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DEPARTMENT OF HUMAN SERVICES

OFFICE OF LONG-TERM LIVING BULLETIN

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SUBJECT:

Individual Service Plan Development, Review and Implementation

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PURPOSE:

The purpose of this bulletin is to provide updated guidance to Office of Long-Term Living (OLTL) service coordination entities (SCE) regarding the person-centered Individual Service Plan development, review, and implementation procedures for OLTL Home and Community-Based Services (HCBS).

SCOPE:

This OLTL bulletin is directed to all enrolled OLTL waiver and program providers of Service Coordination for the Aging, Attendant Care, COMMCARE, Independence, and OBRA waivers and the Act 150 Program.

BACKGROUND/DISCUSSION:

In accordance with 42 CFR 441.301, the Centers for Medicare & Medicaid Services (CMS) require services to be furnished under a written individual service plan (ISP) that is based on a person-centered approach and is subject to approval by the State Medicaid agency. ISPs must identify and address participant's needs, goals, and preferences while incorporating existing resources and supports as identified by the participant.

42 CFR 441.301, 55 Pa. Code §§ 52.25 and 52.26 set forth the requirements for both person-centered service plan development and service coordinator (SC) responsibilities related to service planning. OLTL is issuing this additional guidance to reinforce the appropriate application of service plan development and ongoing SC responsibilities related to the implementation of the ISP.

Person-centered planning is a process directed by the participant with long-term service and support needs. The process may include a representative who the person has freely chosen, and/or who is authorized to make personal decisions for the participant. Person-centered planning also includes family members, legal guardians, friends, caregivers, and any others the participant or his/her representative wishes to include. The person-centered service planning process helps to identify outcomes based on the participant's goals, interests,

strengths, abilities, and preferences. The person-centered planning process assists the participant to articulate a plan for the future and helps determine the supports and services that the participant needs to achieve these outcomes.

PROCEDURES:

To assure that the ISP is developed, implemented, and reviewed in accordance with 42 CFR 441.301, 55 Pa. Code §§ 52.25 and 52.26, the following procedures have been updated.

A. ISP Development Process

The established timeframe for initial ISP development is 15 business days.

SC Responsibilities-Initial ISP:

- Initial ISP development begins when the SC receives the participant's completed information, including the level of care determination (LCD) and the needs assessment. The SC shall review those materials to prepare to discuss with the participant their unmet needs and the ways the participant would prefer to have those needs met. To ensure timeliness of services, the SC should schedule a face-to-face meeting with the participant within two (2) business days of receiving the participant's completed information.
- Initial ISP development should be completed within 15 business days of receiving the participant's completed information. SCs must document the dates when the initial ISP development is completed. Any variance in completing the ISP within the established timeframes must also be documented in the comments section of the Home and Community Based Information System (HCSIS) or journal section of the Social Assistance Management Software (SAMS).
- The SC is responsible to advise the participant during the initial meeting that, if the OLTL program to which he/she was assigned is not adequate to meet his/her needs, the participant can request a transfer to another OLTL program by asking the SC during the initial interview or at any time in the future. Upon receipt of such a request, the SC will review other OLTL program options with the participant, including eligibility requirements and available services. If the participant states that he/she wants to transfer to another OLTL program, the SC will submit the program transfer request.

SC Responsibilities-All ISPs:

To ensure compliance with 42 CFR 441.301(4), 55 Pa. Code §§ 52.25 and 52.26, the SC is responsible to address and document the following person-centered components into the ISP.

