



Transforming State LTSS Access Programs and Functions into A No Wrong Door System for All Populations and All Payers

Administration for Community Living
Centers for Medicare & Medicaid Services
Veterans Health Administration

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Application Due Date: 07/15/2014

Department of Health & Human Services
Administration for Community Living

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Applications that fail to meet the application due date will not be reviewed and will receive no further consideration. You are strongly encouraged to submit your application a minimum of 3-5 days prior to the application closing date. Do not wait until the last day in the event you encounter technical difficulties, either on your end or, with <http://www.grants.gov>. Grants.gov can take up to 48 hours to notify you of a successful submission.

The U.S. Administration for Community Living (ACL), the Centers for Medicare & Medicaid Services (CMS) and the Veterans Health Administration (VHA) have developed this Funding Opportunity Announcement (FOA) to assist states in the planning of a No Wrong Door (NWD) System to help individuals access long term services and supports (LTSS). The NWD System will make it easy for people of all ages, disabilities and income levels to learn about and access the services and supports they need. The NWD System will also provide states with a vehicle for better coordinating and integrating the multiple access functions associated with their various state administered programs that pay for LTSS. Specifically, the funds being made available under this FOA are to support a state-led 12-month planning process to identify the key actions the state will need to take to move forward with the development and implementation of a NWD System that has the functional and operational capacity described in this FOA. At a minimum, the following state agencies must be involved as full partners in co-leading this planning process: the State Medicaid Agency, the State Unit on Aging, and the state agencies that serve or represent the interests of individuals with physical disabilities, individuals with intellectual and developmental disabilities, and the state authorities administering mental health services. The planning process must involve meaningful input from key stakeholders including consumers, their advocates, Area Agencies on Aging, Centers for Independent Living, local Medicaid agencies, local organizations that serve or represent the interests of individuals with physical disabilities, individuals with intellectual and developmental disabilities, and individuals with mental/behavioral health needs, Veteran Service Organizations, as well as service providers, and other relevant public and private entities. States must make every effort to meaningfully include persons who use LTSS in all aspects of the planning process. States may also involve other state agencies in the planning process.

Most states have already developed programs that help consumers understand and access their LTSS options using various federal grants and authorities, such as Aging and Disability Resource Center grants,

Money Follows the Person grant funding, and the Balancing Incentive Program, but few states have developed a statewide system to access LTSS that reflects the functionality and operational capacity of the NWD System described in this FOA. If a state is successful in competing for a grant award under this FOA, the main “deliverable” at the end of the 12-month planning period is a 3-Year Plan that includes a detailed strategy, work plan, and budget the state will use, pending the availability of additional federal support, to begin transforming the multiple access functions that are administered by its various LTSS programs into a single statewide NWD System to access LTSS for all populations and all payers.

Funding Opportunity Description includes:

A. Background on the Evolution of the NWD System

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A. Background on the Evolution of the NWD System

Finding and accessing the right LTSS can be a daunting task for individuals and their families. The current LTSS System involves numerous funding streams administered by multiple federal, state and local agencies using different, often fragmented and duplicative, access processes involving screening, intake, needs assessment, service planning, and eligibility determination. Individuals trying to access LTSS frequently find themselves confronted with a bewildering maze of organizations and bureaucratic requirements at a time when they are vulnerable or in crisis. This often results in people making decisions based on incomplete, and sometimes inaccurate, information about their options. This can lead to decisions to purchase and/or use LTSS options that are less than optimal for the individual and more expensive than necessary, including decisions to use expensive options such as nursing facility care that can quickly exhaust an individual’s personal resources and result in their spending down to Medicaid.

The consequences of a LTSS System that makes it difficult for people to make informed decisions about their LTSS options has a direct impact on the health, well-being and financial status of our citizens, and it also has a direct impact on our state and federal budgets. This situation will only be compounded as the number of people who need LTSS increases and more and more LTSS products come onto the market. Currently, about 11 million Americans need some form of LTSS each year, and about 70% of all the people now turning age 65 will need LTSS at some point during their life.

In response to this challenge facing our citizens and our nation, the Administration on Aging (now part of the Administration for Community Living) and the Centers for Medicare & Medicaid Services came together in 2003 to create a joint funding opportunity to support state efforts to create “one-stop-shop” access programs for people seeking LTSS. This initiative, known as the Aging and Disability Resource Center (ADRC) Program, was designed to provide consumers with “visible and trusted” sources of information, one-on-one counseling, and streamlined access to services and supports. Recognizing the LTSS System will always involve multiple payers and providers, and therefore always have some degree of fragmentation, the ADRC Program was a “system change” initiative to help states better coordinate and integrate their access functions and create a new “interface” between consumers and the LTSS System in order to make it easier for people to learn about and quickly access the LTSS options that would best meet their needs. The ADRC grant program was based on the most promising practices being implemented at the time by states, including Washington, Oregon and Wisconsin. The ADRC Program in Wisconsin in particular was highlighted as a model in the 2003 FOA because its vision was to serve all individuals in need of LTSS regardless of their age, disability or income, not just people who qualified for public

programs such as Medicaid. The reach of the Wisconsin model was particularly important because most people needing LTSS do not qualify for Medicaid.

AoA and CMS awarded ADRC grants to 12 states in 2003, and each year the number of states participating in the program grew and eventually almost all states and several of the territories received funding to develop ADRC Programs. As the number of participating states grew, the ADRC initiative started to evolve, and several key functions were strengthened. For example, in 2007 CMS made special Hospital Discharge Planning grants available to 10 state ADRC programs to strengthen their involvement in hospital to home care transitions. Then in 2009, supporting care transitions was recognized as a functional component of the ADRC initiative. This work expanded again in 2010 when AoA made special grants available to 16 states to partner with hospitals to build evidence-based care transition programs into their ADRC programs. The capacity of ADRCs to help nursing home residents transition back to the community was significantly bolstered when state Medicaid agencies started to invest in ADRCs to assist with Money Follows the Person transitions, and, then, under the new CMS guidance for MDS Section Q, many Medicaid agencies designated ADRCs to serve as a Local Contact Agency to assist nursing home residents expressing a desire to return home. Today, 42 state ADRC programs have counselors doing MFP transitions and have been designated to serve as a Local Contact Agency under the Section Q guidance.

Another major development in the evolution of the ADRC model occurred in 2008 when the VHA – the nation’s largest health care system - recognized the value of ADRCs in helping consumers develop person-centered plans and direct their own care. In that year, the VHA entered into formal funding agreements with ADRCs to serve as the VHA’s designated entity for delivering the Veterans-Directed Home and Community Based Services Program (VD-HCBS). Currently, over 100 ADRC sites across the country are delivering the VD-HCBS Program. Another development in 2008 included Nursing Home Diversion/Community Living grants to states to strengthen the role of the ADRC in serving non-Medicaid eligible individuals in an effort to reduce the rate that they spend down to Medicaid by diverting them from higher cost LTSS. Then, in 2010 the Affordable Care Act provided \$50 million dollars over five years to support the further development of the ADRC Program. The Affordable Care Act also funded the CMS Balancing Incentive Program to incentivize states to rebalance their Medicaid LTSS spending and required participating states to make changes to their LTSS Systems, including developing statewide NWD programs. Many State Medicaid Agencies included ADRCs in the development of their Balancing Incentive Program NWD. However, other states limited their Balancing Incentive Program NWD to serving Medicaid eligible individuals, and some states developed Balancing Incentive Program NWD totally separate from their ADRC programs.

