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OFFICE OF LONG-TERM LIVING BULLETIN

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SUBJECT: Individual Service Plan Development, Review and Implementation Procedures for OLTL Home and Community-Based (HCBS) Services

BY
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PURPOSE:

The Centers for Medicare and Medicaid Services (CMS) requires that the Office of Long-Term Living (OLTL) assures the timely and individualized development, review and implementation of Individual Service Plans (ISP) for program participants in a consistent manner. ISPs must identify and address each participant's needs, goals and preferences while incorporating existing resources and supports as identified by the participant. This Bulletin is the policy and procedure regarding the initial ISP development, approval, implementation, and monitoring process for OLTL Home and Community-Based Service (HCBS) Waivers and the Act 150 program.

SCOPE:

This OLTL bulletin is directed to all approved OLTL waiver and program providers of Care Management and Service Coordination (CM/SC) for the Aging Waiver, Attendant Care Waiver, COMMCARE Waiver, Independence Waiver, OBRA Waiver and Act 150 Program, Options Program, and Family Caregiver Support Program (FCSP).

* **NOTE:** It should be clearly noted that only the OLTL Medicaid Waiver Programs and Act 150 are subject to the new standardized development, review process **and** documentation requirements outlined in this bulletin. The Options Program and FCSP are **only** subject to the development and documentation requirements clearly stated in this bulletin. The Options Program and FCSP are not subject to the new standardized review process at this time.

This bulletin rescinds and replaces: 2006-HCBS-003 and APD #06-01-03.

BACKGROUND/DISCUSSION:

Presently, there is no uniform procedure for developing, documenting, and implementing ISPs for OLTL HCBS Programs. The lack of uniformity makes it difficult for each agency and OLTL to monitor the initial development and revision of ISPs. This has been raised as a major concern by CMS. Developing a standardized process for ISP development and review will

provide continuity of services, and consistent expectations for participants, providers and OLTL. The standardization of service planning is a step forward in creating a less fragmented system.

DEFINITIONS:

For the purposes of this bulletin, the following definitions apply:

Participant: A person receiving a service under an OLTL HCBS waiver, Act 150 Program, Options Program, and Family Caregiver Support Program (FCSP).

Area Agency on Aging/Service Coordination Agency: The entity responsible for providing information and assistance in support of OLTL HCBS Waivers and Act 150 program.

Care Manager/Service Coordinator (CM/SC) is the individual assisting the participant in accessing needed MA Waiver services, MA State Plan services, and/or other OLTL HCBS program services, as well as medical, social, educational and other services regardless of the funding source. CM/SCs work with, and at the direction of, the participant to identify, coordinate and facilitate services. Care Managers are typically Area Agency on Aging employees, and Service Coordinators are employed by a Service Coordination Agency.

Individual Service Plan: A comprehensive written summary of an individual participant's services and supports. The ISP reflects the participant's goals, preferences, strengths, and needs.

****NOTE: The ISP form replaces the current Service Plan form used in the under 60 waivers.***

HCSIS: Home and Community Based Services Information System is a comprehensive program used for managing data and supporting OLTL's HCBS programs and MA Waivers.

SAMS: Social Assistance Management Software is an extensive program capable of managing data from several organizations in a streamlined, secure environment. SAMS provides integration of data and comprehensive care planning. This system is used for Aging Waiver participants.

Level of Care Assessment: Comprehensive assessment to certify Level of Care. This activity is performed by the Area Agency on Aging (AAA).

CMI: Standard comprehensive assessment tool used by all OLTL HCBS programs to gather information about the participant's strengths, capacities, needs, preferences, health status, risk factors, and desired goals. It also includes other necessary medical, functional, cognitive/emotional and social information used to develop the participant's ISP.

Non-OLTL HCBS Waiver/Program Service: Any service that is not funded through any of the MA Waivers or other HCBS Programs. Examples of non-waiver/program services include, but are not limited to informal supports, any service covered through Medicare, State Plan or other

types of insurance, any service received through a volunteer organization, community resource, or religious organization, etc.

PROCEDURES:

To assure that the ISP is developed, implemented, and reviewed in accordance with 42 CFR 441.302, the following procedures have been established and are effective October 25, 2010.

As defined by OLTL, the initial ISP development process begins when the CM/SC receives the participant's completed Level of Care Assessment (completed by the AAA) and CMI and when financial eligibility has been determined. The initial ISP development process is completed when the final ISP is authorized by OLTL, Bureau of Individual Supports (BIS). For AAA agencies that conduct all these activities, they may be done simultaneously. However, services may not begin without approval from OLTL, BIS.

