Q&A: Person Centered Planning Changes

Prepared By: Elizabeth Edwards
Date: April 16, 2015

Q: Our state's process for developing an individual's service plan for home and community based services (HCBS) is not very person-centered and is inconsistent across the state. I heard that there are new regulations about person-centered planning. How do these regulations change the planning process?

A: The Center for Medicare and Medicaid Services (CMS) issued regulations for person-centered planning for 1915(i) and 1915(c) HCBS programs and HHS issued guidance for person-centered planning for HCBS programs generally. Depending on the state, these changes may significantly change person-centered planning because of new conflict of interest standards and other requirements that ensure the process focuses on the individual participants and their goals and choices.

The person-centered planning (PCP) process is integral to an HCBS participant's meaningful access to their surrounding community. According to CMS, "systems that deliver HCBS must be based upon a strong foundation of person-centered planning and approaches to service delivery."[1] The PCP process in HCBS programs has been affected by two different sources in the past year:

(1) CMS issued final regulations in January 2014 for Medicaid funded home and community based services (HCBS) under 1915(c), 1915(i), and 1915(k) programs. These new regulations not only set standards for the community nature of settings providing HCBS, but they also included new standards for person-centered planning in the 1915(c) and 1915(i) programs.[2] Although states were given up to five years to become compliant with the settings regulations, the regulations affecting person-centered planning were effective March 17, 2014.

[1] Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers, 79 Fed. Reg. 2948, 2988 (Jan. 16, 2014) (to be codified at 42 C.F.R. pts. 430, 431, 435, 436, 440, 441 & 447, *available at* http://www.gpo.gov/fdsys/pkg/FR-2014-01-16/pdf/2014-00487.pdf [hereinafter HCBS Final Rules].

[2] The requirements for 1915(k) regarding choice of community-based settings and documentation of these options may change the process in 1915(k) programs, but the final rules did not specifically change the process for 1915(k) as it did not 1915(i) and 1915(c) programs. *See* 42 C.F.R. § 441.530(a)(1)(ii). Although CMS is attempting to have consistency across HCBS programs, there may be some differences due to statutory differences. *Id.* at 3004.

(2) The U.S. Department of Health & Human Services issued guidance to implement Section 2402(a) of the Affordable Care Act.[3] Section 2402(a) required promulgation of regulations by the Secretary to ensure states develop community-based long-term services and supports (LTSS) systems designed to allocate resources and provide the necessary supports and coordination to, among other things, be responsive to the person-centered needs and choices of older adults and people with disabilities.

While the HCBS regulatory requirements are limited to the 1915(c), 1915(i), and 1915(k) programs, the HHS guidance has a broader interpretation of HCBS that includes Medicaid state plan home health, personal care, case management, and many rehabilitative services benefits.[4] Because the HCBS final regulations governing the PCP process are fairly straightforward, they are not reiterated here.[5] Instead, this Q&A focuses on CMS's interpretations found in responses to comments in the preamble, with additional information from the HHS guidance. Therefore, the following information is mostly what the PCP process is expected to be and where something is required by the regulations it is clearly identified with "must" or "required".

Purpose of Person Centered Planning

The PCP process guides a person to "construct and articulate a vision for the future, consider various paths, engage in decision-making and problem solving, monitor progress, and make needed adjustments to goals and HCBS in a timely manner."[6] Both the HCBS regulations and HHS guidance focus on making the HCBS participant not only the center of the process, but the director of the process to the maximum extent possible.[7] To further this goal, the regulations focus on the individual's strengths and preferences. The process must: (1) provide necessary information and support to ensure the individual directs the process to the maximum extent

[3] The Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (March 23, 2010) and the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (March 30, 2010) (collectively the "Affordable Care Act"). Section 2402(a) is entitled the "Oversight and Assessment of the Administration of Home and Community-Based Services." Section 2402(a) applies to all federal and state programs, including those "other than the state Medicaid program." Affected HHS operating and staff divisions are expected to take active steps to implement the guidance. The guidance outlines the standards for person-centered planning and self-direction that should be reflected in all HHS programs that fund or provide HCBS. HHS, Section 2402(a) of the Affordable Care Act – Guidance for Implementing Standards for Person-Centered Planning and Self-Direction in Home and Community-Based Services Programs (June 6, 2014), *available at* http://www.acl.gov/Programs/CDAP/OIP/docs/2402-a-Guidance.pdf [hereinafter HHS Guidance].

