance that interventions and supports will cause no harm to the individual.

# Person-Centered Service Plan *Review*

- The person-centered service plan must be reviewed, and revised upon reassessment of functional need at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.