

Home and Community Based Services Manual

4.20

PERSON CENTERED CARE PLANNING AND MAINTENANCE

An integral component of a quality assessment process is the development of a person centered care plan (PCCP). The PCCP provides the link between the assessment and decisions regarding Home and Community Based Services (HCBS) authorization. PCCPs, although individualized in accordance with unmet needs of the participant, will generally reflect standard responses to similar problems. HCBS authorized within the PCCP shall be mutually identified as necessary by the participant and the Department of Health and Senior Services (DHSS), Division of Senior and Disability Services (DSDS) or its designee and based on information obtained during the assessment process. The PCCP process assesses the health and safety factors of the participant and outlines the participant's personal goals in order to remain in the least restrictive environment.

The PCCP translates identified facts into a plan for action. The identification of functioning problems, current resources (formal and informal), and unmet needs during the assessment interview shall serve as the foundation for designing the PCCP. A thorough, well-documented assessment and associated Case Notes facilitate a relevant PCCP. The HCBS authorized under the PCCP shall provide reinforcement and enhancement to the current support system of the participant.

The following basic principles shall be used as a guide for PCCP development:

- A comprehensive functional assessment shall determine needs of the participant;
- The participant, and anyone asked by the participant, may be involved in the assessment process;

Note: For a current or potential participant who has an authorized representative (e.g., guardian, or someone with a Durable Power of Attorney (DPOA) that is in effect), it is necessary the authorized representative be informed of the PCCP. If a guardian has been identified, DSDS or its designee shall obtain copies of the guardianship paperwork and attach them to the case record.

- Flexibility of the PCCP shall allow changes as necessary to meet the needs of the participant;
- Planning shall involve both formal and informal supports; and
- The PCCP shall reflect cost consciousness.

The right to self-determination, Code of State Regulation (CSR), and Code of Federal Regulation (CFR) shall necessitate the participant's approval of the PCCP during the assessment process. A PCCP shall be developed with and approved by the participant, or his or her authorized representative, as part of the assessment and authorization of the HCBS process.

A thorough PCCP will:

- Verify which needs are being met by the participant's current formal and informal support system, such as home health services, hospice care, shopping, errands, etc. Authorized HCBS **shall not** replace or duplicate existing formal or informal support systems without adequate documentation that such support will no longer be available to the participant;

Home and Community Based Services Manual

4.20

PERSON CENTERED CARE PLANNING AND MAINTENANCE

- Determine any support systems currently in place which will **not** be continued and the reason why; and
- Determine which tasks require the authorization of HCBS or referral to another entity.

It is generally not appropriate to authorize HCBS when the participant lives with other persons who are able to perform the required services or tasks.

- Tasks such as cleaning identified areas when the areas are shared with other inhabitants of the residence shall not be authorized.
- Tasks that are a primary benefit to a household unit or when members of the participant's household may reasonably be expected to share or do for one another (unless such tasks are above and beyond typical activities household members may reasonably provide for one another) shall not be authorized.

Thorough documentation shall support the reasons why other household members or current support systems cannot complete necessary tasks. Services authorized shall be only those required to meet the needs of the participant. As part of the PCCP development, the following shall be taken into consideration:

- The aide's ability to perform multiple tasks within the same timeframe;
- Size of the participant's living area;
- Assistance provided by others in the household;
- Assistance provided by other formal and informal supports;
- Access to transportation, including the availability for MO HealthNet Non-Emergency Medical Transportation (NEMT). Information regarding NEMT can be found at: <http://dss.mo.gov/mhd/participants/pages/medtrans.htm>;
- Availability of laundry facilities; and
- Any other factors that may influence the type and amount of services required to meet the participant's needs.

In all instances, DSDS or its designee shall authorize the HCBS necessary to meet the participant's identified unmet needs; within the appropriate services guidelines ([see Chapter 3](#)). All service authorizations must be supported by documentation within the HCBS Web Tool and must be reasonable and necessary according to the condition and functional capacity of the participant.

Although a referring entity can make suggestions, with input from the participant, regarding the development of the PCCP, it is the responsibility of DSDS or its designee to determine and arrange the services necessary to meet the needs of the participant.

As documented on the InterRAI HC, DSDS or its designee shall identify, in collaboration with the participant, a backup plan in the event of an emergency **and** when the HCBS provider is unable to deliver services. The backup plan includes who the participant will contact for assistance.