[4] HHS Guidance, *supra* note 3, at 2.

[5] *See* 42 C.F.R. § 441.301(c); 42 C.F.R. § 441.725; 42 C.F.R. § 441.730; 42 C.F.R. §441.735. For previous Q&As regarding the HCBS regulations, *see* Q&A: Medicaid Home and Community-Based Services-Final Rules, http://www.healthlaw.org/about/staff/elizabeth-edwards/elizabeth-edwards-publications/QA-HCBS-Final-Rules, and Q&A: HCBS Transition Plan Advocacy, http://www.healthlaw.org/publications/browse-all-publications/QA-HCBS. *See generally* CMS, Home & Community Based Services, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html.

[6] HHS Guidance, *supra* note 3, at 5.

[7] 42 C.F.R. § 441.301(c)(1) ("The individual will lead the person-centered planning process where possible."); 42 C.F.R. § 441.725(a)(2) (The person-centered planning process is driven by the individual."); HHS Guidance, *supra* note 3, at 5. The process is also supposed to help the team learn more about the person they are working with as well as recognize the person as the expert on goals and needs. HCBS Final Rules, *supra* note 1, at 2988.

possible; (2) provide cultural and accessibility considerations; (3) protect individual choice and occur at the at the convenience of the individual; (4) record alternative settings considered; (5) set standards for conflict of interest protections and qualifications of providers; and (6) require the inclusion of strategies for resolving conflict or disagreement within the process.[8]

The preamble to the HCBS regulations identifies some of CMS's expectations of the PCP process; specifically that it:

- Is based on the person, not his or her diagnosis[9]
- Does not determine whether a setting meets the requirements for being home and community-based.[10]
- Does not require individuals to be more involved than they choose to be in their own planning process; individuals may decline to participate in the process if they so choose.[11]
- Is driven by the individual, not a service provider, and includes the people chosen by the individual.[12]
- Incorporates the ideals stated by CMS in the preamble to the HCBS regulations.[13]
- Articulates and discusses all services and support options available with the individual.[14]
- Assists an individual in finding other housing, services, and supports when the individual is being discharged from services.[15]
- Identifies the aids and services that are necessary for settings to be accessible to participants.[16]

Although the regulations set forth more standards for the PCP process than previously existed, they still only express *what* must occur rather than *how* it must occur.[17] The regulations may not provide many specifics of how the PCP is supposed to be formulated, but they are clear that the process is very active and that it is not about just filling out forms or focused on paper completion.[18] The HHS guidance, however, offers more information on the process for and elements of a person-centered plan.

---

[8] 42 C.F.R. § 441.301(c); 42 C.F.R. § 441.725(a).
[9] HCBS Final Rules, *supra* note 1, at 2980.
[10] "While the person-centered service plan can and does assist individuals with integration into the community, it is not the vehicle to determine whether a setting meets the requirements for being home and community-based." *Id.* at 2990.
[11] *Id.* at 3005.
[12] 42 C.F.R. § 441.301(c)(i); 42 C.F.R. 441.725(a); HCBS Final Rules, *supra* note 1,at 2979. The individual does not drive or control the independent assessment and evaluation, but they are the center of these processes. HCBS Final Rules, *supra* note 1, at 2988.
[13] CMS says this is expressed in the regulation at § 441.725(b)(1). HCBS Final Rules, *supra* note 1, at 2988.
[14] *Id.* at 2989 (CMS responding to comments that individuals must be given information about all available supports and services and that the individual must be given complete and accurate information about his/her right to a fair hearing and that this should be provided at every planning meaning) In addition to the quote, CMS also responded that states have to adhere to part 431 regarding fair hearings. *Id.*
[15] *Id.* at 2961.
[16] *Id.* at 2967.
[17] *Id.* at 3004. CMS does state that it considers the requirements outlined for person-centered planning to confer to individuals the right to a person-centered service plan, and a planning process, that meets these requirements.
[18] *Id.* at 3004.

