

EXHIBIT Z

PERSON-CENTERED SERVICE PLANNING

Federal and state regulations (42 CFR § 441.301, 55 Pa. Code §§ 52.25 and 52.26) require that Person-Centered Planning be used in Medicaid LTSS programs. Person-Centered Planning is a process directed by the CHC LTSS Participant. The process involves a PCPT actively coordinated by the LTSS Participant's Service Coordinator. The PCSP must be developed by the Service Coordinator, the Participant, the Participant's representative, and the Participant's PCPT. The process assists the Participant to articulate a plan for the future and helps determine the supports and services that the Participant needs to achieve identified outcomes.

Note: The information in this exhibit is to be used in conjunction with, and does not replace, the requirements in the CHC 1915(c) HCBS waiver.

Guidelines for Person-Centered Service Planning

- i. The CHC-MCO must deliver LTSS in a person-centered way:
 - a. LTSS must be furnished under a written service plan, based on a person-centered approach that identifies and addresses an LTSS Participant's needs, goals, and preferences while incorporating existing resources and supports as identified by the Participant.
 - b. Service plans must be:
 1. Approved by the CHC-MCO no more than thirty (30) days from the date the Assessment or Reassessment is completed.

PCSP Procedures Overview

- i. General
 - a. The PCSP must be adequate and appropriate according to needs identified by the Assessment.
 - b. If a legal guardian has been appointed for the Participant, the guardian must be an integral part of the PCPT. The Participant's legal guardian

has the right to actively participate on the Participant's behalf in the planning process and to file an appeal or grievance on behalf of the Participant.

- c. If the Participant uses an alternative means of communication or if the Participant's primary language is not English, the process must utilize the Participant's primary means of communication or an interpreter.
- d. The Participant's cultural preferences must be acknowledged and reflected in the planning process.
- e. The CHC-MCO must provide the necessary level of support to ensure that the individual directs the PCPT process to the maximum extent possible and is enabled to make informed choices and decisions.
- f. The Department may review, question, and request revisions to LTSS Participants' PCSPs. The CHC-MCO must provide the Department with monthly aggregate reports on PCSP changes in a format specified by the Department.
- g. CHC-MCOs must annually submit and obtain Department approval of their Service Coordination staffing, caseloads, the required frequency of in-person contact with Participants, and how Service Coordinators share and receive real-time information about Participants and Participant encounters.

ii. Participant Education

- a. The Service Coordinator must educate the Participant on the following:
 - 1. Strategies for resolving conflict or disagreement within the PCPT process, including clear conflict-of-interest guidelines for all members of the Person-Centered Planning Team.
 - 2. Informed choice regarding the services and supports they receive and from whom.

3. Informed choice regarding their right to select their Service Coordinator and to change Service Coordinators at any time.
 4. A method for the Participant to request updates to the PCSP as needed.
 5. The Complaint, Grievance and Fair Hearing Appeals Processes.
 6. How to report abuse, neglect, and exploitation. The Service Coordinator must obtain a signature verifying that the Participant or their representative fully understand the process.
- b. The Service Coordinator provides Participants and their representative, if any, with a Participant handbook within 5 days of enrollment. The handbook is intended to provide Participants with a basis for self-advocacy safeguards. The Service Coordinator educates the Participant and/or their representative on the following:
1. Participant rights and responsibilities;
 2. Participant choice;
 3. the role of the Service Coordinator;
 4. the role of the PCPT;
 5. how to connect to other community resources;
 6. abuse, neglect and exploitation; and
 7. fraud and abuse.
- iii. Content of the PCSP for Participants Receiving LTSS in the Community
- a. The holistic PCSP at minimum must include the following:
1. A Care Management Plan to identify and address how the Participant's physical, cognitive, and behavioral healthcare needs will be care managed. See Section V.G.1 of the CHC Agreement for the required components of PCSP Care Management Plans.