In 2012, recognizing the accomplishments of both the ADRC and Balancing Incentive Program initiatives, as well as the lessons learned from the experience of the participating states, including the variation in functionality and capacity that existed across the states, ACL, CMS and the VHA decided it was time to draw on these experiences. As a result, ACL with its Federal partners are developing national standards, along with a set of tools, metrics, and best practices, all states could use to develop a single “high performing” access system that would effectively serve all populations in need of LTSS, including private pay individuals, and coordinate and integrate all the various access functions carried out by the state administered programs that pay for LTSS. To accomplish this, the 3 federal agencies issued a special funding opportunity – known as the 2012 “Part A ADRC Grant Program”. With the 2012 FOA, ACL officially adopted the “No Wrong Door” System for the ADRC Part A grants. Part A grants were awarded to 8 states (CT, MA, MD, NH, OR, VT, WI and WA) to develop a NWD System in their state so the federal partners could leverage the experience and models emerging in these states to serve as the basis for the development of national standards. Lessons learned from these grants demonstrated that no one agency or network could successfully implement a LTSS access system for all populations and all payers without having multiple agencies and organizations at the state and local level formally involved in the system's operations. The network needs to include agencies and organizations that serve or represent the interests of different LTSS populations. The 2012 Part A grants will end in September 2015, at which time ACL, CMS, and the VHA will have in place:

- National standards for a NWD System for all populations and all payers;
- A national training and credentialing program for NWD System person-centered counselors;
- Measures and tools states can use to document and improve the operational capacity and performance of their NWD System;
- A portfolio of best practices states can use to strengthen various components of their NWD System;
- Official guidance states can use to claim Medicaid administrative funding and VHA funding to support their NWD System infrastructure; and
- Eight states with leadership experience in developing NWD Systems for all populations and all payers that can serve as models for other states.

Looking to the future, the President's FY 2015 Budget Request includes \$20 million each year for five years, for a total of \$100 million dollars, to support the further development of NWD Systems, based on the work and deliverables that will come out of the 2012 Part A Grant Program. This new funding will allow the current 8 states to continue and also bring another 35 states into the NWD System initiative over the next five years. The current FY 2014 FOA is designed to help states prepare for this potential future funding that, if enacted by the Congress, will commence in FY 2015.

B. ACL/CMS/VHA Vision for a NWD System

The ACL/CMS/VHA vision is that each state will have a single statewide NWD System to LTSS for all populations and all payers with the functionality and capacity described in this FOA. Under this FOA, "all populations" means, everyone regardless of a person's age, income or disability and "all payers" means any state administered program that provides LTSS to the populations that will be served by the NWD System. For this FOA, the term Person Centered Counselor references individuals performing person centered counseling within the NWD System. Supporting Appendices to help illustrate the NWD System can be found on the ACL website located at http://www.acl.gov/Funding_Opportunities/Announcements/Index.aspx.

The NWD System functions include:

- **Public Outreach and Coordination with Key Referral Sources;**
- **Person Centered Counseling;**
- **Streamlined Access to Public LTSS Programs; and,**
- **State Governance and Administration.**

Each of these functions are described in detail below and illustrated in the NWD System schematic in Appendix I. The first three functions reflect interactions with individual consumers that are fluid and could occur simultaneously and do not necessarily indicate the sequences of steps that might be needed to help an individual access services. Additionally, the federal NWD System vision recognizes that no one agency or network has the capacity, expertise or authority to effectively carry out all the NWD System functions for all the different populations that will be served by the NWD System. Multiple agencies and organizations at the state and local level will need to be formally involved in the operations of a state's NWD System, all with clearly defined roles and responsibilities, in order for the NWD System to be effective.

The federal vision for the NWD System gives states flexibility in determining how best to organize, structure and operate the various functions of their NWD System. It is expected that states will better integrate and in some cases restructure and strengthen their existing ADRC and/or Balancing Incentive Program NWD programs and other state administered LTSS access programs, in order to realize the joint ACL/CMS/VHA vision for a fully coordinated and integrated system of access to LTSS, as described in this FOA. As part of this vision, States must clearly define the roles and responsibilities of every agency or organization involved in performing NWD System functions and ensure that all of the functions are carried out in a coordinated, high-quality manner. States can delegate some of the NWD System activities (e.g., Person Centered Counseling, the Preliminary Functional Assessment, etc.) to a broad array of local agencies and organizations. A sample of these types of organizations has been provided in Appendix III.

Some agencies and organizations might have the capacity to carry out only the Person Center Counseling function, others the Preliminary Functional Assessment, while others might be able to carry out both functions. As described below, it will be the role of the State NWD System governing body (see section below on State Governance and Administration) to determine which local agencies and organizations perform the various NWD System functions and to ensure that every individual and family member who contacts the NWD System receives the same quality of information and help in accessing LTSS, regardless of where they enter the NWD System.

C. Description of Key Functions of a NWD System for All Populations and All Payers

The following is a description of the key functional components of a fully developed NWD System to access LTSS for all populations and all payers. A visual depiction of the NWD System functions can be found in Appendix I. It should be noted that many of these functions reflect interactions with individuals that are fluid and could occur simultaneously and do not necessarily indicate the sequences of steps that might be needed to help an individual access services.

1. Public Outreach and Coordination with Key Referral Sources

To be a “visible” source of individualized counseling and help with accessing LTSS, the NWD System must proactively engage in public education to promote broad public awareness of the resources that are available from the NWD System. The goal is for citizens of the state to know where they can turn to for unbiased and “trusted” help in understanding and accessing the LTSS options that are available in their communities. A NWD System’s public education efforts should give special attention to underserved and hard-to-reach populations, including people with hearing and visual impairments and limited English speaking populations.

A NWD System must also have formal linkages (e.g., Formal Agreements and Protocols, etc.) with the key referral sources in a given community to ensure the staff in these entities know about the functions of the NWD System and have up-to-date information and tools for quickly identifying and referring individuals to the NWD System. Among the key sources of referral the NWD System must have formal linkages with all of the following entities:

- *Information and Referral Entities: This would include coordination with existing resources such as local Information, Referral and Assistance Programs, statewide 1-800 #'s and 211 systems so staff working for these entities can appropriately and quickly refer individuals to NWD System person centered counselors.*
- *Nursing Homes and other Institutions: A NWD System should be seen as a resource to discharge planners across the state to help facilitate the transition of residents back to the community. The State Medicaid Agency should designate the NWD System, or at least some of the organizations within the NWD System, to serve as a Local Contact Agency under the MDS Section Q guidance, as well as to serve as a vehicle for facilitating transitions under other grant programs like the Money Follows the Person Program.*
- *Acute Care Systems: This would include working with hospitals to put in place protocols for NWD System person centered counselors to partner with hospital discharge planners with the common goal of supporting an individual through a transition that would help the person to successfully return to the community, even if a post-acute nursing home stay was necessary.*
- *VA Medical Centers: This would include direct relationships between organizations within the NWD system doing Person-Centered Counseling and local VA Medical Centers on the implementation of the Veteran-Directed HCBS Program, and other programs the VA may choose to implement through the NWD System.*

The NWD System should be seen as a major resource for health care systems and providers; it will have the capacity to serve as a “front door” to the LTSS System that can quickly link their clientele to a full range of community services and supports. A fully operational NWD System will have formal linkages between and among all the major pathways that people travel while transitioning from one health care

setting to another or from one public program payer to another. These pathways represent critical junctures where decisions are made – usually in a time of crisis - that often determines whether a person is permanently institutionalized or transitioned back to the community. Quick connections to LTSS can also break the cycle of avoidable hospital readmissions.