Importance of Informed Choice[19]

The requirements regarding informed choice may create significant changes for existing PCP processes. Now, the individual must not only be provided information about available services and supports to assist them in meeting their needs and goals, but do so in a way that documents true informed choice.[20] Individuals are supposed to be told about their possible options and the consequences of those choices in a manner that is meaningful to the recipient and easily understood.[21] Because the process should identify settings appropriate for the individual's goals, the choices may include settings with long waiting lists or settings that do not currently have availability.[22] For HCBS programs, one of the choices must include non-disability specific housing, which is supposed to make sure that a placement is the most integrated setting.[23] The process of choosing services and supports, especially housing options, can be very difficult for various reasons, but the informed choice protections are supposed to provide a balance between too much and too little information so the individual understands the array of options appropriate to their needs.[24]

---

[19] The planning process:

> (ii) Provides 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….
> (iv) Reflects cultural considerations of the individual and 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…
> (vii) Offers informed choices to the individual regarding the services and supports they receive and from whom…
> (ix) Records the alternative home and community-based settings that were considered by the individual."

42 C.F.R. § 441.301(c)(1).

[20] 42 C.F.R. § 441.301(c)(1)(ii), (vii) & (ix); 42 C.F.R. § 441.725(a)(2); (6) & (8); HCBS Final Rules, *supra* note 1, at 2976. In response to a comment that in part said that "state should provide unbiased and informed options counseling for individuals seeking HCBS so that individuals are able to choose the setting that best assists them in meeting their needs and life goals", CMS replies that they agree individuals should have meaningful choices that allow them to make decisions that best meet their needs and that this should be addressed as part of the person-centered planning process and included in the person-centered service plan. HCBS Final Rules, *supra* note 1, at 2976.

[21] HCBS Final Rules, *supra* note 1, at 3007. As to the accessibility of choice, CMS says that the final regulation supports the principles that the individual's choice of setting must be an informed choice, based on more than verbal descriptions or pictures of alternatives. *Id.* at 2976.

[22] CMS took out the term "available" from the proposed versions of § 441.530(a)(1)(ii) and § 441.710(a)(1)(ii) to not unduly limit the choices available to an individual during the planning process. HCBS Final Rules, *supra* note 1, at 2976.

[23] *Id.* at 2989; *see also* 42 C.F.R. 441.301(c)(4); 42 C.F.R. 441.710(a)(ii).

[24] HCBS Final Rules, *supra* note 1, at 3010. Part of meaningful choice is to be presented with all available options. " A person-centered planning process is not about promoting certain options deemed to be more "person-centered' or otherwise desirable, than other options. A person-centered process is one that puts the individual in the center, facilitated to make choices that may be agreeable or disagreeable to some participating in the process." *Id.* CMS cites this as the reason for the process of informed choice to be documented. *Id.* As to information, there is supposed to be a balance between an exhaustive list of theoretical options, such as an overwhelming list of providers, and not information to make a choice or choices being overly limited by lack of availability. *Id.* at 3007.

Relationship to Services

The PCP process, because it focuses on an individual's goals, identifies both necessary supports and services from an HCBS program and quality of life goals that may be outside of the HCBS program's direct supports and limitations of the functional needs assessment.[25] A person-centered plan must "reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports."[26] A service plan must be understandable to the participant those supporting him or her, and should include the dollar figures of the budget allocations provided to each beneficiary, the starting date of services/supports, the scope and duration of services, and all other services that are not Medicaid reimbursable.[27] Because unpaid supports may not be compelled and they may change from time to time, the plan must reflect the availability of unpaid support and should be written so it may adjust the proportion of formal and informal supports without starting over at the assessment.[28]

The PCP process is supposed to ensure that services are furnished to individuals with an assessed need and not based on available funds.[29] Although states must provide all needed services to an eligible individual enrolled in an HCBS program, states still have the ability to establish limits on amount, duration, and scope of services.[30] The provisions for the PCP process are supposed to identify the appropriate services and protect a plan from being changed without the individual's consent.[31] Regardless of whether a plan is finalized and agreed

[25] 42 C.F.R. § 441.301(c)(2); 42 C.F.R. § 441.735(b); HCBS Final Rules, *supra* note 1, at 3009; HHS Guidance, *supra* note 3, at 4. "One of the functions of the PCP process is to help the person and the support team to develop innovative and non-traditional ways to meet the goals in the plan. The goals must not be restricted due to a lack of easily identified services or supports." HHS Guidance, *supra* note 3, at 4.

