It Starts with a Person:

The Intersection of Case Management and the Home and Community-Based Services (HCBS) Settings Final Rule

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Foundations of Person-Centered Planning

With the publication of the Home and Community-based Services (HCBS) Settings Final Rule ("Final Rule") in 2014, person-centered planning and practices once again came to the forefront of service delivery. While the concept of person-centered planning had been at play for decades, the Final Rule was the first time the implementation of these practices was explicitly tied to ongoing funding of home and community-based settings under the various Medicaid waiver authorities. Prior to the Final Rule, related provisions could be found in the Deficit Reduction Act of 2005 and the Affordable Care Act (ACA) of 2010. The overhaul of the managed care regulations, released in 2016, also drove home the Centers for Medicare and Medicaid Services (CMS') emphasis on ensuring the presence of a person-centered planning process across Medicaid programs.

While all Medicaid funding authorities have different guidelines, one of the common characteristics across all authorities includes the requirement for a person-centered planning process. The Final Rule specifies the person-centered planning process must:

- Be driven by the individual.
- May include a representative that is freely chosen by the individual.
- Occur at least annually and at times/locations that are convenient for the individual.
- Be reviewed/revised when circumstances change or at request of the individual.

The Final Rule not only defines the characteristics of a home and community-based setting but also sets forth the requirements for modifications to any of those characteristics—further reinforcing the principles of person-centered planning.

Operationalizing the Person-Centered Planning Process and the Final Rule

In our experience supporting states' efforts to conduct site-level assessments for compliance, we see person-centeredness in practice, often more informally through the way services are delivered. Specifically, we hear direct support staff speak to how well they know the individual they support, and observe some of these practices; however, we often do not observe formal documentation of individual choices and preferences. Through the settings assessment process, we often hear, "that's the case manager's job." While those statements are largely accurate, they do not negate the providers' role and responsibility in ensuring the ongoing provision of individual choice in services and supports.

Although an individual's set of choices begin at the case management level, they do not stop once an individual has chosen where they want to live, attend a day program, or work, and who shall provide those services. Nor should these conversations and connections be limited to

once a year. The case manager is responsible for ongoing monitoring of the individual's plan; regardless, the provider should take an active role in establishing and supporting ongoing communication between the provider, the individual receiving services and their respective case manager.

Role of Case Management in Person-Centeredness

Case management (sometimes referred to as service or resource coordination) is the foundation by which individuals receive HCBS waiver services. Without a case management system, particularly one that is person-centered, individuals cannot access needed services, or they access the wrong services, in the wrong setting, at the wrong time. While states work to comply with the Final Rule, it is imperative that states evaluate their case management system as part of this work. At its core, case management for HCBS waivers consists of four key components:

1. Assessment
2. Service Plan Development/Revision
3. Referral and Related Activities
4. Monitoring

Assessment

Assessment is the process by which a case manager assesses the needs, goals, desires, and preferences of an individual. The case manager assesses the needs to determine if an individual has any medical, educational, social, or other service needs. These assessed needs are what assist the case manager and individual to develop a person-centered service plan. During the assessment process, case managers not only obtain information about an individual's needs, but also their goals and preferences as well. The assessment process is both formal and informal. In order to create consistency across a system, states use "assessment tools" to assess an individual's needs, this is the formal process. It's important to note that assessment be thought of and conducted as a process. One tool does not exist to capture 100% of an individual's needs 100% of the time. As such, case managers need to gather information about a person from a variety of sources, often going beyond the tool implemented by the state agency. Assessment also occurs throughout the service plan year when an individual experiences a change in need or some other incident. A specific tool may not be used, but the case manager is still assessing the individual's needs: this is the informal process. Thinking of and conducting assessment as a process is the start of developing the person-centered service plan.

Service Plan Development/Revision

The development of a person-centered service plan can only occur once a person-centered assessment process is conducted. Not only must the development process be conducted in compliance with person-centered planning rules from CMS, but also the actual written document must comply with person-centered requirements. The process begins with the individual deciding who they want to have present during the service plan meeting. This is a switch from how service plans are often developed in states, particularly for individuals with intellectual and developmental disabilities. Many states already employed a team approach to service plan development, and while the Final Rule does not prohibit a team approach, it requires the team be chosen by the individual. No one is automatically included. The role of the

case manager here is to support the individual and to help the individual lead the service plan process. Additionally, for any providers not in attendance at the service plan meeting, the case manager's role is to develop the service plan with the individual, to include which services the individual needs along with the frequency and duration the individual needs for each service.

Referral and Related Activities

Once a person-centered service plan is developed, the referral process begins. The case manager must provide options and choice to the individual by sharing information about the providers qualified to provide the needed and documented services. Once the individual identifies providers the case manager then contacts those providers to make a referral to see if they are able to meet the individual's needs and preferences. While referring for services, the case manager must keep the individual apprised of the responses from providers and discuss any modifications the provider has said are necessary to safely provide services to the individual. Any modification of rights must be documented by an assessed need and agreed to by the individual. Once the service plan is final, the individual will have a plan with services authorized to meet their needs and goals; the service plan will truly be about the individual.