2. Person Centered Counseling

Person Centered Counseling (PCC) is the NWD System term for person centered planning which is an approach when working with individuals that is now being required in the LTSS System under multiple Medicaid regulations, including the Person-Centered Planning provisions in the recently issued Home and Community Based (HCBS) “Settings Rule” <https://www.federalregister.gov/articles/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider>. The relevant language from this Rule is included in Appendix V. The HCBS Rule establishes clear expectations for person centered planning and recognizes it as foundational for the delivery of effective HCBS. The HCBS Rule is the result of several years of work within CMS, other agencies across the DHHS (including ACL), and multiple stakeholder groups across the country through the federal public rule making process. As such, it is a highly vetted statement on Person Centered Planning.

Through the use of PCC, the NWD System will empower individuals to make informed choices about their LTSS options consistent with their personal goals, and to successfully navigate the various organizations, agencies and other resources in their communities that provide LTSS. PCC is very different from and requires a different skill set compared to tradition case management and other commonly used techniques for counseling individuals with LTSS needs, and it will take time for our current LTSS workforce to develop the knowledge and skills required to fully embrace and effectively use PCC. A visual representation of the core functions for a PCC Counselor can be found in Appendix II. The scope and breath of the specific knowledge, skills and abilities required for someone to be competent in doing PCC in a NWD System are delineated in Appendix IV. A number of the Part A States are implementing PCC by bolstering and upgrading the skills of their ADRC Options Counselors, and we expect many states will do the same while continuing to use the term Options Counseling since a number of states have codified the term in law (as they have done with the term Aging and Disability Resource Center).

PCC is a process that is directed by the person with LTSS needs. It may include a representative whom the person has freely chosen, or who is authorized to make personal or health decisions for the person. PCC must also include family members or legal guardians for non-emancipated minors. PCC efforts should also involve the individuals receiving care or services to the maximum extent possible even if they are not the legal representative in the planning process. During PCC, the person identifies their strengths, preferences, personal goals, needs (medical and LTSS) and desired outcomes. The role of the NWD System person centered counselor in the context of PCC is to enable and assist people to identify and access a unique mix of paid and non-paid services to meet their needs. Services listed on a plan are not guaranteed but are the desires and preferences of the person. As part of the PCC process, the person’s goals, preferred methods for achieving them, and a description of the training, recreational, transportation, therapies, treatments, and other services needed to successfully achieve the person's goals become part of a written services and support plan. The plan must be consistent with the person’s overall preferences. Preferences may include, but are not limited to, the following quality of life domains:

- Culture, including language and health literacy
- Housing
- Family and Friends
- Employment
- Community Integration
- Behavioral Health
- Recreation
- Vocational Training
- Relationship Building

- Other choices

The NWD System person centered counselor assists the person to construct a vision for his/her future, articulate that vision, consider various paths, engage in decision-making and problem solving, monitor progress and make needed adjustments in a timely manner. The NWD System person centered counselor supports individual responsibility including taking appropriate risks (e.g. back-up staff, emergency planning). The methodology currently available for ensuring the person is in charge of their own lives is PCC. The independent living philosophy is the result of people with disabilities getting together over 30 years ago to demand equal rights in health care and the broader society by demedicalizing and deinstitutionalizing their lives. It is a philosophy based on empowerment, inclusion, and self-determination. One of the primary aspects of the independent living movement is the idea of consumer direction over the planning process and the delivery of services and supports.

NWD System person centered counselors will be competent in PCC, and subsets of these NWD System person centered counselors will have specialized experience and expertise in serving the different segments of the LTSS population, and/or be able to carry out specialized NWD System functions. For example, helping people transition from hospitals or nursing homes back to the community or supporting teenage children with intellectual or developmental disabilities and their families to facilitate successful transitions from secondary education to adulthood, such as the transition to post-secondary education or to competitive, integrated employment. If individuals so desire and have the option available, the NWD System person centered counselor can also support them in self-directing their own services and supports. In collaboration with VHA, PCC is a core function offered to veterans who are found eligible for the Veterans Directed HCBS program. This self-directed service delivery model supports veterans living in the community and works with the veteran to develop a person centered plan in order for the veteran to self direct their own services. Specific planning is also needed for transition-aged youths as they move to adulthood and transition to jobs and/or post-secondary education which includes transitioning into new programs and assuming an adult role in PCC.

If an individual appears to be eligible for one or more public programs, the NWD System person centered counselor will help them through a seamless process of service activation and if appropriate having their eligibility for public programs determined and, if deemed eligible, assisting them through the enrollment process and service activation. ACL and CMS are in the process of developing a national technical assistance, training and credentialing program to help states implement PCC. The training and credentialing program is being developed with input from the 8 Part A ADRC States and will be rolled out in 2015 and initially targeted to the person centered counselors working in state NWD Systems. CMS will provide technical assistance to states in the development of system wide person-centered planning initiatives and more specific technical assistance to states to come into compliance with the person-centered planning provisions of the new regulations.

The NWD System PCC function involves five basic steps: 1) conducting a personal interview; 2) developing a person-centered plan; 3) facilitating access to private services and supports; 4) facilitating streamlined access to public programs; and 5) conducting ongoing follow-up. These components involve a fluid process where individuals can access different components at various stages:

i. **A personal interview**, which starts with an open ended conversation with the individual, his or her representative and/or family members as appropriate, that includes elements of screening and assessment to confirm the person needs LTSS and if they have any needs that require immediate action. If so, the NWD System person centered counselor will act to help the individual address the immediate needs. The NWD System person centered counselor will continue with the interview and go through an iterative process with the individual, and others as appropriate, to identify his/her personal strengths, values, preferences and personal goals.

ii. **Development of a person centered plan** that puts in writing:

- the strengths, preferences, personal goals and needs identified by the individual;

- the desired and available options identified by the individual for realizing their personal goals and meeting their LTSS needs that, based on weighing the pros/cons of various options, may involve a mix of informal supports, community options and other private as well as public resources and include exploration of self-directed options where individuals can hire, direct and fire their own workers and pay for their services and supports through an individual budgeting process; and,
- the immediate next action steps to be taken in the decision-making and planning process.

iii. Facilitating access to private sector services and supports that involves:

Assisting the individual, with others if appropriate, in determining how best to pay for and arrange the delivery of services, including helping the individual to assess the sufficiency of his/her own personal resources.

NOTE: Most people who need LTSS do not qualify for public LTSS programs. Accordingly, NWD System person centered counseling includes the critical process of facilitating access to private pay services and community resources, including services that will be covered out-of-pocket and/or through other community resources. NWD System person centered counselors also assist people, who are on waiting lists for publicly funded programs, to access local community based LTSS needed to live in the community.

iv. Facilitating streamlined access to public programs for those who appear eligible for one or more public LTSS options such as Medicaid, state revenue programs, and/or Veterans programs.

The NWD System's streamlined access to public programs function includes all the processes and requirements associated with conducting formal assessments and/or determining an individual's eligibility for any state administered program that provides LTSS to the NWD System populations. States will use their NWD System to better coordinate and integrate these functions and processes so consumers experience an access process that is seamless and expeditious, and the public's expenditures on administering these access functions are better spent. The NWD System's interface between consumers and public LTSS programs should ensure that:

- individuals are assessed once via a common or standardized data collection method that captures a core set of individual-level data relevant for determining the range of necessary LTSS, therefore only asking individuals to tell their story once;
- the eligibility determination and enrollment process, even if the person is applying for multiple public programs, is as streamlined and timely as possible; and,
- the process takes into account and gives priority attention to the consumer's personal goals and preferences and consumer feedback is continually collected and used to improve the performance of the state's LTSS access functions and processes.