[26] 42 C.F.R. § 441.301(c)(2); 42 C.F.R. § 441.725(b)(5); HCBS Final Rules, *supra* note 1, 2990 & 3008.

[27] 42 C.F.R. § 441.301(c)(2)(vii); 42 C.F.R. 441.735(b)(7); HCBS Rules, *supra* note 1, at 2991. In response to a comment that stated a plan should include this list of items, CMS responded, "We agree that the person-centered service plan should be comprehensive and the language in the final rule supports this concept." HCBS Rules, *supra* note 1, at 2991.

[28] *Id.* at 3008. Natural supports may not be compelled and must be provided voluntarily in lieu of paid supports. 42 C.F.R. § 441.301(c)(2)(v); 42 C.F.R. § 441.725(b)(5).

[29] *Id.* at 2955 (citing 42 C.F.R. § 441.725(b)); *see also* 42 C.F.R. § 441.301(c)(1). States are expected to provide needed services to an eligible individual enrolled in the waiver. HCBS Rules, *supra* note 1, at 3009.The requirement for services to be based on the needs of the individual is based on the statute at 1915(i)(1)(G). HCBS Final Rules, *supra* note 1, at 2990.

[30] HCBS Final Rules, *supra* note 1, at 2991,3009. In response to comments that the full range of services authorized by statute and included in the state's waiver proposal be made available to participants, CMS responded that these observations about all needed care "are the logical complement to the proposed language about unnecessary care. Taken together they address proper utilization of services. We agree that states must provide needed services to an eligible individual enrolled in the waiver…while unnecessary or inappropriate services should not…" *Id.* at 3009 (in reference to 42 C.F.R. 441.301(c)(2)(xii)); *see also* 42 C.F.R. § 441.725(b)(12).

[31] 42 C.F.R. § 441.301(c)(1)(viii) & (c)(2)(ix); 42 C.F.R § 441.725(a)(7) & (b)(9); HCBS Rules, *supra* note 1, at 2990.

upon, even in writing, an individual maintains the right to appeal service changes under the fair hearing requirements.[32]

Addressing Individual Responsibility & Risk[33]

A significant piece of the PCP process is evaluating and highlighting individual responsibility, including taking appropriate risks.[34] The PCP process helps determine how a person can be supported in community activities, not how to protect the person in the community. Any decision made to reduce risk is not supposed to abridge the independence, freedom, or choice of participants.[35] If a risk is emergent or due to changing circumstances, the planning team is expected to identify temporary measures to be used if needed, and the update the plan when needs have stabilized. The regulations also stress the importance of back-up strategies to address changing or emerging circumstances.[36] Previous planning processes may have focused more on how a person could be protected, so these changes may be quite a cultural shift and will likely require training and monitoring.

Role of an Individual's Representative[37]

The planning process is centered on the individual and the individual's representative is expected to have a participatory role, as needed and as defined by the individual.[38] The individual directs the process to the maximum extent possible and the process facilitates an individual making informed choices and decisions, with the other participants providing insights into the individual's strengths, needs, and preferences.[39] The facilitator helps to identify and sort

---

[32] In response to a comment that the regulation should be clear that a plan that is finalized and agreed to in writing should not preclude the right to appeal, CMS said that the fair hearing requirements of part 431, subpart 3, apply to all Medicaid services so it is not necessary to revise the regulation. *Id.* at 2991.

[33] The person-centered service plan must "Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed." 42 C.F.R. § 441.301(c)(2)(vi); 42 C.F.R. § 441.725(b)(6).

[34] HHS Guidance, *supra* note 3, at 5. The process is not supposed to be constrained by any pre-conceived limits on the person's ability to make choices. *Id.* at 6; *see also* 42 C.F.R. § 441.301(c)(1)(vii); 42 C.F.R. § 441.725(a)(6).