Home and Community Based Services Manual

4.20

PERSON CENTERED CARE PLANNING AND MAINTENANCE

NOTE: A backup plan shall designate specific entities (e.g., provider, DSDS, etc.) or specific individuals (e.g., family, friends, etc.) and contact information to be called. In addition, if the participant lives with another person, that person shall be included in the backup plan.

Example: 1st contact: (name of adult child) to include a phone number; 2nd contact: (name of friend) to include a phone number; 3rd contact: (provider), to include a phone number.

Collateral Contacts

Additional information may be needed to assist in PCCP development and coordinate care for the participant. Independent collateral contacts shall not compromise the rights and confidentiality of the current or potential participant. When considering collateral information during the design of the PCCP, sufficient documentation shall explain any discrepancies in the expressed wishes of the participant.

Unless prevented by circumstances, as documented, a discussion shall be conducted with the current or potential participant/authorized representative during the assessment and PCCP process indicating what information will be obtained and sources contacted subsequent to the interview. The appropriate privacy policies shall be reviewed with the current or potential participant/authorized representative ([see Chapter 9](#)).

Resources which may assist in PCCP development include:

Medical sources: Information regarding the current medical condition, history, and limitations may be obtained through CyberAccess (see the “Medical Rx” drop down), physicians, hospitals, clinics, and home health agencies.

Relatives, neighbors, and friends: These individuals may be able to provide additional observations and information regarding the current or potential participant, when identified as a part of the informal support system.

Other Social Agencies: Information may be available through local community agencies providing support or services to the current or potential participant.

Agencies: Services may be accessed through various state agencies and funding sources designed to care for participants with specific medical conditions. Participants in need of such services shall be referred and care coordinated in an effort to maximize state and federal resources. Information shall be obtained to determine and coordinate services currently authorized by other state agencies e.g. other Divisions within the DHSS, or the Department of Mental Health (DMH) ([see Policy 4.35](#)).

Process

DSDS shall complete all face-to-face assessments and related PCCP activities including entry of the prior authorizations for HCBS as soon as possible, not to exceed fifteen (15) business days from the receipt of the **referral**. Upon completion of the assessment with the message of ‘Criteria Met’ the PCCP shall be initiated by the selection of ‘Submit Assessment’. This will

Home and Community Based Services Manual

4.20

PERSON CENTERED CARE PLANNING AND MAINTENANCE

enable the Care Plan Services tab at the bottom of the Assessment Screen. DSDS shall prior authorize HCBS within policy restrictions and program limitations (see [Chapter 3](#)).

- Priority indicators determined during the assessment process will display for the particular case on the Participant Case Summary. This indicator is determined at the Assessment or Prior Authorization Screen. These indicators are intended to assist the HCBS provider in prioritizing service delivery in instances such as temporary staffing shortages, natural or other disasters, and acts of terrorism. Document the level of priority by evaluating circumstances (i.e., support system, confusion, and noncompliance) on the assessment tool. Priority/Risk indicator of one (1) shall be used when the lack of HCBS would pose a serious threat to the health, safety, and welfare of the current or potential participant. Discretion shall be used in assigning high priority. A fragile, unreliable or insufficient support system must be documented in Case Notes justifying high priority status.
- Enter a Priority Risk Code.
- Services shall be selected from the available drop down list based on the unmet needs of the participant.
- The 'Effective Date' cannot precede the level of care determination. Although the 'End Date' is editable and can be adjusted to meet the needs of the participant it defaults to the last day of the last full month within 365 days from the level of care determination, and cannot be extended beyond this date.
 - When the PCCP is being changed, the new 'Effective Date' shall be after the 'End Date' of the previous posted prior authorization.
- The monthly unit total for each selected service will be auto calculated based on the frequency information that was mutually identified and agreed upon and entered.
 - Specific services may have associated tasks. Suggested tasks that are mutually identified and agreed upon shall be selected. Suggested times and frequencies are provided for these tasks as a tool. Task frequencies that are significantly different from the suggested time and frequency shall be documented within the case (assessment and Case Notes).
 - DSDS shall ensure that the requested services are within the prescribed cost maximums as outlined this policy. Total cost of care will be displayed on the Prior Authorization Detail screen.

Note: When internet access is not available, paper copies of the HCBS-3a In-Home Services Worksheet and HCBS-3c CDS Worksheet shall be utilized until such time that the information can be entered into the HCBS Web Tool.

Cost Maximums

The total cost of the PCCP shall be compared to and **not** exceed the HCBS Cost Maximums (see Policy 3.00, [Appendix 2](#)).