NWD System person centered counselors can help states make their NWD System streamlined access function more seamless and responsive to consumers and more cost efficient and effective for the state. For example, to expedite Medicaid eligibility determinations, some state Medicaid agencies may involve NWD System person centered counselors in conducting the preliminary functional and preliminary financial eligibility determination processes. This helps to ensure that applications reflect consumer preference and personal goals, are "camera ready" when they are submitted to the Medicaid agency's eligibility workers. As a result, the burden of the application process is reduced for both the Medicaid staff and the consumer and, in many instances, applications are processed more efficiently with fewer errors and are more responsive to consumer needs and preferences.

This process requires the person centered counselor to work in close coordination with the staff responsible for administering the program's formal procedures and requirements that are involved in assessing needs and determining eligibility, and includes:

- facilitating the individual's completion of applications and eligibility determinations;
- facilitating the individual's input into the development of the program's formal service plan that is

required by the program to ensure it is as consistent as possible with the individual's preferences and personal goals identified in their person centered plan; and,

- if necessary, helping the individual arranging for financial management services (FMS) when he/she chooses self-direction, and/or assisting with the choice of a support broker/agent.

v. Ongoing Follow-up:

Person Centered Counseling includes the critical function of on-going follow-up, working with the individual and others as appropriate, including the case manager of any public program that is involved, to help ensure the services and supports identified in the individual's person centered plan are initiated and meeting the individual's needs, and that other aspects of the individual's person centered plan not covered by public programs are addressed through other resources, strategies and supports.

NOTE: NWD System PCC can be particularly helpful for individuals on waiting lists for public program, like Medicaid waiver programs, to assist them in examining and activating resources that are available from other sources that can provide interim and/or alternative services and supports.

3. Streamlined Access to Public Programs

As noted above, the NWD System's Streamlined Access to Public Programs function includes all the processes and requirements associated with conducting formal assessments and/or determining an individual's eligibility that are required by any of the state administered programs that provide LTSS to any of the NWD System population. All these public access processes and requirements must be part of, and integrated into, the state's NWD System's streamlined access function, so states can use their NWD System as a vehicle for optimally coordinating and integrating these processes to make them more efficient and effective, and more seamless and responsive for consumers. Most states have developed programs that help consumers understand and access their LTSS options, using various federal grants and authorities, including Aging and Disability Resource Center grants, Money Follows the Person funding, and the Balancing Incentive Program, but few states have developed statewide systems that reflect the functionality and operational capacity of the NWD System described in this FOA. If a state is successful in competing for a grant award under this FOA, it is expected the state will fully integrate its ADRC, Balancing Incentive Program (if applicable) and other state administered LTSS access programs that serve the key populations targeted under this announcement into a single statewide No Wrong Door System to LTSS for all populations and all payers as described in this FOA.

The Medicaid eligibility and determination process often includes a two-stage process - conduct a preliminary and then a final functional and financial assessment. The preliminary assessment is the level I screen of a State's core standardized assessment process - when individuals making inquiries about LTSS go through an initial screen, which collects preliminary financial and functional data and points to potential needs and program eligibility. Those applicants who are considered potentially eligible at the level I screen will receive the comprehensive level II assessment. During stage 2, the Final Determination of Functional and/or Financial Eligibility completes the process that officially determines which individuals are Medicaid eligible based on clinical or functional criteria for public programs and/or based on his/her income and assets. Eligibility determination is usually based on the findings of a comprehensive functional or clinical assessment. For Medicaid, the assessment is often completed in person by staff who have received standardized training and have been designated by the Medicaid agency to perform this function. In some states, the person who conducts the preliminary assessment with the individual is also authorized to make a final determination of functional eligibility. In some cases, a separate individual must review, verify and make the determination or the information from the assessment is run through an automated eligibility determination tool and then verified. The financial eligibility criteria for Medicaid are established in the Medicaid State Plan and/or in HCBS Waiver eligibility criteria.

As noted above, NWD System person centered counselors can add significant value to the Medicaid eligibility determination process. The Medicaid agency may train and even designate NWD

System person centered counselors to participate in and facilitate the assessment process, using information they collected during the PCC encounter, as well as helping the consumers they are working with to gather additional information and documents not collected during the PCC process. Many of the Part A states have delegated the preliminary assessment to the NWD System person centered counselors. As noted below, its critical to not equate the PCC process with the formal assessment and care planning process associated with public programs. The NWD System person centered counselors can help ensure applications are "camera ready" when they reach the Medicaid office, thereby reducing the burden of the application process for both Medicaid staff and consumers. Even if the NWD System person centered counselor is not designated to do the preliminary assessment, the data gathered by the NWD System person centered counselor during the PCC process should be fed into the preliminary assessment and then automatically transferred into the final assessment process.

4. The Intersection of the NWD System Person-Centered Counseling and Streamlined Access to Public Programs

The PCC process, for purposes of this FOA, must be kept independent and is usually much broader in scope than any assessment process that is tied to a program or service eligibility, even though both processes can and should feed into each other. Once an independent person centered plan is complete, the information in the plan should be used to inform the program and service eligibility processes. Gaps between services and support needs that are *identified* in the person centered plan, and those that are made *available* through the program and service eligibility processes, must be documented in the person centered plan along with strategies for achieving the person's goals that cannot be met through public programs.

For instance, a person may have a goal to gain competitive employment. However, the public program assessment process may find the person ineligible for the supported employment service because the threshold level of functional need has not been met. This conclusion must not be used to coerce, discourage, or otherwise negatively influence the person's desire to find employment. It must instead be presented as a temporary challenge to the achievement of the goal. The person centered counselors and others on the NWD System team must work together to assist the person in developing and documenting creative approaches to meeting the goal. Additionally, the NWD System must find ways to capture gaps in services and supports identified through the PCC process and use the information to improve the options for people.

5. State Governance and Administration

The governance and administration of a NWD System must involve a collaborative effort among multiple state agencies, since no one state agency has the authority or expertise to carry out all of the functions involved in a NWD System as described in this FOA. The NWD System is a critical component of any well-developed, person-centered state LTSS System, and therefore, its governance and oversight should be lodged in a Cabinet level body - either a new or existing one - and should be part of the state's oversight of its LTSS System. The NWD System governing body should be responsible for coordinating the on-going development, implementation, financing, evaluation and continual improvement of the state's NWD System. It must include representatives from the State Medicaid Agency, the State Unit on Aging, and the state agencies that serve or represent the interests of individuals with physical disabilities, individuals with intellectual and developmental disabilities, and the state authorities administering mental health services. Senior staff from these agencies should be designated as full partners in managing the on-going development and implementation of the NWD System. States may involve other state agencies, such as the budget office or the agency administering programs for Veterans as members of its NWD System governing body.