[35] "Restricting independence or access to resources is appropriate only to reduce specific risks, and only when considered carefully and reflected in the person-centered service plan." HCBS Final Rules, *supra* note 1, at 2991. The regulations set forth a clear process and protections for when the additional requirements for provider owned/controlled settings may be modified in the person-centered plan. This process must be individualized and maintains maximum independence and limits restrictions as much as possible. *See, e.g.,* 42 C.F.R. 441.301(c)(2)(xiii); 42 C.F.R. 441.725(b)(13).

[36] HCBS Final Rules, *supra* note 1, at 3008; *see also* 42 C.F.R. § 441.301(c)(2)(vi); 42 C.F.R. § 441.725(b)(6).

[37] 42 C.F.R. § 441.301(c)(1); 42 C.F.R. § 441.735. The individual representative provision is not intended to require an individual to have a representative, but to require states to allow the option for an individual to choose a representative for the purpose of participating in decisions related to the person's care or well-being when the individual requires assistance in making such decisions, and to have policies for the process for authorization, the extent of decision-making authorized, and safeguards. HCBS Final Rules, *supra* note 1, at 2995.

[38] HCBS Final Rules, *supra* note 1, at 3005. There are differences in the role of the individual's representative if state law confers decision-making authority on the legal representative as the rule does not abridge the legal authority of a parent of a minor child or legal guardian.

[39] *Id.* at 3006. CMS states that with skillful facilitation, individuals can express themselves to the fullest extent. *Id.*

out differing views among those present.[40] For many with previous experience in PCP processes, the regulations may cause a shift in who is driving the planning process and this change may be difficult for facilitators, providers, and families to adhere to consistently without strong monitoring, especially early in implementation.

The HCBS regulations clarify the role of an individual's representative, but this is role is prescribed more fully for 1915(i) programs. For 1915(c) waivers, the regulations make it clear that the individual is the leader of the PCP process and that "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."[41] The regulations for 1915(i) programs have similar language regarding the individual driving the plan, but these regulations also have a specific provision that fully defines the term "individual's representative."[42] Among other things, this provision clearly states that even when the representative has decision-making authority, the individual will lead the PCP process to the extent possible.[43] Individual representatives for participants in 1915(i) programs also have clearer guidance about substituted judgment and when the State can refuse the authorized representative of the individual's choice.[44]

Qualifications of Person Centered Planning Facilitators[45]

In addition to ensuring the requirements in the regulations regarding the PCP process are met, states must also determine the qualifications of the entities who will conduct the assessments and the person-centered planning process.[46] The regulations issued in 2014 added minimum qualifications for 1915(i) state plan providers, which must include conflict of interest standards, training in assessment of individuals whose physical or mental condition may trigger a need for HCBS and supports, and an ongoing knowledge of current best practices to improve health and quality of life outcome.[47] There is no transition period allowed to fully meet these

[40] 42 C.F.R. § 441.301(c)(1)(v); 42 C.F.R. § 441.725(a)(5); HCBS Final Rules, *supra* note 1, at 3006. If professionals take control from individuals in a person-centered planning process, then the requirements of the rule are not met. HCBS Final Rules, *supra* note 1, at 3006. The outcome that is expected by these rules is that the individual directs the process, with appropriate supports as needed. *Id.*

[41] 42 C.F.R. § 441.301(c)(1).

[42] *Compare* 42 C.F.R. § 441.301(c)(1) *with* 42 C.F.R. § 441.725(a); *see also* 42 C.F.R. 441.735(a).

[43] 42 C.F.R. § 441.735(a).

[44] 42 C.F.R. § 441.735(c). In the final regulations, CMS changed the term "best interest" to "substituted judgment" and noted in the preamble the guidelines from the National Guardianship Association regarding substituted judgment. HCBS Final Rules, *supra* note 1, at 2994.

[45] There is a general requirement for 1915(c) waivers that requires the state agency to describe the qualifications of the individual or individuals who will be responsible for developing the individual plan of care. 441.301(b)(2). The 2014 HCBS regulations added more specificity for the qualifications for provider qualifications for 1915(i) state plans. 42 C.F.R. § 441.730(a).

