

June 6, 2014

TO: Heads of Operating Divisions
Heads of Staff Divisions

SUBJECT: Section 2402(a) of the Affordable Care Act – Guidance for Implementing Standards for Person-Centered Planning and Self-Direction in Home and Community-Based Services Programs

Section 2402(a) of the Affordable Care Act requires the Secretary to ensure all states receiving federal funds develop service systems that are responsive to the needs and choices of beneficiaries receiving home and community-based long-term services (HCBS), maximize independence and self-direction, provide support coordination to assist with a community-supported life, and achieve a more consistent and coordinated approach to the administration of policies and procedures across public programs providing HCBS.

The attached guidance contains standards on person-centered planning and self-direction of HCBS that should be embedded in all HHS funded HCBS programs as appropriate. The guidance is consistent with the final rule from the Centers for Medicare & Medicaid Services on Medicaid HCBS and meets the requirement in section 2402(a) for a more consistent administration of policies and procedures across programs. This guidance is the Department's first step in implementing section 2402(a).

HHS agencies that administer HCBS programs are to apply these standards on person-centered planning and self-direction as you develop or revise regulations, policies and guidance, provide technical assistance, offer funding opportunities, or take other relevant actions. The agencies most directly affected by this guidance include:

- Administration for Community Living
- Centers for Medicare & Medicaid Services
- Health Resources and Services Administration
- Indian Health Service
- Substance Abuse and Mental Health Services Administration
- Administration for Children and Families

If your agency is not listed above, you are encouraged to review this guidance and consider how the programs you administer, including your research and demonstration programs, could be used to promote the use and further enhancement of person-centered planning and self-direction.

All HHS agencies are encouraged to share this guidance with relevant stakeholders, including funded agencies, contractors, advocacy groups, advisory councils, associations, and others who may have a role in the home and community-based system.

This guidance is not intended to supersede or otherwise conflict with existing regulations or guidance, nor does it provide a basis for enforceability on non-Departmental entities. Section 2402(a) does not prescribe a specific timeframe for achieving full implementation. However, it is expected the affected agencies will take active steps to implement this guidance.

The Administration for Community Living will coordinate section 2402(a) activities within the Department as part of the work of the Community Living Council Strategic Plan. Sharon Lewis, my Senior Advisor for Disability Policy and Principal Deputy Administrator for Community Living, will chair an interagency team to oversee the implementation of this guidance and future section 2402(a) activities. I am asking the Heads of the agencies listed above and other interested Operating Divisions and Staff Divisions to let Sharon know who you want to represent you on this group. This interagency team will develop annual work plans (including a roll-out plan of this guidance to stakeholders), share lessons learned and best practices, and report to the Secretary on an annual basis on the progress being made in implementing section 2402(a). For your reference, a list of the members of the June 2010 workgroup that contributed to the development of this guidance is enclosed.

For questions regarding this guidance, please contact Shawn Terrell, Administration for Community Living at (202) 357-3517 or shawn.terrell@acl.hhs.gov.

Thank you for your support in implementing section 2402(a).

Kathleen Sebelius

Enclosures:

- HCBS Section 2402(a) Guidance
- Roster of June 2010 Section 2402(a) Workgroup

Guidance to HHS Agencies for Implementing Principles of Section 2402(a) of the Affordable Care Act:

Standards for Person-Centered Planning and Self-Direction in Home and Community-Based Services Programs

Introduction

The Patient Protection and Affordable Care Act (Pub. L. 111–148, enacted on March 23, 2010), amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152, enacted on March 30, 2010), collectively referred to as the Affordable Care Act (ACA), includes section 2402(a), entitled “Oversight and Assessment of the Administration of Home and Community-Based Services.” This section requires promulgation of regulations by the Secretary of Health and Human Services (HHS) to ensure states develop community-based long-term services and supports (LTSS) systems designed to allocate resources and provide the necessary supports and coordination to be responsive to the person-centered needs and choices of older adults and people with disabilities in ways that maximize their independence and ability to engage in self-direction of their services, and achieve a more consistent and coordinated approach to the administration of policies and procedures across public programs.

LTSS are assistance with activities of daily living and instrumental activities of daily living provided to older people and adults with disabilities that cannot perform these activities on their own due to a physical, cognitive, or chronic health condition. LTSS may provide care, case management, and service coordination to people who live in their own home, a residential setting, a nursing facility, or other institutional setting. LTSS also include supports provided to family members and other unpaid caregivers. LTSS may be provided in institutional and community settings.

For purposes of this guidance, home and community-based services (HCBS) are services and supports that assist older adults and people with disabilities (including mental health and substance use disorders) to live with dignity and independence in community settings. HCBS complement medical and other traditional health services, and help people to maintain and improve health and quality of life in their chosen community setting. HCBS play an important role in healthcare integration efforts, including the evolution of health and medical homes, and care transitions.