The established timeframe for initial ISP development is 25 business days. Expedited Access or Enrollment (currently known as Community Choice), is being addressed outside the scope of this bulletin and clarification will be forthcoming. Counties where "Community Choice" is currently operational will continue to follow current procedures until otherwise notified. However, that does not exclude these counties from ensuring that comprehensive ISPs contain the outlined required information in this bulletin upon submission.

ISP development is a collaborative process between the participant, a representative of the participant if chosen, the CM/SC, and others as identified by the participant. This process is participant driven, and the ISP must address the needs, preferences and goals of the participant. In addition, the participant's choice of service model, service type and service provider is also fundamental to personalized planning.

CM/SC Responsibilities:

1. For all initial ISP's, the CM/SC schedules a face-to-face meeting with the participant within five (5) business days of receiving the participant's completed information, including the Level of Care Assessment and CMI. The CM/SC schedules the service planning meetings at times and places that are convenient to the participant. Any deviation from the established timeframes must be documented and the reasons must be documented in HCSIS or SAMS.
2. The CM/SC assures that the ISP is reviewed and updated at least annually within the re-evaluation due date as well as when a participant's needs change.
3. The CM/SC must review the information gathered from the Level of Care Assessment, CMI and other sources if applicable to ensure that the ISP will incorporate and coordinate the necessary services and supports to avoid institutionalization and meet the needs and preferences of the participant.
4. CM/SC must coordinate services and supports with all third-party payers, formal and informal supports, and other community resources to assure that funding sources through OLTL are the payer of last resort and that there is no duplication of service.
5. The CM/SC shall not request or authorize services or a combination of services selected or desired by the participant or the representative when the participant's

physical, cognitive or emotional condition and overall ADL and/or IADL functioning does not require the service(s) to improve or maintain his or her functioning and/or condition.

6. The CM/SC is responsible for implementing and monitoring the ISP.

A. Initial ISP Development Process

1. The service planning process begins with the CM/SC review of the Level of Care Assessment and CMI that were completed during the eligibility and enrollment processes. These assessments provide the basis from which discussions begin with the participant about their unmet needs and ways the participant would prefer to have those unmet needs met, both through the OLTL HCBS Waiver or Program in which they will participate and through non-OLTL HCBS Waiver or Program services.

   During the initial visit for ISP development, the participant has the right to include a representative, family, friends, advocates or others as part of their ISP development. The CM/SC and others as identified at the participant's request will discuss the following:

   - Needs
   - Goals
   - Preferences
   - Barriers/Risks
   - Informal Supports
   - Individual and Emergency Back-up plans

2. The CM/SC reviews the Level of Care Assessment and CMI with the participant and actively engages the participant to identify OLTL HCBS Waiver and non-Waiver/Program services that will best meet his/her needs, goals, and preferences.
3. The CM/SC discusses with the participant the services and supports that are available in the participant's area.
4. The CM/SC must discuss the participant's strengths, including existing support systems, participant's capabilities (physical, emotional, intellectual, etc), skills and available community resources. These must be incorporated into the ISP.
5. The ISP must address the preferences of the participant. When having the discussion and review of a participant's identified unmet needs, the CM/SC will listen to the participant express how they prefer to have those identified unmet needs met. This may include, but is not limited to, agency staff and informal or natural supports such as friends, family, neighbors, local businesses, schools, civic organizations, community resources, and/or volunteer organizations.
6. The ISP must be individualized for the participant and account for the participant's preferences. Because non-OLTL HCBS Waiver/ Program services may be important in meeting the needs of a participant, the ISP must coordinate non-OLTL HCBS Waiver/Program services and supports.
7. The ISP development process includes the identification of potential barriers or risks to the participant. The presence of risks does not mean participants are excluded from receiving services.
   - Barriers/risks are initially assessed during the OLTL HCBS application process.