1. **Information/Choice**

   The SC is responsible for:

- Educating the participant about OLTL programs, services, and participant rights and responsibilities by reviewing the participant information materials developed by OLTL.
- Providing information to participants about how to make a request for changes to their services, including providing information on how the participant and/or representative may request meetings to revise the ISP whenever necessary.
- Informing the participant and/or representative on the processes for solving conflict or disagreement within the process.
- Informing participants of their right to choose service providers before services begin, at each reevaluation, and at any time during the year when a participant requests a change of providers. The SC is responsible for providing the participant with the OLTL Service Provider Choice Form, explaining what the form is used for, and ensuring that the participant has reviewed and signed the form.
- Providing the necessary information and support to the participant and/or representative to make informed choices about services and service delivery models available to the participant. This includes the provision of auxiliary aids, the use of an interpreter, and/or other supports when needed for effective communication.
- Informing the participant and/or representative about the full range of HCBS services and supports that are available to achieve the participant's identified goals.
- Informing participants of the opportunities to engage in community activities of the participant's choice. This may include shopping, attending religious services, etc. The participant's cultural preferences must be acknowledged and reflected in the planning process.
- Informing participants on fair hearing and appeal rights and assist with fair hearing and appeal requests as appropriate.

2. Goals, Needs, Preferences, and Strengths

The SC is responsible for:

- Scheduling the service planning meetings at times and places that are convenient to the participant.
- Involving the participant in the development of the ISP. In addition, the participant has the option to include a representative, family, friends, advocates, or others. The participant may choose to include his/her direct service provider as part of the person-centered planning process; however, the direct service provider may not develop the ISP.
- Discussing the participant's strengths, including existing support systems, participant's capabilities (physical, emotional, intellectual, etc.), skills, and available community resources.
- Identifying the participant's goals and ensuring they are documented in the participant's own words, with clarity regarding the amount, duration, and scope of services that will be provided to assist the person to achieve the identified goals.

- Discussing the participant's goals related to employment and volunteer opportunities, including any supports available to assist the participant in achieving employment goals.
- Coordinating the necessary services and supports to meet the needs and goals of the participant and documenting in the ISP.
- Confirming that the setting where the participant resides is chosen by the individual and is integrated and supports full access to the community in accordance with the participant's goals.
- Informing the participant about the option to self-direct his/her services and the benefits and risks to self-direction. The discussion should include at a minimum; employer related responsibilities, the need to appoint a representative if applicable, and the process of hiring, training, and firing direct care workers. The SC is responsible for informing the participant of the timeframes relative to the Vendor Fiscal/Employer Agent (VF/EA) and the choice of receiving Agency model services until the required employer and direct care worker paperwork is completed and the worker is approved to start delivering services to the participant.

NOTE: If a participant chooses the Services My Way (SMW) service model available in the Aging and Attendant Care waivers, the following additional steps are required:

- The SC assigns a dollar value to the service plan, (i.e., calculates an individual budget).
- The SC submits the individual budget to OLTL using the designated process and upon receiving approval from OLTL the SC develops a spending plan with the participant during a face-to-face visit. The SC then submits the spending plan to OLTL for approval.

3. Coordination of Services

The SC is responsible for:

- Working to align resources with the participant's needs, goals, and preferences.
- Actively coordinating with other individuals and/or entities essential in service delivery for the participant.
- Linking participants to community resources. Coordinating services and supports with all third-party payers, community services/programs, formal and informal supports, and any other resources to assure that OLTL is the payer of last resort and that there is no duplication of service.
- Establishing accountability and agreeing on the responsibilities of the providers, the participant, and/or representative.
- Providing ongoing assistance in gaining access to needed State Plan and HCBS services, as well as needed medical, social, educational, and other services, regardless of the funding source.
- Identifying and coordinating any employment or housing needs identified by the participant and/or representative.

- Discussing and exploring transportation options to ensure the participant has access to needed community activities**.**
- Identifying and documenting the specific person or persons, and/or agency or other entity providing services and supports.
- The SC will consider all participant needs for the entire ISP plan year and the ISP development process should include a participant's routine activities that may occur throughout the year in order to ensure an appropriate amount of services and supports are coordinated.
- Coordinating transitions to and from settings. This requires communication between providers and participants and/or representatives. (For example, if a participant is hospitalized, the SC is responsible to assist the participant in transitioning from the hospital setting back to his/her community setting where he/she was receiving waiver services.