Once established, some initial responsibilities for a NWD System governing body would include:

- Setting up a process that will ensure key stakeholders have meaningful input into the ongoing development and implementation of the states' NWD System. Stakeholders should include

consumers, their advocates, Area Agencies on Aging, Centers for Independent Living, local Medicaid agencies, local organizations that serve or represent the interests of individuals with physical disabilities, individuals with intellectual and developmental disabilities, and individuals with mental/behavioral health needs, Veteran Service Organizations, as well as service providers, and other relevant public and private entities;

- Developing criteria and/or process to determine what organizations at the state and local level should play a formal role in carrying out NWD system functions;
- Developing criteria and/or process to determine what (if any) sub-state regions and/or substate entities would be used to support the state's administration and oversight of the local entities carrying out NWD System functions;
- Designating and developing formal agreements and funding arrangements with the state and local organizations that are selected to carry out NWD System functions;
- Developing a communications strategy and process that will facilitate on-going communication among the many different agencies and organizations playing formal roles in the NWD System;
- Identifying the existing public resources currently being used to support access functions across the multiple state administered programs that provide LTSS, and determining how these resources can best be coordinated and integrated to align their operation and performance with the NWD System functions outlined in this FOA; and,
- Making recommendations to the Governor on key aspects of the NWD System's design, development, financing, and on-going administration.

A robust Management Information System (MIS) that builds on and leverages existing state MIS systems is essential for a state to be able to effectively and efficiently gather and manage information from the many entities that will be carrying out NWD System functions, as well as from individual consumers who use the NWD System. These activities will involve collecting, organizing, analyzing and reporting information across state MIS systems and across the agencies and organizations that make up the NWD System in order to provide a comprehensive summary of relevant information to inform top-to-bottom decision-making about the NWD System. The MIS should track consumer level data, including data and information from the person centered plans, such as information on the use of services and supports, and gaps between the services used and the services identified in the person centered plan. The system will have to comply with Health IT standards and should also support the use of Personal Health Records to enable information and data to flow with consumers from their initial entry into the NWD System all the way through follow-up. Individual data must be collected in a way that ensures confidentiality, but **limits the repeated collection of the same information from individual throughout his/her tenure in the LTSS System.** NWD System staff responsible for managing MIS activities are likely to be involved in overseeing data collection activities, meeting reporting requirements, working with IT vendors to maintain and improve IT applications and programs across NWD System organizations, and training end-users on how to use the system, including the collecting, recording and reporting of required data. The MIS system should support on-going program management, planning, budgeting, and continuous quality improvement at both the state and local level as well as state level policy development.

The NWD System's Continuous Quality Improvement (CQI) process must involve getting input and feedback from the many different customers who use or interact with the NWD System, including individuals and their families, system partners, advocates, providers and professionals in the health and LTSS systems, on the responsiveness of the NWD System to their varying needs. The CQI process should also involve the administration of a complaint and grievance processes and tracking and addressing complaints and grievances. To be effective, the CQI process needs to include performance goals and indicators related to their NWD System's key aims:

- (a) **Visibility** on the extent to which the public is aware of the existence and functions of the NWD System;
- (b) **Trust** on the part of the public in the objectivity, reliability, and comprehensiveness of the assistance available from the NWD System;

(c) **Ease of Access** including reductions in the amount of time and level of frustration and confusion individuals and their families experience in trying to access LTSS, additionally physical locations should be accessible and all written materials should be accessible by all populations and ADA 508 compliant;

(d) **Responsiveness** to the needs, preferences, and unique circumstances of consumers, including feedback from individuals as it relates to the outcomes of their interaction with the NWD System, especially in relation to the NWD System's ability to enable the individual to realize his/her personal goals that were established during the PCC process; and,

(e) **Efficiency** and **Effectiveness** including reductions in duplicative intake, screening, and eligibility determination processes for state administered programs, increases in the number of people who are diverted to more appropriate and less costly forms of support, and the ability of the NWD System to help the state in the rebalancing of its LTSS System, and other indicators to document the value of the NWD System at improving government performance and lowering public costs.

D. Funding Application Requirements

As noted in the Executive Summary, ACL, CMS and the VHA are issuing this FOA to assist states in the planning process to develop a NWD System to LTSS for all populations and all payers. Specifically, the funds being made available under this FOA are to support a state-led 12-month planning process to identify the key actions the State will need to take in order to develop and implement a NWD System with the functions and operational capacity described in this FOA. The planning process must involve multiple state agencies and input from key stakeholders including consumers, their advocates, Area Agencies on Aging, Centers for Independent Living, local Medicaid agencies, local organizations that serve or represent the interests of individuals with physical disabilities, individuals with intellectual and developmental disabilities, and individuals with mental/behavioral health needs, Veteran Service Organizations, as well as service providers, and other relevant public and private entities. At a minimum, the following state agencies must be involved as full partners in co-leading this planning process: the State Medicaid Agency, the State Unit on Aging, and the state agencies that serve or represent the interests of individuals with physical disabilities, individuals with intellectual and developmental disabilities, and the state authorities administering mental health services. States may involve other state agencies in the process, such as the budget office or the agency administering programs for Veterans.

If a state is successful in competing for grant funds under this FOA, the main “deliverable” the state will have to submit to ACL/CMS/VHA at the end of the 12-month planning period is a 3-Year Plan that includes a detailed strategy, work plan, and budget that the state will use, pending the availability of additional federal support, to begin transforming the multiple LTSS access functions and processes across its various LTSS programs into a single integrated statewide system of access to LTSS with the functionality and operational capacity of a NWD System for all populations and all payers as described in this FOA. Most states have already developed programs that help consumers understand and access their LTSS options, using various federal authorities and grants, such as ADRC grants, Money Follows the Person grants, and the Balancing Incentive Program, but few states have in place a statewide system that reflects the functionality and capacity of the NWD System described in this FOA. It is expected that states will better integrate and in some cases restructure and strengthen their existing ADRC and/or Balancing Incentive Program No Wrong Door programs and other state access programs, as part of its effort to develop a NWD System as described in this FOA.

In the application for funding under this FOA for the 12-month planning process, the applicant must describe in as much detail as possible the challenges and opportunities the state faces in developing a statewide NWD System with the functional and operational capacity described in this FOA. Specifically, the application must focus on the NWD System functions of Person Centered Counseling and Streamlined Access to Public Programs.

For the Person Centered Counseling Function, the state's application for funding under this FOA must address:

1. The major challenges and opportunities, including infrastructure, workforce development and financing challenges and opportunities, the state will face in developing and fully implementing the function as described in this FOA;
2. Examples of strategies and tactics the state will explore during the 12-month planning process that it could use over the next 3 years to address these challenges and opportunities;
3. Evidence of the state's readiness to address the challenges and leverage the opportunities it faces in this area, including its willingness to explore the use of new and/or the reallocation of existing funds that are administered by the state, including federal Medicaid administrative matching funds, to move forward in implementing this function.