Monitoring

Case managers conduct monitoring to assure the health and welfare of individuals. Monitoring must be purposeful and related to the individual and his or her needs, services, satisfaction with services, and any other concerns. The case manager is responsible for ensuring that services are provided in accordance with the service plan – the services are addressing the assessed needs, and the frequency and duration align with the authorized amounts. Case manager monitoring should not only occur with the individual, but also with the providers as well. Providers and case managers must work together to identify and address any concerns with the individual's services and health and welfare. States may also use case management monitoring to determine compliance with the Final Rule requirements. States choosing to implement this, must ensure that case managers and case management entities are trained and knowledgeable about the settings requirements and what is and is not compliant.

These four components of case management are not linear, but cyclical. While the process starts with assessment for someone new, monitoring is not where case management ends. When a case manager conducts a monitoring activity, that activity may lead to changes to an individual's service plan. Case managers must be well versed in their role as this is the foundation by which a person-centered system exists. If a case manager does not successfully complete all components, the providers have further difficulty fulfilling their role. In turn, the individuals suffer most, and person-centeredness in the delivery of their services is compromised.

Provider Responsibilities in a Person-Centered System

Even though the process starts with individuals and their case managers, the settings where individuals receive services, and their staff play a critical role in supporting individuals consistent with person-centered practices. In most cases, providers see and interact with individuals more than the case manager. As such, the providers and case managers must collaborate. This includes the sharing of information about the individual, so both can properly provide support and fulfill the individual's goals and needs outlined in their person-centered plan.

To facilitate a successful collaboration, providers and their staff should begin by establishing communication channels with the case manager. For each individual served, the provider should know who the case manager is and how to contact them. This will also further support the individual in facilitating ongoing connections between the individual and their respective

case manager, understanding this communication should be ongoing. This process should be much more than just annual service planning. An individual cannot be fully supported, and the provider cannot properly fulfill the goals of a person-centered system, if communication is only occurring once a year. Finally, and most critically, is the provider ensuring the operationalization of the individual's plan is truly based on their needs, wants, goals and preferences -- and not those of the staff providing support.

Closing the Gap: Best Practices to Help Make the Shift to Person-Centeredness

Moving forward, case managers and provider staff must work together. Person-centeredness cannot simply be forms completed by agencies and individuals, nor can it be an agency stating they are "person-centered." There must be a shift in how the agencies and providers interact with each other and ultimately the individual. Case managers and providers must take the plan from conceptualization to operationalization. We have provided some best practices to help both case managers and providers make the shift.

Establish working relationships. Building relationships between case management and providers can only help the individual. When problems arise, having a solid relationship can help resolve those issues sooner.

Know the plan. The person-centered plan should never be a simple document that just exists between the individual and their case manager. Setting staff should know this plan inside and out in order to be able to fully support the individual and their goals.

Listen to the person. Engage in active listening. It is always possible that the individual is saying something different than what their plan states, especially if formal conversations are only occurring annually. Just as our needs and preferences change, so do those of individuals receiving services. If the individual's choices or preferences have changed, connect them with their case manager and facilitate the communication.

Conduct quarterly meetings. Case management agencies and provider agencies who develop relationships outside of the typical referral and monitoring, are better positioned to provide the highest quality of services to individuals. Quarterly joint meetings are one way in which both agencies can build a relationship. These meetings can help each agency stay apprised of what is going on in their respective roles and they can also be used to troubleshoot problems, either between agencies or systemically.

Training, training, training. Training is critical. Training on system changes, policy and regulatory changes, and roles and responsibilities of each player in a person-centered system is crucial. While each provider does not need to know the ins and outs of the other's day-to-day job, overviews of their roles and changes impacting their jobs can help both case managers and providers collaborate for the good of the individual.

Federal regulations set the floor, not the ceiling. Federal regulatory changes such as the Final Rule set the minimum for what is required of HCBS programs. States have the flexibility to go above and beyond these minimum requirements and create a truly person-centered system. Compliance with the Final Rule provides the opportunity for states to redesign their system, not just the services and settings.

The Final Rule provided the opportunity for states to dive in and evaluate their entire HCBS and/or long-term services and supports systems. Engaging in visioning and strategic planning sessions can direct the state's efforts and ensure the agency's goals are aligning with the programmatic goals. From reviewing the state's respective statutes and policies that govern these programs to "boots on the ground" settings assessments, this is the time to identify any gaps in service delivery and effectuate change for those most impacted – the individuals receiving services.

We know the clichés are true – change does not happen overnight, and it isn't always easy. However, the benefits of creating a person-centered system and closing the gaps between case management and service delivery are beyond measure.

About the Author

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To learn more about Case Management and the Home and Community-Based Services (HCBS) Settings Final Rule, contact us today.

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