- Barriers/risks are assessed through the Level of Care Assessment and CMI that is completed during a face-to-face interview with the individual at the time of enrollment. Through the Level of Care Assessment and CMI, barriers/risks will be identified and summarized into categories according to health/medical, community, and behavioral risks.
- The CM/SC will review the information listed above to assist in identifying any additional potential barriers during the ISP planning process.
- Once the participant has identified his/her ISP goals, the CM/SC will compare those goals against the identified barriers/risks to see what, if any, risks are viewed as barriers to reaching the desired outcomes determined by the participant. Together, the participant, participant's representative (if applicable), and the CM/SC will discuss any identified and potential barriers/risks to determine if the barriers/risk can be mitigated.
- If the barrier/ risk can be mitigated, the CM/SC will document and include the risk mitigation plan as part of the participant's action steps in reaching their desired goals and outcomes.
- The CM/SC will document the content of the discussion in the ISP and specifically indicate any barriers or risks that are reviewed that the participant decides not to address as part of the ISP.
- The participant will sign a statement as part of the ISP agreement that indicates the CM/SC reviewed the barriers/risks associated with the participant's goals. This process will verify that the participant has participated in the discussion and has been fully informed of the barriers/ risks associated with his/her goals while respecting the individual's choice and preferences in the service planning process.
- The CM/SC will identify if any of the services available through the HCBS program would be appropriate for the participant's circumstances related to risk/barriers. The CM/SC will remain sensitive to the needs and preferences of the participant when identifying any risks/barriers or possible services that would assist the participant with addressing these circumstances.

8. As part of the ISP development process, the participant and CM/SC are responsible for ensuring all ISP's have an individualized back-up plan. An individualized back-up plan must clearly outline the steps to be taken in the event that routine services are not able to be delivered. Based on the participant's preferences and choice, strategies may include, but are not limited to the use of family and friends of the participant's choice, and/or agency staff. If a participant's back-up plan fails, he/she may utilize an agency model to provide emergency back-up coverage. Temporary Nursing Facility respite can be considered as part of the back-up plan if no other informal supports or options are available **and** it is the participant's choice. The CM/SC is responsible for assisting with development and regular monitoring to validate that the strategies and back-up plans are working and are current.

9. As part of the ISP development process, the participant and CM/SC are responsible for ensuring that the ISP incorporates an emergency back-up plan for serious emergencies that might cause a disruption in routine services being delivered to the participant for an extended period of time. Examples of what might cause a disruption in routine services being delivered for extended periods of time might include severe storms, floods, or any

type of community-wide disaster. A plan for these types of scenarios must be addressed in the ISP.

10. **CM/SC must document/address the following information in the ISP to meet the requirements of BIS for final approval:**
    - Level of Care Assessment completed
    - CMI completed
    - OLTL services reflect identified unmet needs
    - Participant's goals, strengths, and capabilities
    - Coordination of waiver/program and non-waiver/program services
    - Informal Supports
    - Any non-waiver/program services (Third Party Liability)
    - Community resources
    - Any barriers/risks
    - Assignment of responsibilities to implement and monitor the plan
    - Individual back-up plan
    - Emergency back-up plan
    - Choice of providers is offered
    - Chosen service model
    - Chosen providers
    - Review of rights and responsibilities
    - Contact with the participant, families and providers in service/journal notes
    - Individuals who participated in the development of the ISP
    - The frequency and duration of all services

11. At the time of the initial ISP planning visit, the CM/SC must obtain the signatures of the participant, participant's representative and any others involved in the planning process, indicating they participated in, approve and understand the services outlined in the ISP and that services are adequate and appropriate to the participant's needs. Every participant must receive a copy of his/her ISP in a format that is easy to understand. A copy of the final signed ISP is given to the participant and a copy of the final signed ISP must be kept in the participant's file at the CM/SC agency.

CM/SC finalizes the initial ISP

12. All the ISP information must be captured onto a standard ISP form and documented in HCSIS or SAMS. The CM/SC reviews, organizes and enters the ISP into HCSIS or SAMS database for review by a CM/SC Supervisor. The CM/SC supervisor reviews the content of the ISP to assure all required elements are included.
13. If an RN consultation is necessary due to a participant's complex medical issues, this must be documented. An RN signature directly on the ISP is not required to start services.

Note: Detailed instruction for all required data entry and systems locations will be included in a HCSIS Data Entry Guidebook and SAMS User Manual.

Initial ISP submitted for state approval

14. After reviewing the ISP in HCSIS or SAMS the CM/SC supervisor submits the final ISP to BIS regional staff. All service plan meetings and discussions must be documented in the appropriate locations in HCSIS or SAMS.
15. It is the responsibility of the CM/SC and CM/SC supervisor to ensure that the ISP is developed accurately and in accordance with established criteria in order to assure service delivery is not delayed.
16. If a participant chooses the Services My Way (SMW) service model and the service plan is approved, the CM/SC assigns a dollar value to the service plan, i.e. calculates an Individual Budget. The CM/SC submits the Individual Budget to BIS using the designated process. Upon receiving approval from OLTL, the CM/SC develops a Spending Plan with the participant during a face-to-face visit. The CM/SC submits the spending plan to BIS using the designated process. Upon receiving approval from OLTL, the Fiscal/Employer Agent (F/EA) pays the invoices in accordance with the spending plan. For more detailed information regarding SMW, please see the SMW manual located at http://ltlinpa.com/portal/server.pt/community/long_term_living_home/3950.
17. CM/SC's must document the dates when ISP development steps were completed. Any variance in completing the ISP within the established timeframes must also be documented in the comments section of HCSIS or journal section of SAMS.