Home and Community Based Services Manual

4.20

PERSON CENTERED CARE PLANNING AND MAINTENANCE

- The automated cost computation is based on the highest number of units that could be delivered in any given month (i.e., 31 day months).
- The total monthly prior authorization costs will be displayed on the Prior Authorization Screens.
- At **no time** shall the Adult Day Care service (i.e., Adult Day Care Waiver or a service within the Aged and Disabled Waiver) authorization in combination with any other HCBS exceed 100% of the established cost maximum. This includes any service authorized by the Bureau of Special Health Care Needs (BSHCN) through the Health Children and Youth Program (HCY).
- At **no time** shall either PC and/or CDS units exceed 60% of the established cost maximum; including when authorized in combination with other HCBS.

NOTE: The cost of RN visits are not included in the 60% of the average statewide monthly cost for care in a nursing facility restriction for basic personal care.

- The combined cost of all State Plan funded services shall not exceed 100% of the average statewide monthly cost for care in a nursing facility.
 - State Plan services include Personal Care Assistance (Consumer-Directed Model) (CDS), Personal Care (Agency Model) (PC), Advanced Personal Care (Agency Model) (APC), and Authorized Nurse Visit (Agency Model) (RN).

NOTE: When the care plan includes an authorization for RN services, the cost of one RN visit shall be excluded from the calculation of a care plan's cost.

For participants who receive RN visits for GHE only, the cost of two RN visits shall be excluded from the calculation of a care plan's cost.

- The cost of Personal Care Services authorized through the Department of Mental Health, Developmental Disability (DD) Waivers is not to be included in the calculation of cost cap maximums.
- The combination of State Plan and ADW (except when Adult Day Care is authorized through the ADW) or State Plan and ILW services **can** exceed the 100% cost maximum by the amount of ADW or ILW services, provided the participant's unmet needs require the amount of service authorized **and** Bureau of Long Term Services and Supports (BLTSS) has first approved the PCCP.

When the combination of State Plan and ADW or State Plan and ILW services exceed the 100% cost maximum:

- The appropriate supervisor for the DSDS staff shall review all PCCP requests over the 100% cost cap to ensure the participant's unmet needs require the amount of service requested.

Home and Community Based Services Manual

4.20

PERSON CENTERED CARE PLANNING AND MAINTENANCE

- If documentation supports the request, the request to exceed the cost cap shall be forwarded to DSDS (BLTSS) for consideration and approval prior to authorization over the 100% of the cost cap.
- Pending the approval from BLTSS to exceed the cost cap, HCBS can be authorized up to the 100% of the cost cap, excluding PC and/or CDS which may never exceed 60% of the cost cap.
- If after initial authorization up to the established cost maximum, approval from BLTSS is obtained, the PCCP shall be adjusted and the service authorization(s) processed in the HCBS Web Tool.

Provider selection

- It is the right and responsibility of the participant, legal guardian and/or authorized representative to choose the HCBS provider(s) involved in the delivery of services identified through the assessment and PCCP process. DSDS or its designee shall explain to the participant that selecting a provider is part of the PCCP process. The participant must be informed of the qualified provider(s) in his/her geographic location.
- When the participant is unable to choose a provider, a provider list may be printed from the Home & Community Services Provider Database. This list shall be shared with the participant, legal guardian, or his/her representative to assist in the selection process. Participants may contact potential provider(s) to discuss specific company practices (such as policies, hours, etc.).
- Provider selection within the HCBS Web Tool is **not** required at the assessment and requested services summary.

Note: Provider selection is required on the Prior Authorization screens in order to submit the prior authorization to Medicaid Management Information Systems (MMIS).

- Upon selection of a specific provider, the provider's data will be displayed in the service line item.
- DSDS or its designee shall coordinate all service authorizations with the selected provider to ensure HCBS initiation and delivery. This may involve multiple contacts to ensure the provider's capacity to deliver the HCBS. The provider may review information within the HCBS Web Tool including the PreScreen, Assessment, and proposed PCCP based on their user rights to assist in determining their capacity for delivery. All contacts made with or on behalf of the participant shall be thoroughly documented in Case Notes.
- In areas where it is known that providers are experiencing staff shortages, the participant should be asked to note a backup provider in the event that the first provider of choice is not able to accept a new case.