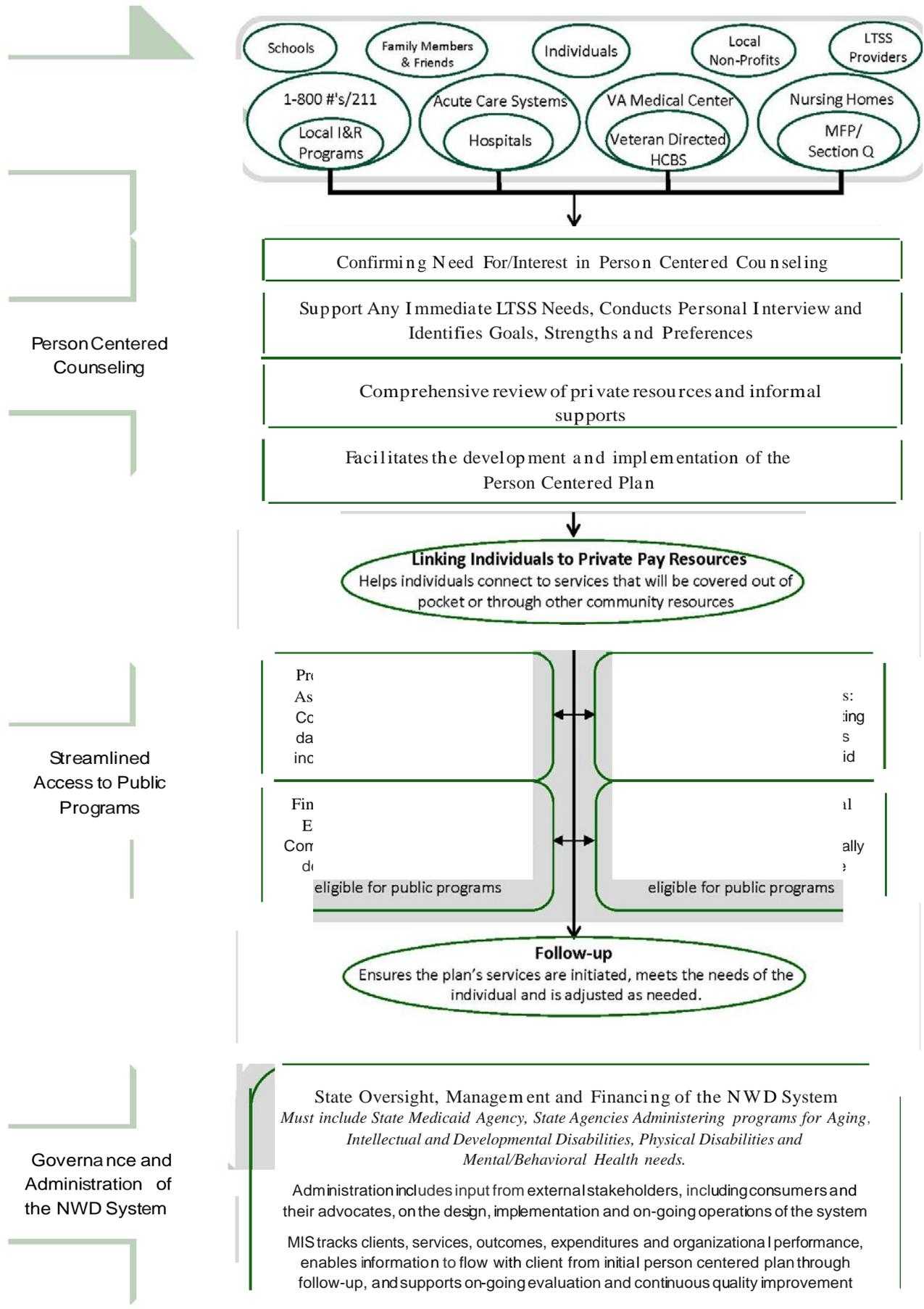
For the Streamline Access to Public Programs Functions, the state's application for funding under this FOA must address:

1. The major challenges and opportunities, including major administrative and regulatory challenges and opportunities, the state will face in developing and fully implementing this function as described in this FOA;
2. Examples of strategies and tactics the state will explore during the 12-month planning process that it could use over the next 3 years to address these challenges and opportunities;
3. Evidence of the state's readiness to address the challenges and leverage the opportunities it faces in this area, including its willingness to explore the use of new and/or the reallocation of existing funds that are administered by the state, including federal Medicaid administrative matching funds, to move forward in fully implementing this function.

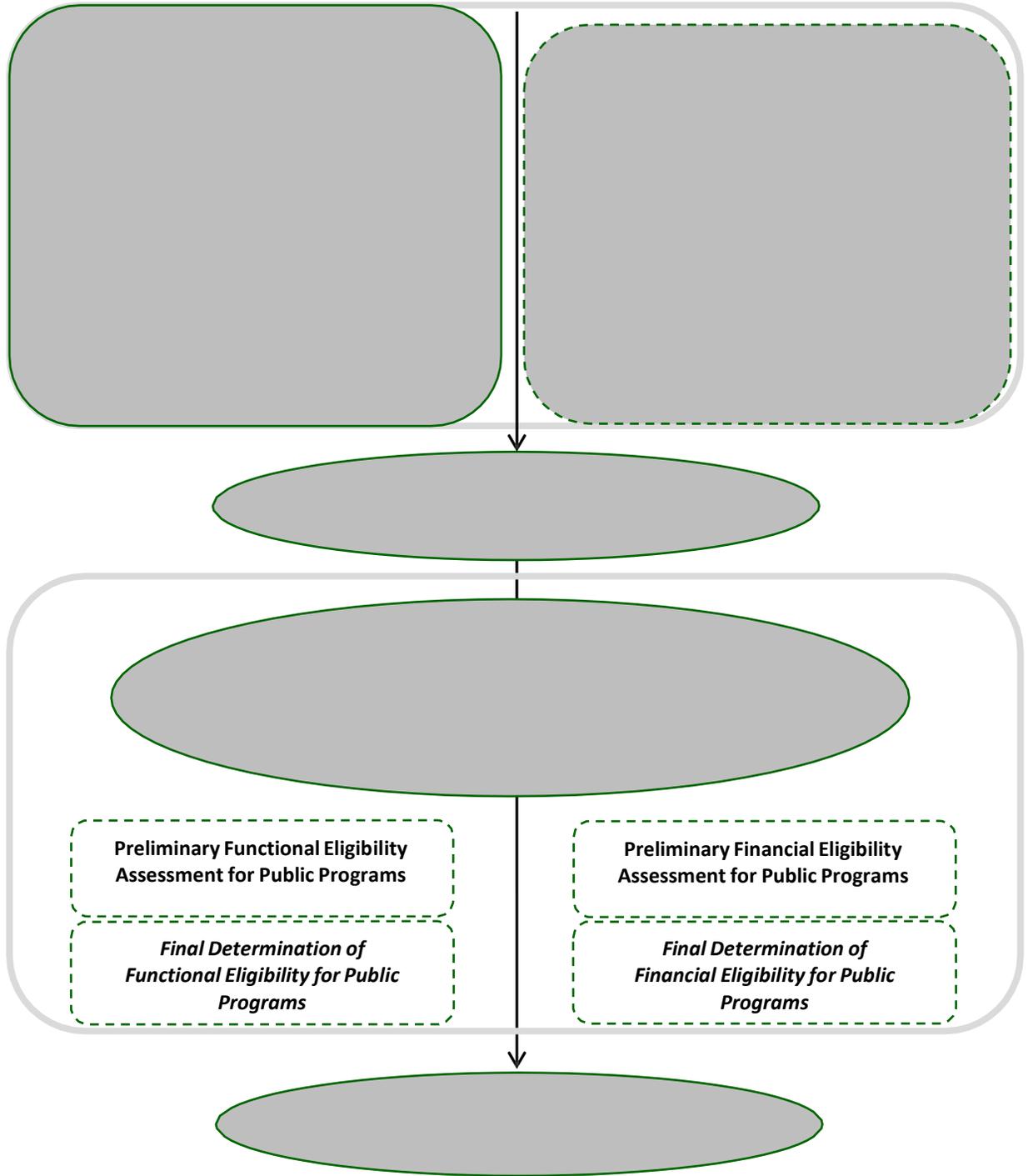
The application for funding under this FOA, must also describe the process and methodology the state will use, including the methods and analytical techniques it will use, during the 12-month planning process to further analyze and better document the current challenges and opportunities it faces in the areas of Person Centered Counseling and Streamlined Access to Public Programs, as well as how it plans to identify and analyze options for transforming the way it conducts these functions so they align with the Person Centered Counseling and Streamlined Access Functions described in this FOA.

