Home and Community-Based Services

Requirements for Person-Centered Plans for Home and Community-Based Services

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Content Summary

This booklet describes the person-centered planning process and provides the general requirement for a person-centered plan for home and community-based services, including home health, personal care services, and self-directed care. In addition, the booklet reviews the common errors made in person-centered plans that may lead to improper payments and provides sources for promising practices for improvement.

The Centers for Medicare & Medicaid Services (CMS) and the States are increasing educational outreach about home and community-based services (HCBS) to enhance awareness of and engage providers and beneficiaries in efforts to reduce payment errors and fraud, waste, and abuse in the Medicaid program.

The Medicaid Integrity Program, established under the Deficit Reduction Act of 2005, and the President's November 2009 Executive Order 13520 Reducing Improper Payments and Eliminating Waste in Federal Programs are two comprehensive strategies that protect the integrity of the Medicaid program.

As part of these programs, CMS has analyzed data produced by the Payment Error Rate Measurement (PERM) program to identify areas that may be at high risk for improper payments and to target root causes for errors. Due to these PERM-identified payment errors, CMS implemented a supplemental measure to further assess HCBS. Through its analysis, CMS identified multiple payment errors and root causes.

This booklet has been developed to educate providers about the major causes of payment errors and to maintain program integrity. These are the key terms used in this document:

- **Home and Community-Based Services:** includes home health care; private-duty nursing; personal support services; home-delivered meals; adult day care; durable medical equipment (DME), supplies, and home modifications; respite care; and other needed services.
- **Beneficiary:** includes the person receiving Medicaid HCBS and their legal guardian, family member, or other support.
- **Provider:** includes physician; nurse practitioner; registered nurse; licensed practical nurse; aide; private or not-for-profit agency; case manager; State Medicaid agency (SMA) or State sister agency; Medicaid DME, supplies, and devices supplier; home modification business; or other providers of HCBS.
- **Person-centered plan:** synonymous with plan of care, care plan, individual service plan (ISP), individual education plan (IEP), or other terms used to describe a written individual plan based on individual needs, goals, and preferences that includes HCBS.

This booklet summarizes the requirements for person-centered plans in Medicaid HCBS programs. After reading this booklet, providers should be able to describe:

- The purpose of person-centered plans;
- Person-centered plan requirements for Medicaid HCBS;
- The role of providers in developing and updating person-centered plans;
- Common errors in person-centered plans identified through PERM analysis;
- The importance of provider participation in reducing or eliminating improper payments while continuing to provide quality care; and
- Where to go for additional resources.

Necessity of Person-Centered Plans

The person-centered planning process is an ongoing process involving the beneficiary, their family, and other supports. Its intent is to identify and address a beneficiary's changing strengths, capacities, goals, preferences, needs, and desired outcomes. The information gathered in the process along with medical assessments is used to create a person-centered plan. The plan is necessary to address a beneficiary's long-term care needs as an alternative to institutionalization.[1, 2] Person-centered plans for home health services have additional requirements. Check with your SMA for more information.

Requirements

Federal regulations require a written person-centered plan for HCBS whether services are provided through the State Medicaid Plan or through a waiver program. The use of Federal funds is not approved for HCBS waiver services that are provided without a person-centered plan.[3] Some States, such as Nevada,[4, 5] Colorado,[6] and Rhode Island,[7] require a "plan of care" with physician authorization and SMA approval for home health services and a "person-centered plan" with State agency approval for personal care and other HCBS offered through waiver programs.

It is important to note that some States contract with managed care organizations (MCOs) to provide long-term services and supports, including HCBS, for eligible beneficiaries. Other States may collaborate with State sister agencies to provide HCBS to eligible beneficiaries. In those instances, the beneficiary must follow the policies of the MCO or the State sister agency for proper payment to be made to a provider.

Once a beneficiary's eligibility for Medicaid HCBS is determined, a comprehensive assessment of the beneficiary's physical, psychosocial, and functional needs is completed. The beneficiary, their treating physician, or qualified case manager review the results and develop a person-centered plan. Reassessments must be completed at least annually or when a beneficiary has a change in circumstances.[8]

When reassessments are completed, the person-centered plan should be reviewed and updated accordingly. Some States have additional language, updates, or monitoring requirements for a person-centered plan, including reviewing the person-centered plan at more frequent intervals.[9] For example, some States require that a person-centered plan for Medicaid home health services include measurable treatment goals[10] and require no more than 60-day intervals between reviews.[11] Check with your SMA for additional requirements.