4. Health and Welfare

The SC is responsible for:

- Addressing the health and welfare needs of the participant, as well as strategies identified by the participant to maintain his/her life in the community setting of his/her choice.
- Addressing any potential risks to the participant. Identified risks can include health/medical, community, and behavioral risks. Together, the participant, participant's representative (if applicable), and the SC will discuss a plan to reduce the impact of any risks and ensure the participant is fully informed of the impact of their decisions.
- Any effort to restrict the right of a person to realize preferences must be justified by a specific and individualized assessed safety need and documented in the ISP. The following requirements must be documented in the ISP when a safety need warrants a restriction:
    - The specific and individualized assessed safety need.
    - The positive interventions and supports used prior to any modifications or additions to the ISP regarding safety needs.
    - Documentation of less intrusive methods of meeting the safety needs that have been tried, but were not successful.
    - A clear description of the condition that is directly proportionate to the specific assessed safety need.
    - A regular collection and review of data to measure the ongoing effectiveness of the safety modification.
    - Established time limits for periodic reviews to determine if the safety modification is still necessary or can be terminated.
    - Informed consent of the person to the proposed safety modification; and
    - An assurance that the modification itself will not cause harm to the person.
    - The participant's signature on the ISP (MA546) indicates consent.
- Assisting with development of the individualized back-up plan and regular monitoring to validate that the strategies and back-up plans are working and are current. 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 back-up coverage.

- Ensuring that the ISP incorporates an emergency back-up plan (emergency preparedness plan) for serious emergencies that might cause a disruption in routine services being delivered to the participant for an extended period of time. Examples include severe storms, floods, or any type of community-wide disaster that may require an evacuation from the participant's home, or require the participant to 'shelter in place' for a period of several days. A plan for these types of scenarios must be addressed in the ISP.

5. Participant Signature Requirements

At the time of the ISP planning visit, the SC must obtain the signatures of the participant and/or representative and any others involved in the planning process, indicating they participated in, approved, and understand the services outlined in the ISP. If modifications are made to the ISP after the planning visit, the SC is responsible to mail or email a copy of the modified ISP to the participant and/or representative for a signature.

Every participant must receive a copy of his/her ISP (MA 546) in a format that is easy to understand. The ISP must reflect cultural considerations of the individual and is to be provided to the participant in first person plain language and in a manner that is accessible to the participant and/or representative. A copy of the final signed ISP is given to the participant and the original final signed ISP must be kept in the participant's file at the SC agency.

6. Electronic Documentation Requirements:

The SC must document all elements of the person-centered ISP as listed above in addition to the requirements listed in 55 Pa. Code § 52.25 and 42 CFR 441.301 to meet approval of OLTL. The information captured on the ISP (MA 546) must be entered into HCSIS or SAMS in accordance with the most recent HCSIS Data Entry Guidebook, SAMS User Manual and the SAMS crosswalk.

B. ISP Review

ISP submitted to OLTL for approval

After reviewing the ISP in HCSIS or SAMS the SC supervisor submits the final ISP to OLTL. It is the responsibility of the SC and SC supervisor to ensure that the ISP is developed accurately and in accordance with 55 Pa. Code § 52.25 in order to assure service delivery and payment are not delayed.

OLTL review of the ISP

Upon receipt of the initial ISP, OLTL reviews the content within 10 business days by comparing the ISP against the required information as outlined in 55 Pa. Code § 52.25. As appropriate, staff reviewing ISPs will consult with a Registered Nurse or the medical director on staff at OLTL. If the plan meets the requirements, OLTL notifies the SC and SC supervisor of approval through SAMS HCSIS or SAMS.

If OLTL determines the SC did not meet the plan requirements, OLTL will contact the SC supervisor to inform him/her of any deficiencies and/or corrections needed through the comments section of HCSIS and through the Activities and Referrals function and the journal section in SAMS. The SC will make the necessary revisions to the plan and re-submit for approval.