Home and Community Based Services Manual

4.20

PERSON CENTERED CARE PLANNING AND MAINTENANCE

Care Plan Review

HCBS Care Plan Participant Choice Statement

- Upon completion of the selection of all requested services, DSDS or its designee shall review and complete the Home and Community Based Services Care Plan and the appropriate Participant Choice Statement with the participant.
- or all open HCBS cases, the Participant Choice Statement shall be complete and current.

All information on the Participant Choice Statement and applicable Rights and Responsibilities form(s) shall be discussed with the current or potential participant. The following information shall also be discussed:

- Any special considerations necessary for the provider when staffing the case; and,
 - The current or potential participant should be aware that information will be forwarded to the provider as a necessary condition to the provision of services. Examples include:
 - Requirements of the aide's ability to lift a certain amount of weight; or
 - When the PCCP involves tasks that necessitate the provider to be informed of the current or potential participant's mental or physical condition including any communicable diseases such as HIV or AIDS, TB, hepatitis, etc.
 - Pursuant to Section 191.656, RSMo providers serving an individual with HIV or AIDS may only disclose the health status of the individual to employees providing direct health care services to the individual only after the provider has determined the employee has a reasonable need to know. Such disclosure should be done in strictest confidentiality and prohibit further disclosure.
 - When bookkeeping or reading of participant's mail is a necessary task, family or close friends should be used – when possible.

Completion of the Authorization within the HCBS Web Tool

- Check the certification box upon completion of the PCCP review and select 'Service Selection Complete'.
- A new case stage will be created on the Participant Case Summary Screen 'Prior Authorization – Care Plan Services' in a **pending** status. To complete the HCBS authorization and 'post' a prior authorization to MMIS, services must be approved and submitted on the Prior Authorization Screens.
- Prior Authorization Screens
 - To approve the pending 'Prior Authorization – Care Plan Services' navigate to the Prior Authorization Header screen and associated Prior Authorization Line Item Detail screen. Additional processing steps are provided in [Policy 10.05](#).
- The completed Participant Choice Statement shall be scanned and attached to the participant's electronic record in the HCBS Web Tool.

Home and Community Based Services Manual

4.20

PERSON CENTERED CARE PLANNING AND MAINTENANCE

- Every HCBS participant shall receive a copy of the completed and signed Participant Choice Statement and the associated Prior Authorization-Care Plan detailing the participant's HCBS service(s), authorization date(s), provider(s) total monthly units and associated tasks and frequencies.
- Providers shall be instructed to access the HCBS prior authorizations via the HCBS Web Tool.
- A 'Care Plan Service' Activity will be created for the assigned HCBS providers to alert them of the authorization. HCBS providers may monitor their work queue in order to retrieve these authorizations. However, this activity will not substitute for verbal communication as required between DSDS or its designee and the selected provider(s). This activity will remain in the associated providers work queue for 7 days at which time it will drop out of the work queue.
- DSDS or its designee shall contact the referring HCBS provider when the participant has chosen another provider for authorization of HCBS. DSDS or its designee shall inform the referring HCBS provider that the authorization was processed per the request of the participant and did not result in authorization to the referring provider.
- Physician Notification shall be completed for all **initial** HCBS authorizations (see below).

Physician Notification of Care Plan

- By state regulation, the participant's primary care physician shall be informed of, and have the opportunity to be involved with the development of the care needs for their patient.
- DSDS shall notify the participant's physician of the initial Prior Authorization for HCBS via the Physician Notification of Care Plan within three (3) business days of the date of approval of the PCCP.
- The associated copy of the Prior Authorization- Care Plan shall be attached to the Physician Notification of Care Plan for forwarding to the physician.
- This notification is required only at **initial** authorizations of all HCBS, regardless of the service authorization.
 - The Physician Notification of Care Plan informs the physician of the availability of electronically monitoring their patient's PCCP by utilizing the Department of Social Services, (DSS) MO HealthNet Division's (MHD) web based tool, CyberAccess.
- Physicians may contact DSDS or its designee to discuss the PCCP and make recommendations. The PCCP shall comply with the recommendations or requests of the physician, unless sufficient justification is documented to the contrary. Any modification that adversely impacts the participant shall require notification as outlined in the Adverse Action policy ([see Chapter 5](#)).
 - Any decision to *not* comply with physician recommendations or requests, (i.e., statutory or regulatory violation, etc.) shall be reviewed and approved by the

Home and Community Based Services Manual

4.20

PERSON CENTERED CARE PLANNING AND MAINTENANCE

Adult Protective and Community Supervisor and documented in Case Notes. Notification to the physician shall be made, in writing, as to why the physician's recommendation or request is not being followed. All documentation shall be maintained within the HCBS Web Tool.