Federal regulations require that a person-centered plan:

- Be established and periodically reviewed by the beneficiary's treating physician or qualified case manager;
- Be developed in consultation with the beneficiary, the beneficiary's treating physician, health care support professional or other appropriate professional as determined by the State, and where appropriate the beneficiary's caregiver;

- Be based on the most recent comprehensive assessment of the beneficiary's physical, psychosocial, and functional needs;
- Take into account the extent of and need for any family or other supports for the beneficiary;
- Identify the amount, duration, and scope of the services to be provided to the beneficiary (or if the beneficiary elects to self-direct personal support services, the services funded);
- Indicate the type of provider for each service; and
- May identify additional service needs of the beneficiary.[12]

Most SMAs have developed specific forms for providers to use when completing assessments, plans of care, individual service plans, and authorizations for home health services or DME, supplies, devices, and environmental modification.[13] Check your SMA provider website or call the provider relations unit for all required forms.

While no two State Medicaid programs are exactly the same, States divide the assessment and person-centered plan forms for HCBS into two specific services: home health and personal support. HCBS provided through waiver programs may require either form, depending on the program and the level of care needed by the beneficiary. There are additional service plan requirements for beneficiaries that choose to self-direct a portion of their care.[14] Authorization forms for medically necessary DME are usually attached to the assessment and person-centered plan forms as appropriate. A more detailed description of the requirements for each person-centered plan is provided below.

Home Health Services

Home health services are a mandatory benefit under the Medicaid State plan; however, States have the option to provide physical therapy, speech-language therapy, or occupational therapy as part of the home health benefit. States can provide home health services as part of waiver programs if they expand the nature or amount of services provided under the State Medicaid Plan but do not duplicate State plan services (for example, the State Medicaid Plan allows four home health aide visits per week, and the waiver program offers four additional home health aide visits for a total of eight visits).[15] Federal regulations require that items and services provided under the home health benefit be ordered and furnished under a written person-centered plan.[16] The person-centered plan must be signed by the beneficiary's treating physician, must be incorporated into the beneficiary's permanent record, and must relate the items and services ordered to treat the beneficiary's condition. Some States follow Medicare guidelines for a person-centered plan for home health services:

- A home health agency may provide services under written orders once the person-centered plan is signed by a physician or nurse pursuant to physician orders;
- A person-centered plan must be signed by a physician before claims may be submitted; and
- A written person-centered plan must be reviewed at 60-day intervals.[17]

Most SMAs require prior authorization before home health services can be provided. As such, the prior authorization request is incorporated into the person-centered plan form provided by the State. Whether using a State-required form or not, a beneficiary's person-centered plan should include the following information:

- Their information (for example, name, contact information, date of birth, Medicaid identification number, other insurance, and social situation, including living arrangements and support available from family or friends);
- Guardian or responsible party information;
- Provider information (ordering provider and service provider);

- Support caregiver(s) information and availability; and
- School services (children under age 18 or 21 depending on Federal program and State criteria).[18, 19]

The plan must also meet the following criteria:

- Indicate their diagnosis;
- Describe their service needs related to their diagnosis;
- Indicate the type and frequency of the services needed (for example, skilled care 30 minutes per day, 3 days per week for wound care; parenteral nutrition 45 minutes per day/15 minutes per meal; medical supplies for wound care and nutrition);
- Include measurable treatment goals and anticipated outcomes;
- Must be reviewed by their treating physician and State-agency-specified professional at least every 60 days, or more frequently if there is a change in their circumstances; and
- Must be authorized with the signature of a physician or representative (registered nurse or nurse practitioner) when changes are made.[20, 21, 22]

Personal Support Services

Medicaid beneficiaries are not required to be homebound and are not required to need skilled care services as a condition to receive unskilled services such as personal support services.

Medicaid personal support services are defined as help with performing the activities of daily living (ADLs) and the instrumental activities of daily living (IADLs). ADLs include eating, bathing, dressing, toileting, and transferring. IADLs include personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, and money management.[23]

Some States require that a beneficiary have deficiencies in a specific number of ADLs and IADLs to be eligible. For example, Rhode Island requires deficiencies in at least two ADLs or three IADLs.[24]

Personal support services are an optional benefit under a Medicaid State plan. In addition, States may choose to provide personal support services as part of a 1915(c) waiver program or an 1115 demonstration waiver program. States can use waiver authority to design programs for specific groups of residents with specific needs. Personal support services must be:

- Recommended by a beneficiary's treating physician in a person-centered plan or in accordance with a service plan approved by the State;
- Provided by an approved provider; and
- Provided in an individual's home or other location as authorized by the State.[25]

Unlike State Medicaid Plan home health services, HCBS personal support services and waiver services may be provided by State sister agencies such as the State Department of Aging or State Department of Disabilities and monitored by a State-agency-specified professional, who is usually a case manager.[26, 27]

Most States require prior authorization for the State Medicaid Plan optional personal support services but may not require prior authorization for personal support services provided through waiver programs. States require providers to submit a personal support services application packet to supplement the beneficiary application that includes:

- A medical assessment;
- A comprehensive assessment of the beneficiary's physical, psychosocial, and functional needs; and possibly a
- Prior authorization form (dependent on services ordered).