C. ISP Implementation

Within two (2) business days of receiving authorization of the ISP from OLTL, the SC must forward the Service Authorization Form to the direct service provider of each service authorized on the ISP.

Also within two (2) business days of receiving the authorization of the ISP from OLTL, the SC must notify the participant of the approval.

D. ISP Monitoring and follow-up

The SC is responsible for monitoring and follow-up, including responding to changes in participants needs. The SC must comply with Pa. Code § 52.26, 42 CFR 441.301, and any additional OLTL policies related to monitoring participant service plans.

An SC may become aware of a request for change in service through the following resources:

- Participant and/or representative
- Service Providers
- Caregivers/Family
- Informal Supports
- Social workers/discharge planners

Adjustments to the participant's ISP may be necessary to address changes in the participant's condition or situation. Periodic reviews, either 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, the 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. When an SC becomes aware of a request for a change in service either through the participant and/or representative, service provider, or through regular ongoing monitoring, he or she should review the Care Management Instrument (CMI) to identify the area of change.

Examples of changes that would require a change in service include, but are not limited to, the following:

- 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.

When a change in service is identified through the review of the CMI, the SC should complete the following:

- Document the resources explored, including any community supports or programs prior to any adjustments to the ISP.
- A critical revision to the participant's ISP is completed in HCSIS. The justification for the change in service must be documented in HCSIS, or an action in the activities and referrals section is completed in SAMS.

The SC supervisor may authorize changes to the ISP under the following guidelines and circumstances:

- When there is a necessary temporary change in services. A temporary service is a time-specific (120 days) 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.

NOTE: Any changes made to the ISP must be documented in HCSIS or SAMS.

E. Annual Re-evaluations:

In addition to the requirements stated in section A of this document, the SC is responsible to address and document the following additional components at the time of the annual reassessment.

The SC is responsible for:

- Ensuring the ISP is reviewed and updated at least annually within the re-evaluation due date (within 365 days of participant's LCD).
- Conducting the annual re-evaluation during a face-to-face visit.
- Reviewing and updating the CMI with the participant and discuss any adjustments to the ISP that may be necessary based on the completion of the CMI.
- For Aging waiver participants only, in addition to the ISP and CMI, the LCD must be updated annually. The SCE must refer the participant to their local Area Agency on Aging (AAA) for a new LCD. The referral must be made early enough so that the LCD and ISP review can be completed within 365 days of the previous LCD.

- Providing and reviewing the standard packet of informational materials developed by OLTL.
- Identifying any change in need that results in an increase or decrease in services and reviewing the information with the participant and updating the ISP.
- Updating HCSIS or SAMS indicating that an annual reassessment was completed and include documentation of any changes or updates to the plan.
- Ensuring the participant remains financially eligible for the waiver program by checking the Eligibility Verification System (EVS).
- Forwarding the updated Service Authorization Form to the providers identified on the participant's ISP notifying them of any updates.

Completion of Forms

At the time of the annual reassessment visit, the SC is responsible for reviewing and completing the following required forms with the participant:

Freedom of Choice Form
Provider Choice Form
The CMI
The LCD for Aging waiver participants only
The ISP (MA 546)
Service Authorization Form (MA 560)
Act 150 Fee Determination/Redetermination Form (for Act 150 Program only)
Participant Information Materials
The MA 561 (only when there is a denial, reduction, or termination of services)

It is the responsibility of the SC and SC supervisor to ensure that all participant and ISP information is up-to-date and accurate on an ongoing basis.

All ISPs are subject to the OLTL retrospective review process. If at any time during a retrospective review of a service plan it is discovered that the plan is missing information, or an annual review was not completed in a timely manner, the SCE may be cited by OLTL for non-compliance in accordance with 55 Pa. Code § 52.25(j).

This bulletin rescinds and replaces OLTL bulletin **54-15-06, 59-15-06.**

In addition, all OLTL policy documents or parts of policy documents that are inconsistent with the content of this bulletin are hereby rescinded.

ATTACHMENT:

Individual Service Plan (MA 546)

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:
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