2. An LTSS Service Plan to identify and address how LTSS needs will be met and how services will be provided in accordance with the PCSP. The requirements for the LTSS Service Plan are in Section V.G.2 of the CHC Agreement. In addition to the requirements listed in the CHC Agreement, the CHC-MCO must also include the following in the PCSP and PCSP process:
 - A. Individualized and emergency back-up plans to ensure the health and safety of Participants.
 - i. Service Coordinators must review the PCSP quarterly to validate that the strategies and back-up plans are working and are current.
 - ii. Service Coordinators must update back-up plans as necessary, or if the back-up has failed at any point.
3. The PCSP must document the following:
 - A. The Participant's eligibility and CHC/MA ID number;
 - B. The names of individuals who participated in the PCSP process;
 - C. The Participant's household composition (i.e., does the individual live alone, with a sibling or other relative, or friend?);
 - D. The Participant's emergency contacts;
 - E. The Service Coordinator must describe contact with the Participant, family members, and providers in the case management notes of the PCSP.
 - F. The Service Coordinator's quarterly review of the Participant's back-up plan, including updates to the back-up plan if necessary;
 - G. The Participant's completed Assessment, including the Diagnosis, Medications, Allergies, and Medical Contacts;
 - H. Any CHC services that reflect unmet needs identified in the Assessment;

- I. The Participant's strengths and capabilities;
- J. That the Participant was offered a choice of network providers;
- K. The review of rights and responsibilities with the Participant;
- L. The Participant's delivery preferences for all services;
- M. Any barriers, risks, and mitigation strategies;
- N. The assignment of responsibilities to implement and monitor the PCSP;
- O. A list of the Participant's preferences for employment, education, and community engagement, as well as an overview of the discussion the Service Coordinator had with the Participant on these issues;
- P. When a participant uses informal supports, the CHC-MCO must discuss with and document in the PCSP each informal support's availability, willingness, and ability to provide the needed HCBS and the participants' acceptance of assistance from that informal support. The PCSP also must identify each informal support, and, with respect to each informal support, the day(s) and number of hours per day informal supports is provided, as well as the specific type and scope of services provided.
- Q. If the Participant does not have informal support, include reasons why informal support is not available;
- R. The type, scope, amount, duration, and frequency of services needed by the Participant;
- S. Justification for all services;
- T. If a service definition requires a physician prescription, documentation that the Service Coordinator obtained the prescription prior to adding the service to the PCSP; and
- U. If the Participant refuses to have a need addressed, when the Participant refused to have the need addressed and why the Participant chose for the need to remain unaddressed.

iv. Content of the PCSP for Participants Receiving LTSS in Nursing Facilities

1. For nursing facility residents, nursing facilities are responsible to develop care plans and provide services consistent with state licensing requirements and federal conditions of participation. The Department of Health will continue to enforce state licensing requirements and act as the State Survey Agency for federal survey and certification purposes.
2. The CHC-MCO Service Coordinator will review a Participant's nursing facility care plan as part of coordination of care and provide input into the plan. The CHC-MCO Service Coordinator will work with the nursing facility staff to determine the services that the Participant needs and the roles of who should be providing the services in the PCSP process. The CHC-MCO Service Coordinator will be responsible for the coordination of Medicare benefits, Veterans benefits, behavioral health services, and other health coverage insurers and supports in conjunction with the nursing facility. A separate PCSP does not have to be created as long as the NF care plan includes all appropriate services, goals for transitioning to the community (if desired by the Participant), and how Medicare benefits, Veterans benefits, behavioral health services, and other health coverage will be coordinated.

v. PCSP Process

1. The Service Coordinator describes and explains the concept of person-centered service planning to the Participant and/or his or her representative.
2. Prior to a PCPT meeting, the Service Coordinator works with the Participant and/or his or her representative to coordinate attendees and meeting dates, times and locations. The Participant chooses who to invite and when and where meetings will take place.
3. The Service Coordinator provides information to the Participant and to his or her representative, if any, in advance of the planning meeting so that the Participant can make informed choices about their services and service delivery in order to effectively develop a PCSP.