Whether using a State-required form or not, a written person-centered plan for personal support services should include the following information:

- Beneficiary's information (for example, name, contact information, date of birth, Medicaid identification number, other insurance, and social situation);
- Guardian or responsible party information;
- Provider information (ordering physician, if applicable, case manager, and service providers);
- Support caregiver(s) information and availability; and
- School services (for children under age 18 or 21, depending on Federal program and State criteria).[28, 29]

A person-centered plan must also:

- Indicate the beneficiary's diagnosis;
- Describe the beneficiary's service needs related to their diagnosis;
- Include the beneficiary's expectations, service needs, and goals;
- Indicate the type and frequency of the services needed (for example, bathing assistance 30 minutes per day, 3 days per week);
- Indicate the level of assistance the beneficiary needs (for example, hands-on assistance, cueing, or supervision);
- Be reviewed by the beneficiary's treating physician or State-agency-specified professional at least once per year, or when there is a change in beneficiary circumstances; and
- Be authorized with the signature of a physician or State-agency-specified professional when changes are made.[30, 31, 32]

Self-Directed Care Option

When the beneficiary chooses the self-directed care option, sometimes referred to as the consumer-directed care option, the beneficiary's treating physician or other state designated person must assist the beneficiary or the responsible party in completing the authorization for the self-directed care option. Once the beneficiary is approved, the person-centered plan is developed to include the elements identified in the person-centered plan for HCBS. In addition, the person-centered plan must also:

- Specify the services that the beneficiary or responsible party would be directing;
- Identify methods the beneficiary or responsible party will use to select and dismiss the service providers;
- Specify the roles of family members and others who may assist the beneficiary in self-directed services;
- Describe how the service plan is developed through a person-centered process directed by the beneficiary or the responsible party;
- Include risk management techniques that recognize the roles and sharing of responsibilities;
- Assure the needed resources and training to direct services are in place; and
- Individualized budget for the consumer-directed services (optional).[33]

Common Errors in Person-Centered Plans for HCBS

Improper payments for HCBS may occur when Medicaid funds are paid to the wrong provider, are paid in the wrong amount, are not supported by documentation or policy, or are used for services other than those identified in the person-centered plan. PERM data was analyzed to determine the root cause of errors in HCBS billings. The analysis identified common errors related to written person-centered plans as a primary reason for improper payments. These errors included:

- Assessments or reassessments not completed within time frames established by Federal and State guidelines;
- Establishment and review of person-centered plans not completed within time frames established by Federal and State guidelines;
- Person-centered plans do not include current physician authorization for services or DME where applicable;
- Amount, duration, scope, funding allocation, and professional level of provider for each type of service provided are not included in the person-centered plan; and
- Beneficiaries are uninformed about their person-centered plan.

There are some promising practices that can be integrated into the person-centered plan development process to correct a majority of the errors found. These include implementation of simple yet effective quality control measures for person-centered plans. Further information can be found in the "Common Errors in Person-Centered Plans That Lead to Improper Payments for Home and Community-Based Services" fact sheet in this toolkit.

Conclusion

Federal regulations require a written person-centered plan for HCBS whether services are provided through the State Medicaid Plan or through a waiver program. The use of Federal funds is not approved for HCBS waiver services that are provided without a person-centered plan.

Items and services provided under the State Medicaid Plan home health benefit must be ordered and furnished under a written person-centered plan. Unlike home health services, personal support services and waiver services may be provided by State sister agencies such as the State Department of Aging or State Department of Disabilities

and monitored by a State-agency-specified professional who is responsible for developing and monitoring the person-centered plan. Some States provide form templates to providers to create the person-centered plan in a standard format. There are additional requirements when a beneficiary chooses to self-direct all or part of their care.

Improper payments for HCBS may be caused by errors with person-centered plans. These errors include services provided to a beneficiary that are not authorized in the plan, no signature from the beneficiary's treating physician (required for home health services) or case manager on the plan, an outdated beneficiary reassessment, or an expired plan.

As a provider, you can play a significant role in the fight against Medicaid fraud, waste, and abuse. CMS hopes you share its commitment to eliminate payment errors and fraud, waste, and abuse in the Medicaid program. By increasing your awareness of common errors and applying remedies in your daily practice, you will help strengthen the integrity of the Medicaid program and reduce improper payments. For further information, review the toolkits about HCBS at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html on the CMS website.

Additional Resources

Information about the person-centered planning process for HCBS can be found in Chapter 4, Section 4442.6 of the State Medicaid Manual available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html on the CMS website.

State-specific information about person-centered plan requirements and forms for authorization and beneficiary assessment for Medicaid home health services may be found in your SMA Provider Manual and Forms sections of your SMA website.

State-specific information about person-centered plan requirements and related forms for authorization and beneficiary assessment for personal support services may be found on your SMA or State sister agency website.

To see the electronic version of this booklet and the other products included in the "Home and Community-Based Services" Toolkit, visit the Medicaid Program Integrity Education page at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html on the CMS website.

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