[46] In response to comments that the PCP facilitator should have certain qualifications, such as knowledgeable of all community-based options (not only those that are considered readily available) and have the ability to present options in a way that is accessible and sensitive to the person's disability-related communication needs, CMS said it expects that PCP providers have adequate training to perform the PCP and intends to provide additional guidance on the process and how it is intended to apply across Medicaid HCBS programs. HCBS Final Rules, *supra* note 1, at 2978.

[47] *Id.* at 2991, 2993.

qualifications–the person must be qualified prior to performing assessments or plan development.[48]

Conflict of Interest Provisions

One of the important additions to the PCP process for HCBS is the establishment of clear standards for conflict of interest protections.[49] CMS clearly stated in the preamble to the regulations, that it "agree[s] that complete independence of the person(s) facilitating the planning process is important to promote the statutory objectives."[50] For 1915(c) waivers the PCP process must have clear conflict of interest guidelines for all participants and 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 plan.[51] For 1915(i) state plans, the conflict of interest standards are more detailed and require that the individual conducting an individualized independent evaluation, independent assessment, or service plan development is not:

- Related by blood or marriage to the individual
- Any paid caregiver of the individual
- Responsible for the individual's finances or health-related decisions
- A provider or hold a financial interest in or are employed by any of the entities that provide care[52]

Upon approval, a state may be granted an exception from the last category regarding providers if it meets certain criteria.[53] States may have a similar exemption from the provider prohibition for 1915(c) waivers.[54] If this exception is used, the State plan or waiver must include provisions assuring separation of functions within the provider entity and the state must guarantee the independence of the functions within the provider entity, possibly including firewall policies separate staff that perform assessments and develop person-centered plans from those that provider services in the plan. [55] In addition, there must be meaningful and accessible procedures for individuals and representative to appeal to the state.[56]

---

[48] *Id.* at 2992.
[49] 42 C.F.R. § 441.301(c)(1)(v)-(vi); 42 C.F.R. § 441.730(b); *see generally* HHS Guidance, *supra* note 3, at 6.
[50] HCBS Final Rules, *supra* note 1, 3006 (citing 441.301(c)(1)(vi)).
[51] 42 C.F.R. § 441.301(c)(1)(v)-(vi).
[52] Assessment and service planning should not be performed by providers of the services prescribed. 42 C.F.R. § 441.730(b).
[53] The state must demonstrate that the only willing and qualified agent to perform independent assessments and develop person-centered service plans in a geographic area also provides HCBS and the State devises conflict of interest protections including separation of agent and provider functions within provider entities. 42 C.F.R. § 441.730(b)(5).
[54] 42 C.F.R. § 441.301(c)(1)(vi). The State must demonstrate that the only willing and qualified entity to provide case management and/or develop person-centered service plans also provides HCBS. *Id.*
[55] 42 C.F.R. § 441.301(c)(1)(vi); 42 C.F.R. § 441.730(b)(5); HCBS Final Rules, *supra* note 1, at 2993. CMS also said it will not permit states to circumvent these requirements by adopting state or local policies that suppress enrollment of any qualified and willing provider. HCBS Final Rules, *supra* note 1, at 2993.
[56] HCBS Final Rules, *supra* note 1, at 2993; *see also* 42 C.F.R. § 441.730(b)(5).

Managed care entities are not prohibited from conducting assessments or service planning. In the preamble, CMS specifically mentioned that managed care organizations, including capitated systems, have successfully performed the assessment and PCP process functions.[57] The rule does not prevent providers from participating in assessment and planning processes, but requires that an independent agent retain the final responsibility for these functions.[58]

Although a provider may never be in charge of the process or plan, whether or not the provider is in attendance is subject to the choice of the individual and the circumstances. Some actions, such as intimidating the individual so as to inhibit the person from voicing problems, are clearly prohibited. Because of the variance in provider-participant relationships, the rule does not provide more specificity and simply requires that the state establish clear conflict of interest guidelines for all parties who participate in the planning process.[59]