4. The Service Coordinator, along with the PCPT, utilizes the assessments, documentation obtained from direct services and discussions with the Participant to secure information about the Participant's needs, including health care needs, preferences, goals, health status, and available, willing and able informal supports to develop the PCSP. This information is captured by the Service Coordinator and then documented in the Participant's record.
5. Service Coordinators ensure that the PCSP includes sufficient and appropriate services to maintain health, safety and welfare, and, for CHC Waiver Participants, provides the support that an individual needs or is likely to need in the community to avoid institutionalization. Service unit calculations must be accurate and appropriate. Each Participant need must be addressed unless the Participant chooses for a need not to be addressed.
6. The Service Coordinator reviews, in conjunction with the Participant, the Participant's services to ensure the services are adequate to meet the desired outcomes. Revisions are discussed with the Participant and incorporated into the PCSP. All service plan meetings and discussions with the Participant are documented in the Participant's record.
7. Annually, the Service Coordinator provides the Participant with the choice of receiving community services in the CHC Waiver, nursing facility services, or no LTSS services. Completed forms detailing this must be maintained in the Participant's file.
8. Participants are also given the choice of willing and qualified Providers within the network at each Reassessment and at any time during the year when a Participant requests a change of services. The Service Coordinator must document the Participant's choice of provider as part of the Participant's PCSP. As noted above, the Service Coordinator must also document that the Participant was offered a choice of network providers.
9. The Service Coordinator provides Participants and/or his or her representative with information on services and supports available to

LTSS Participants and the processes for selecting qualified Providers of services.

10. For Participants receiving home and community-based services, the Service Coordinator also provides information regarding opportunities for Participant-Directed Services and responsibilities for directing those services. The Service Coordinator must document these discussions in the Participant's record.
11. The Service Coordinator gathers information on an ongoing basis to ensure the PCSP reflects the Participant's current needs. The Service Coordinator discusses potential revisions to the PCSP with the Participant and individuals important to the Participant. All changes to existing PCSPs must be documented in the Participant's record.
12. The Service Coordinator must obtain the electronic or written signatures of the Participant, Participant's representative and any others involved in the planning process, indicating they participated in the process, they approve and understand the services outlined in the PCSP, and that services are adequate and appropriate to the Participant's needs. The PCSP is not considered complete until all of the required signatures are received. If a Participant refuses to sign their PCSP, not because they do not agree with the plan, but because they simply refuse to sign it at that time and there is no representative to sign on their behalf, the PCSP should not be deemed invalid due to lacking the signature. For instances where this occurs the Service Coordinator should document the refusal of the Participant to sign the document and note verbal consent of the PCSP by the Participant. The Service Coordinator should attempt to obtain the Participant's signature during their next interaction. A Participant may also sign indicating disapproval of the plan if the Participant disagrees with the PCSP. When this occurs, the Service Coordinator must provide the Participant with a denial notice within two (2) business days that includes his or her right to file a grievance, and assist the Participant through the process as appropriate. Every Participant must be given a copy or mailed a copy of his or her PCSP

within two (2) business days of when initial completion or subsequent revisions are finalized. A copy of the signed PCSP is given to the Participant as well as all members of the PCPT who the Participant consents to receiving the PCSP or portions of the PCSP.

13. If the CHC-MCO makes the decision to deny in whole or in part, reduce, suspend or terminate a service or item in the Participant's PCSP, the CHC-MCO must use the templates specified by the Department to issue a written denial notice which meets the following criteria:
 - A. Written at a 6th grade reading level;
 - B. Written in an individualized manner;
 - C. Specifically references the service or item that is being reduced or denied;
 - D. Includes specific references to approved medical necessity guidelines, rules, or protocols on which the decision is based.
14. Section V.B.2e of the CHC Agreement contains a limited number of exceptions to the notice requirement. One exception is the receipt of a clear written statement signed by a Participant that he or she no longer wishes to receive the requested service or gives information that requires termination or reduction of services and indicates that he or she understands that termination will be the result of supplying that information. If this occurs the CHC-MCO must still offer the Participant appeal rights. The CHC-MCO may not consider a Participant's signature on the PCSP in itself to be a "clear written statement" as described in V.B.2e.
15. If the Participant grieves the CHC-MCOs authorized PCSP, the Service Coordinator must provide the final, approved PCSP to the Participant at the conclusion of the grievance process.
16. Once the PCSP is authorized by the CHC-MCO, the Service Coordinator communicates the service plan content to the Participant and to the Participant's appropriate service provider or providers to ensure that

service delivery matches the approved PCSP. The CHC-MCO must approve the PCSP prior to the provision of services.

17. The Service Coordinator initiates a Reassessment at least annually (at least once every 365 days) and when either there is a significant change in the Participant's situation or condition, a trigger event occurs, or the Participant requests Reassessment.
18. The CHC-MCO must complete the PCSP in a format approved by the CHC Agreement and enter the PCSP in the CHC-MCO's designated information system.