OLTL Responsibilities:

1. **State review of the initial ISP**
   BIS regional staff will check HCSIS and SAMS daily to identify initial ISPs that indicate a request for review. Upon receipt of the submitted ISP, BIS reviews the content of all initial ISPs by comparing the ISP against the required information referenced in #11 and provides a final decision within ten (10) business days of receipt of the completed ISP. Notification will be sent through SAMS or HCSIS. If additional information is required from the CM/SC or a clarification or modification to the ISP is made by BIS, this must occur within the ten (10) day period.

   *The CM/SC is required to check HCSIS or SAMS daily for a response or request for additional or clarifying information.

2. **Requirements met**
   If the plan meets the requirements, a final decision is sent to the CM/SC supervisor and CM/SC within ten (10) business days of receipt of the completed ISP, through SAMS or HCSIS.

   The timeframe for approval may be shorter than ten (10) business days if the ISP is submitted correctly, with the required content documented and in accordance with the criteria outlined in this bulletin. It is the responsibility of the CM/SC and CM/SC supervisor to ensure that the ISP is developed accurately and in accordance with established criteria in order to assure service delivery is not delayed.

3. **Requirements not met**
   If BIS determines the requirements are not met, BIS contacts the CM/SC supervisor to inform them of any deficiencies, discrepancies and/or corrections needed through the Activity and Referral function within SAMS and through the comments section of HCSIS. CM/SC will submit corrections to the plan within three (3) business days. A discrepancy includes any waiver service that is documented without an identified unmet need for that waiver or program service as indicated in the Level of Care Assessment. In addition, any service that is coordinated or documented without justification will be returned to the CM/SC and CM/SC supervisor for correction and follow up.

   In the event BIS determines that the initial ISP does not meet the requirements outlined in this bulletin, the modified plan must be discussed by the CM/SC with the participant in person within 5 business days of notification from BIS and the participant's signature (or that of the participant's representative) is required on the modified ISP and Notification of Service Determination and the Right to Appeal form.

B. ISP Implementation:

1. Within two (2) business days of receiving authorization of the ISP from BIS, the CM/SC must provide specific detailed information to service providers of the participant's choice regarding the type, scope, amount, duration, and frequency of the service authorized. Also included should be demographic information necessary for the delivery of the service (i.e. address, phone) and any information specific to the participant's needs and preferences that are directly related to the service being provided.
2. Within two (2) business days, the CM/SC must notify the participant of the approval, modification or denial of the ISP in writing using the Notice of Service Determination and the Right to Appeal form. If the services are denied or modified from the initial ISP that was submitted by the CM/SC after consultation with the participant, the CM/SC must provide the participant with the reason(s) for denial or reduction, as well as the written notification of participant appeal rights within two (2) business days.

C. ISP Monitoring and follow up:

1. CM/SC are responsible for monitoring participant service plans and documenting the following in the journal notes in SAMS or designated section of HCSIS:
   - The participant is receiving the amount of services that are in the approved ISP.
   - The participant is receiving the frequency of services that are in the approved ISP.
   - The participant is receiving the authorized services that are in the ISP.
   - The participant is receiving the amount of support necessary to ensure health and safety.
   - If the participant has reported any health status or other events (such as a hospitalization, scheduled surgery, etc.) or changes that might impact his/her

ability to perform activities of daily living that prompt a need for temporary or permanent changes to service delivery. Other follow up to identify what discharge services are and are not being provided through the participant's health insurance must also be included.
- The participant is receiving the duration of services that are in the ISP.
- There is no duplication of services including waiver and non-waiver services.
- Contacts with individuals, families and providers.
- That the required information is in completed ISP.
- That the recommended and chosen services are being implemented

2. Individual Service Plan Updates and Revisions

Over time, adjustments to the participant's ISP may be necessary to address changes in the participant's condition or situation. The ISP shall be updated at least annually. As noted above, periodic reviews, either those regularly scheduled or those resulting from changed circumstances of the participant, may prompt more frequent revision and updates. Additionally, at any time during the year, participants may request changes to their ISP or the CM/SC may become aware of a change in the participant's medical condition, financial situation or living circumstances that may prompt the need to review and revise the ISP.