The awards under this FOA will be issued as Cooperative Agreements, and the successful applicants must agree to work with the ACL and its federal partners and technical assistance vendors on all aspects of the state's planning process. In addition, ACL and federal partners will ask states to volunteer to pilot test - within the first three months of the grant period - a NWD Systems Management Tool that the federal partners are currently developing with input from the Part A States. As noted below, this will help the successful states to further document the current capacity of its LTSS access system and how it compares to that of the NWD System described in this FOA. As noted above, ACL, CMS and the VHA are currently partnering with the 8 Part A States to develop a number of products that will be available in mid-to late 2015 to help states across the nation to implement a NWD System for all populations and all payers. These tools include the NWD System Management Tool which, among other capabilities, will be able to generate data and information that a state's NWD System governing body will be able to use to carry out its functions and report to the Governor and the Legislature on the current status of its NWD System as compared to the federal vision as well as to help formulate multi-year budget and program development strategies. By mid-to late-2015, the federal partner agencies will also issue national standards for a NWD System, and make available a national training and credentialing program for NWD System Person-Centered Counselors, as well as a portfolio of best practices states can use to develop and strengthen various components of their NWD System, and official guidance on claiming Medicaid administrative funds and the use of VHA funds to support NWD System functions.

Appendix 1: No Wrong Door System Functions



Appendix II: Person Centered Counseling Functions in a No Wrong Door System



Core Competencies: Required of all staff performing Person-Centered Counseling



Specialties: Performed by subsets of Person Centered Counselors who also have specialized knowledge and experience



Streamline Access: Some of these functions can be performed by Person Centered Counselors at the discretion of the state

Appendix III: Examples of Organizations That Could Be Designated by the State to Perform NWD System Functions

Appendix IV: Knowledge, Skills and Abilities for Person Centered Counseling (January 2014)

Competencies

<p><i>Conduct One-to-One Person Centered Interview</i></p> <ol style="list-style-type: none"> 1. Confirm the person needs LTSS and explain how Person-Centered Counseling can assist the person in getting his/her needs met. 2. Conduct interview using person-centered approach, in person's preferred setting, and include family or representative as requested/needed while insuring that the person maintains control of the process 3. Work with the person to identify, prioritize and respond to any immediate needs 4. Work with the person to identify the on-going/longer-term issue(s) that the person wants addressed 5. Work with the person to examine factors that will influence how his/her needs can best be met including, use of or interest in self direction, private resources such as personal, family and community supports, special designations that may carry health/service benefits, e.g. Veteran, and any family support needs 6. Take appropriate action to ensure privacy and confidentiality of information shared by the person 7. Document encounter activity and information to use for ongoing work with the person and for completion of appropriate assessment instruments and eligibility 	<ol style="list-style-type: none"> 1. Understands role and functions of the Person-Centered Counseling for LTSS, and how it supports the mission of the No Wrong Door Access System for LTSS 2. Understands philosophy and importance of person-centeredness, self-direction/self-determination and independent living and the importance of each person directing the planning process 3. General understanding of basic issues related to different LTSS populations, including older adults, persons with physical disabilities, persons with intellectual/developmental disabilities, traumatic brain injury, and persons with Alzheimer's disease or cognitive impairment 4. General understanding of behavioral health issues and when to link a person to other professionals for more in-depth information about specific services and supports 5. General understanding of the special housing issues facing many persons with LTSS needs, including those transitioning from nursing facilities and other settings. 6. Understands that people will have different needs, including needs that must be addressed immediately and those that will need additional discussion, planning, as well as needs that will require specialized expertise that will necessitate involving other professionals and/or lay individuals in 	<ol style="list-style-type: none"> 1. Able to explain the role of Person-Centered Counseling and how the process helps the person maintain community living in the context of his/her self-defined goals, strengths, values, and preferences. 2. Able to communicate in manner that is understood by others using accessible formats, language, adaptive tools and when appropriate, involve other individuals when special language, cultural or other issues require additional attention 3. Able to work with the person, and others as necessary, to identify most appropriate approaches to resolve immediate needs 4. Able to keep the person at center of process when the family and/or others are part of the counseling process. 5. Able to use active listening and engagement skills to understand the person's perspective and views on what is important to and for him/her 6. Able to facilitate information sharing between the person, his/her family, and others involved in the process, using a range of proven tools and techniques such as open ended questions, a communication chart, problem solving and motivational interviewing techniques 7. Able to work with all people regardless of age, disability, or culture, and seeks advice from as well as the involvement of other specialists when needed.

forms as needed	<p>the planning process.</p> <p>7. Understands that people may have difficulty communicating due to physical, medical, intellectual, or cultural issues</p> <p>8. Understands how culture and diversity may impact communication styles, health knowledge, beliefs and health behaviors related to health care and human services</p> <p>9. Understands issues related to neglect, self-neglect, abuse and exploitation and the legal and administrative requirements related to handling and reporting such conditions</p> <p>10. Understands that the individual's private resources and family as well as community programs may be important resources for people with LTSS needs</p> <p>11. Understand need and rules for personal privacy and confidentiality</p>	<p>8. Able to recognize signs of neglect or abuse and the legal and administrative procedures for handling and reporting it.</p> <p>9. Able to recognize that a person may need behavioral health services and be able to use the proper techniques and protocols for linking people to behavioral health services</p> <p>10. Able to gather, organize, and use technology, to document all information needed for a person-centered, strength based-assessment, including inputting the relevant information – either directly or through others – into assessment tools and eligibility forms required by public programs that provide LTSS in cases where the person may be eligible for those programs</p> <p>11. Able to obtain any necessary signed release of information or consent forms as needed</p>
<p><i>Develop Person-Centered Plan</i></p> <p>1. Based on the person's goals, preferences, supports, needs and experience, work with the person to identify the full range of appropriate private and public resources that are potentially available to the person, including participant directed options. Discuss details of specific options of interest to the person including costs, eligibility, how each may work with the person's formal and informal supports and resources, and the pros and cons and benefits of each option based on what is important to and for the person</p> <p>2. Based on the person's goals, desired outcomes, and specific choices, work with</p>	<p>12. Understands the relevant private and public programs, services and supports that are available in the geographic area covered by staff person doing the NWD person-centered counseling, including approximate costs, cost-sharing, and the specific eligibility requirements and/or application process(es) associated with each option</p> <p>13. Understands participant-direction philosophy and the unique features of participant directed programs including role of support brokers and financial management service (FMS) entities, and participant employer responsibilities</p> <p>14. Understands of the role that housing, health promotion, and transition programs</p>	<p>12. Able to research services and supports using national, state, local resources and tools to identify available benefits and services</p> <p>13. Able to identify and discuss resources that most closely suit the person's goals, needs, and preferences</p> <p>14. Able to show how options compare including which private and public options can be combined, which options may allow participant direction, maximize independence, use resources most efficiently, support family members involved in the person's plan..</p> <p>15. Able to identify and discuss potential problems with particular options and possible alternatives</p>