- The completed Physician Notification of Care Plan shall be scanned and attached to the participant's record in the HCBS Web Tool.

Initial 10 Day Follow-Up

- DSDS shall follow-up within 10 days of the initial authorization on all HCBS authorizations of new participants.
- At a minimum, a telephone contact with the participant is required. For participants who have no phone or are unable to communicate by phone DSDS shall contact either the provider(s) or other individuals who are formally involved in the participant's care. DSDS shall:
 - Review the PCCP to ensure that it is adequate to meet the assessed needs.
 - Changes in the PCCP and associated HCBS authorizations as a result of the 10 day follow up may be made when it is determined appropriate to adequately meet the needs of the participant.
 - Any modification that adversely impacts the participant shall require Adverse Action notification as outlined in [Chapter 5](#).
 - Validate that the HCBS provider(s) have initiated service delivery of the specific HCBS.
 - DSDS shall make all necessary contacts with the HCBS providers to determine the reasons why HCBS has not been initiated.
 - The PCCP and the associated HCBS authorizations may be changed to a new provider at the request of the participant. DSDS shall offer the participant a list of available providers and process any PCCP changes.
- All information shall be documented in Case Notes.

Care Plan Maintenance

DSDS or its designee shall conduct all PCCP maintenance activities within the HCBS Web Tool. PCCP maintenance activities consist of requests for either increase or decrease in current tasks or units of service; addition or deletion of services; or change in the HCBS provider Staff shall reference Web Tool – Care Plan Change [Policy 10.10](#) for HCBS Web Tool processing. DSDS or its designee may receive a request for a care plan change through several different sources including, but not limited to:

- The participant or his/her authorized representative;
- The HCBS provider;
- Formal or informal support;
- A community resource (i.e., senior center, hospital, etc); or

Home and Community Based Services Manual

4.20

PERSON CENTERED CARE PLANNING AND MAINTENANCE

- Participant's physician.

Administrative oversight of HCBS includes timely action and closing of cases with an expired care plan. However, extenuating circumstances may preclude closing a case on a timely basis. These may include, but are not limited to:

- Participant is deceased and DSDS did not receive notification;
- Participant has requested a hearing due to an adverse action;
- Participant is waiting for a hearing decision; and/or
- DSDS is waiting for the return of physician or other collateral information.

When such circumstances delay the timely closing of cases with an expired care plan, DSDS or its designee shall make the appropriate documentation in Case Notes in the participant's case record with follow-up as necessary until the closing action is completed.

As with any maintenance activity, the principals of the PCCP process shall be followed.

- The participant, or their authorized representative, shall be consulted in **all** instances when a change to a care plan has been requested. DSDS or its designee shall make additional contacts, as necessary, to verify status changes that warrant the requested modification to the PCCP.
- DSDS or its designee shall coordinate with the participant's HCBS provider on all changes to the PCCP.
- If a new service type is added to the care plan between annual reassessments, mail the participant the appropriate Rights and Responsibilities form.
- When changes are made to a PCCP for a participant authorized for services through the Department of Mental Health (DMH), a copy of the new PCCP shall be forwarded to the DD support coordinator (see [Appendix 7](#)).
- All maintenance activities that adversely affect the participant's PCCP shall be subject to the adverse action process ([see Policy 5.00](#)).
- Reductions or Closing requests that are initiated by the participant or their legal representative are not considered adverse actions and do not require adverse action notice. In instances where a participant requested reduction or closure of services, staff shall verify the identity of the participant or legal representative and document in the HCBS Web Tool Notes. Actions of this nature may be taken immediately. DSDS or its designee shall stay within the allowable cost maximums outlined in this policy and assure that the participant is eligible for the requested modification (see Chapter 3).
- Care plan change requests resulting in a decrease **only** are to be authorized with an effective date on the first day of the first month following date of change. This does not apply to care plan changes that include both an increase and a decrease. When a care plan change includes both an increase and a decrease, the effective date is based on participant need and provider availability. Therefore, effective dates for care plan changes with both an increase and a decrease may fall during the middle of the month.

Home and Community Based Services Manual

- All contacts shall be documented in Case Notes (see [Policy 4.30](#)).

DSDS or its designee shall complete all care plan maintenance activities and documentation in the participant's case record in the HCBS Web Tool.