Timing of Person Centered Planning

The planning process is required to occur at times and locations of convenience to the individual.[60] The preamble to the regulations says that this part of the rule is intended to address the problem where the planning process is scheduled entirely at the convenience of the state and/or provider agency. Although recognizing that timeliness is critical, CMS declined to put standards on timeliness because the need for planning can range from urgent to optional.[61] States are expected to respond to urgent needs more quickly than to other types of requests in order to meet the health and welfare requirements of the HCBS program, which may occur through an expedited process.[62]

States must ensure the person-centered service plan process is timely and includes a method for the individual to request updates to the plan.[63] At minimum, a plan must be reviewed at least every 12 months, but the plan may be reviewed and revised as often as is needed when the individual's circumstances or needs change significantly, and at the request of the individual,

---

[57] HCBS Final Rules, *supra* note 1, at 2993. There was specific concern from commenters about managed care organizations and in particular, capitated models, citing inescapable conflicts. CMS responded saying it has experience with states where it is working in managed care and capitated models and therefore disagrees that it does not work. CMS also notes that they are not restricting these activities to case managers. *Id.* at 2994. CMS has also discussed the PCP in previous guidance about managed LTSS. *See generally* CMS, Guidance to States Using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs (May 20, 2013) 10-11, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf.

[58] *Id.* at 2993-4.

[59] *Id.* at 3006.

[60] 42 C.F.R. § 441.301(c)(1)(iii); 42 C.F.R. § 441.720(a)(3); *see also* HHS Guidance, *supra* note 3, at 5 (identifying as one of the process elements, "The process is timely and occurs at times and locations of convenience to the person, his/her representative, family members, and others.").

[61] HCBS Final Rules, *supra* note 1, at 3006. A feedback mechanism should exist so that the person or representative to report on progress, issues and problems and so that changes can be made in an expedient manner. HHS Guidance, *supra* note 3, at 8.

[62] HCBS Final Rules, *supra* note 1, at 3007.

[63] 42 C.F.R. 441.301(c)(1)(viii); 42 C.F.R. §441.725(a)(7); HCBS Final Rules, *supra* note 1, at 2990; *see also* HHS Guidance, *supra* note 3, at 6 (stating there must be a clear process for individuals to request updates and that the entity must respond to such requests in a timely manner that does not jeopardize the person's health and safety).

authorized representative or healthcare provider.[64] The individual or the individuals and representative must have control over who is notified about updates and planning scheduling.[65]

State Monitoring

States are expected to perform appropriate quality monitoring that should include substantial feedback provided by individuals who received or are receiving services.[66] The HHS guidance expects that a process for monitoring PCP is implemented at the federal, state, and local levels and is incorporated as an integral component of quality improvement activities across HCBS programs.[67] Although not directly a part of monitoring the planning process, the responsibility of states to ensure that the choices available to individuals meet the regulations regarding qualities of HCBS settings is an important piece of monitoring proper person-centered planning.[68]

Potential Implementation Issues & Advocacy Recommendations

States are supposed to currently comply with the HCBS regulations related to person-centered planning. This means the PCP process should not be included as one of the compliance goals in the State Transition Plan for the HCBS regulations – it should already be happening.[69] Some states are incorporating improved monitoring mechanisms for the PCP process into their plan, but advocates should monitor whether a plan to come into compliance with the PCP process is part of the state transition plan. For some programs, significant changes should occur in the planning process and the state should have changed provider qualifications, policies, and performed education where necessary. In particular, advocates should evaluate the current system to determine if it is conflict free and, if the state is using the exception, that there are appropriate safeguards in place. Another major area of change may be the role of the individual, their representative and the providers; advocates should examine the state's monitoring mechanisms for these issues. Advocates are often regularly involved in person-centered planning processes and they should become familiar with the regulations and guidance and monitor the processes for compliance, notifying the state of issues where necessary.

[64] *Id.* at 2991; *see also* HHS Guidance, *supra* note 3, at 6. ("The PCP must be reviewed at least every twelve months or sooner, when the person's functional needs change, circumstances change, quality of life goals change, or at the person's request.")
[65] HCBS Final Rules, *supra* note 1, at 3007-8 (citing health information and privacy protections).
[66] *Id.* at 2988.
[67] HHS Guidance, *supra* note 3, at 8.
[68] HCBS Final Rules, *supra* note 1, at 2975.
[69] The person-centered planning regulations were effective March 17, 2014.