<p>the person and, as appropriate, other relevant individuals to develop a written person-centered plan.</p> <p>3. Work with the person to share copies of the plan with other relevant people so all involved parties can review it, including the actions required for implementation</p>	<p>can play for people with LTSS needs.</p> <p>15. General understanding of private LTSS insurance, reverse mortgage programs and other private options that can help people plan ahead for their LTSS needs.</p> <p>16. Understands that the person is the one who determines what the best option is for him/her unless he/she requests that another person make the decision; or there is a legally mandated representative.</p> <p>17. Understands that choosing the best options can be challenging to the person and/or family, and may create conflicts within families</p> <p>18. Understands what a person-centered plan is, and that it can take many different forms depending on the person.</p>	<p>16. Able to facilitate agreement among all involved on course of action using a variety of proven tools and techniques such as motivational interviewing, problem resolution, including conflict resolution involving family members, to support decision making</p> <p>17. Able to use technology to document OC activity, generate a written plan and securely exchange information with partnering organizations and across service settings and programs as needed</p>
<p>Facilitate Streamlined Access to LTSS</p> <p>1. Work with the person to access services and supports identified in the person - centered plan that could be paid for from his or her own resources or that are available through unpaid family members, or natural/informal supports</p> <p>2. Work with the person, and others as appropriate, to collect any additional information needed to complete applications for any public programs, services and supports, including but not limited to Medicaid, that are identified in the person's plan, including functional/level of care and financial eligibility determinations</p> <p>3. Work with the person to submit all relevant applications and to navigate the eligibility determination process(es) for the private and public programs identified in the person's plan</p>	<p>19. Understands enrollment, eligibility and costs of range of services and supports and programs that could be paid from a person's own resources. Understands eligibility process and requirements for public administered programs that provide LTSS offered in the state/local area, including but not limited to Medicaid; also understands LTSS programs available to Veterans.</p> <p>20. Understands in detail the different types of state administered programs that provide LTSS, including managed care, and how these programs operate in the state and/or local jurisdiction including the role of participant direction and financial management services (FMS) entities, and what makes participant directed programs different from traditional home and community based services.</p>	<p>18. Able to work with the person to successfully navigate all relevant application and/or eligibility processes, including completing and submitting all required application forms and documentation.</p> <p>19. Able to work successfully with other professional in the NWD and LTSS system who play a formal role in access to LTSS from the beginning of the application process, through a formal determination of eligibility, and then, as appropriate, though on-going follow-up with the person that may necessitate changes to the services and supports the person is receiving .</p> <p>20. As needed and appropriate, able to use contacts and tools to identify and involve other specialists to assist the person in implementing his/her person-centered</p>

<p>4. Work with the person, and others as appropriate, to identify any barriers to quickly accessing the services and supports identified in the person’s plan, and advocate with the person and, as appropriate, with others including relevant program officials, to develop and implement strategies to minimize or eliminate barriers to full implementation of the plan.</p>	<p>21. Knows the relevant people who play a formal role in access to LTSS, including the people responsible for formal assessments and eligibility determination processes for the public and private programs in the geographic area covered by the individual carrying out the NWD person-centered planning function.</p>	<p>plan. 21. Able to work collaboratively with teams, providers, and other public and private agencies and organizations to facilitate the activation of the services and supports identified in person-centered plans. 22. Able to facilitate enrollment in participant directed programs</p>
<p>Ongoing Follow-Up and Documentation</p> <p>1. Maintain contact with the person and/or family to learn if services have started, benefits have been received, goals are being met, as well as for feedback on the NWD process, or any issues that need to be addressed</p> <p>2. Works with the person, and others as appropriate, to assist with revision(s) to the person centered plan as the person’s needs or circumstances change</p> <p>3. Documents the process and information related to the plan’s on-going implementation, including services and supports provided, goals being met, outcomes achieved, and feedback from the person and others on the NWD process; reports this information as appropriate to the person and other relevant individuals.</p>	<p>22. Understands importance of follow-up to the person and the NWD system</p> <p>23. Understands agency/program specific requirements and reasons for on-going follow-up, including how information collected during this phase is used by officials responsible for the operation of the NWD system to improve the effectiveness and efficiency of the NWD system as well as the overall LTSS system.</p> <p>24. Understands applicable local, state and federal documentation standards and reporting requirements</p>	<p>23. Able to determine what level of follow-up is needed and desired by the person</p> <p>24. Able to solicit feedback from the person and/or family on service activation process/success, satisfaction with plan and services, attainment of goals, any additional requests or issues, and provide assistance as requested including changes to person-centered plan</p> <p>25. Able to organize, document and report on follow-up activity and consumer feedback according to local, state and federal requirements using appropriate tools and IT/MIS systems</p> <p>26. Able to provide professional feedback to the appropriate individuals in the NWD system on process, outcomes, successes, and needed system improvements.</p>

Appendix V – Person Centered Planning Provisions

Person Centered Planning for 1915(c), 1915(i)

§441.725 Person-centered service plan.

(a) Person-centered planning process. Based on the independent assessment required in §441.720, the State must develop (or approve, if the plan is developed by others) a written service plan jointly with the individual (including, for purposes of this paragraph, the individual and the individual's authorized representative if applicable).

The person-centered planning process is driven by the individual. The process:

- (1) Includes people chosen by the individual.
- (2) 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.
- (3) Is timely and occurs at times and locations of convenience to the individual.
- (4) 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, consistent with §435.905(b) of this chapter.
- (5) Includes strategies for solving conflict or disagreement within the process, including clear conflict of interest guidelines for all planning participants.
- (6) Offers choices to the individual regarding the services and supports the individual receives and from whom.
- (7) Includes a method for the individual to request updates to the plan, as needed.
- (8) Records the alternative home and community-based settings that were considered by the individual.

(b) The person-centered service plan. The person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports.

Commensurate with the level of need of the individual, and the scope of services and supports available under the State plan HCBS benefit, the written plan must:

- (1) Reflect that the setting in which the individual resides is chosen by the individual. The State must ensure that the setting chosen by the individual is integrated in, and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.
- (2) Reflect the individual's strengths and preferences.
- (3) Reflect clinical and support needs as identified through an assessment of functional need.
- (4) Include individually identified goals and desired outcomes.
- (5) 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. Natural supports are unpaid supports that are provided voluntarily to the individual in lieu of State plan HCBS.

- (6) Reflect risk factors and measures in place to minimize them, including individualized backup plans and strategies when needed.
- (7) Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with §435.905(b) of this chapter.
- (8) Identify the individual and/or entity responsible for monitoring the plan.
- (9) Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.
- (10) Be distributed to the individual and other people involved in the plan.
- (11) Include those services, the purchase or control of which the individual elects to self-direct, meeting the requirements of §441.740.
- (12) Prevent the provision of unnecessary or inappropriate services and supports.
- (13) Document that any modification of the additional conditions, under §441.710(a)(1)(vi)(A) through (D) of this chapter, must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:
 - (i) Identify a specific and individualized assessed need.
 - (ii) Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
 - (iii) Document less intrusive methods of meeting the need that have been tried but did not work.
 - (iv) Include a clear description of the condition that is directly proportionate to the specific assessed need.
 - (v) Include a regular collection and review of data to measure the ongoing effectiveness of the modification.
 - (vi) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
 - (vii) Include informed consent of the individual; and
 - (viii) Include an assurance that the interventions and supports will cause no harm to the individual.
- (c) Reviewing the person-centered service plan. The person-centered service plan must be reviewed, and revised upon reassessment of functional need as required in §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.