A CM/SC may become aware of a request for change in service due to the changing needs of a participant through the following resources:

- Participants
- Service providers
- Caregivers
- Informal/formal supports
- Social workers/discharge planners

Process:

When a CM/SC receives a request for a change in service, he or she should:

a. Explain to the participant that approval of waiver services is specific to an individual's need and situation.
b. If the service change request is appropriate according to the participant's needs, a critical revision to the participants plan is completed in HCSIS and the justification for the change in service must be documented in HCSIS. An action in the activities and referrals section must be completed in SAMS to indicate and document any changes in a participant's ISP.

Examples of changes that would require a change in service include:

- Change in physical health (improvement or decline)
- Change in environment

- Loss or gain of informal supports
- Change in primary caregiver
- The participant has reached a goal or desired outcome and no longer requires the same duration of service

c. The CM/SC must notify the participant of any approval, reduction or denial of any service request in writing using the Notice of Service Determination and the Right to Appeal form within ten (10) business days.

3. The CM/SC supervisor may authorize changes to the ISP under the following guidelines and circumstances:

- When there is a justified temporary change in services. A temporary service is a time-specific increase or addition in a **service** that has a specific begin and end date. A temporary service may or may not be a planned event.
- When there is an emergency or unplanned event. An emergency or unplanned event is an unexpected/sudden event that results in an **immediate need** for a change or increase in the existing ISP, generally due to an event occurring with the identified caregiver that is necessary for the health and welfare of the participant.
- When there is a need for a one-time service or product, which is a service or product that participants require **one time only**, but which is not calculated as part of the current service plan, and it is not anticipated that there would be the need to order the service or product again in the future.
- Items or services that **are** needed or anticipated being needed at varying frequencies or amounts each ISP period, e.g., a personal assistant for escort to medical appointments or specialized transport to medical appointments. These would require the anticipated amount of units to be part of the ongoing ISP request that is submitted for review.
- Clarification in the ISP would be where the variable increase in the units or frequency of the product orders would be noted clearly. This would include a piece of durable medical equipment (not covered by Medicare or the State Plan), installation of grab bars, ramps, stair glides, seat lift chairs and other such items. Any one-time service or product (s) whose individual costs per item to be charged to the HCBS Waiver program is less than $500 need not be reviewed through ISP review. Those in excess of **$499.99** require review.

All changes and updates to a participant's ISP must be documented in HCSIS or SAMS at the time of the change or update. It is the responsibility of the CM/SC and CM/SC supervisor to ensure that all information is up-to-date and accurate on an ongoing basis.

- The HCBS waiver/programs must be the payer of last resort. The CM/SC must document and justify the purchase of the service or product and must document attempts to obtain purchase through other resources (private insurance, Medicare, State Plan and any other local resources available). This information must be documented in the Service Notes in HCSIS and the Journal section in SAMS.

4. OLTL reserves the right to review and assure, at any time, that ISPs are adequate, reasonable and appropriate, and that services identified in the ISP are necessary in accordance with the requirements established by OLTL and that are outlined in this bulletin.
   - Any deficiencies or issues identified through the review of the ISP will be presented to the CM/SC for remediation. The CM/SC will be notified through communication from BIS in the comments section of HCSIS or email (Aging Waiver). BIS expects the CM/SC to outline a strategy to correct the issue(s), submit to BIS for approval and follow up with notification of remediation.
   - The remediation should include communication strategies for notifying the participant of any service that may be affected due to the discrepancy of any service that has been coordinated. If the end result is a reduction or denial of a service, the CM/SC must provide the participant with written notice of his/her appeal rights within ten (10) business days.
   - A discrepancy would include any waiver service that is documented without an identified unmet need for that service and any service that is coordinated or documented without justification. Discrepancies will be presented to the CM/SC for remediation and follow up.

OLTL's Quality Improvement Strategy

A monthly ISP review report is generated by BIS and made available to Quality Management, Metrics and Analytics (QMMA) for tracking, trending, and analysis of the ISP development process, including content of the ISP and documentation that the timeframes are met according to the procedures outlined in this bulletin. These reports become part of the evidence submitted to the CMS for assurance monitoring. In addition, the QMET teams will be conducting on-site monitoring visits to CM/SC provider agencies to assure that ISP's are being implemented, monitored, and reviewed in accordance with OLTL procedures.

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:
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