This guidance is not intended to supersede or otherwise conflict with existing regulations or policies, or other guidance issued by HHS. Affected HHS operating and staff divisions are expected to take active steps to implement the guidance. HHS agencies should use it to develop or revise requirements and options, as appropriate, within programs that offer or impact policies related to HCBS. Specifically, the standards in this guidance should be used in future program regulations, program policies, funding opportunities, technical assistance contracts, grant opportunities, and other programs funding HCBS. The statute applies to all federal and state programs, including those “other than the state Medicaid program,” as cited in section 2402(a) of the ACA. HHS staff performing duties such as contract monitoring and grant administration must have the knowledge and capacity to report on the implementation of this guidance to the Secretary upon request.

This initial guidance serves as an important first step in implementing section 2402(a) of the ACA. It outlines the standards for person-centered planning (PCP) and self-direction (SD) that should be reflected in all HHS programs that fund or provide HCBS.

Background

Over the past forty years federal, state, local, and tribal governments have developed and financed HCBS for older adults and people with disabilities across the lifespan to promote community living, and to avert or minimize institutionalization.

The scope of HCBS offered under various federal and state programs is significant. For example, HCBS provided under Medicaid waiver and state plan authorities include programs authorized under section 1915(c) of the Social Security Act (the Act); newer programs under sections 1915(i), 1915(j) and the 1915(k) of the Act; and other HCBS that may be covered under the Medicaid State Plan such as home health and personal care. HCBS may also be offered in a managed care environment through for example, concurrent section 1915(b) and (c) Medicaid waivers or section 1115 demonstration projects. HCBS are often included in initiatives and demonstrations to improve care for Medicare-Medicaid dually eligible beneficiaries. In 2014 the Centers for Medicare & Medicaid Services (CMS) issued a related final regulation on HCBS and related guidance that outlines requirements for PCP and SD. Medicaid State plan home health, personal care, case management, and many rehabilitative services benefits are HCBS.

HCBS are also offered through block grant programs administered by the Substance Abuse and Mental Health Services Administration and grants from other HHS operating divisions including the Administration for Community Living (ACL), the Health Resources and Services Administration, and the Indian Health Service. The ACL and CMS are presently working with the U.S. Department of Veterans Affairs to expand the availability of HCBS for veterans. There are also many programs offered by states, territories, and the District of Columbia that provide HCBS using non-federal payment sources, or combined resources.

The number of HCBS programs and wide variation in services, eligibility rules, delivery systems, payers, and associated regulatory authorities create significant challenges for states and programs that have day-to-day responsibility for implementation. This can result in administrative duplication; inconsistent policies; gaps in service adequacy; inconsistencies in plans of care; poor service quality; fraud, abuse, and mistakes; and other issues.

The impact of these differences among HCBS policies and practices on the people who need HCBS is significant. Individuals, families, and caregivers are often faced with navigating a confusing maze of policies and bureaucracies, which can impede access. System framework issues also contribute to fragmented services, duplicative efforts, people not receiving the services they need for which they are eligible, or individuals not having access to preferred services such as self-directed HCBS that maximize choice, control, and satisfaction.

This guidance will improve the efficient administration and consumer experience of programs at the state, federal, and community levels by aligning HCBS to standards for PCP and SD, and by enhancing the ability of HHS's oversight of PCP and SD.

Approach to Implementation and the Development of Standards

In response to a 2010 request from the Secretary of HHS, the Office on Disability, now under the umbrella of the ACL, convened a workgroup on section 2402(a) implementation that included staff from the following agencies:

- Administration on Aging (now an ACL component)
- Administration on Intellectual and Developmental Disabilities (now an ACL component)
- Assistant Secretary for Planning and Evaluation
- Centers for Medicare & Medicaid Services
- Health Resources and Services Administration
- Indian Health Service
- Office for Civil Rights
- Substance Abuse and Mental Health Services Administration

The workgroup met regularly over the course of two years as members considered a range of options and strategies for implementing section 2402(a) of the ACA. In addition to implementation strategies the workgroup discussed key focus areas including PCP, SD, workforce competency and adequacy, quality of life, and a definition for HCBS. The workgroup developed concept papers, conducted interviews with subject matter experts, and engaged in outreach to key stakeholders including advocacy groups, state associations, people with disabilities and older adults, providers, and other federal departments and agencies.

A consensus emerged among members of the workgroup that the initial focus of internal HHS guidance should be on two areas, PCP and SD, as a first step toward implementing important provisions of section 2402(a) of the ACA in a manner that supports consistent application and availability across state and federal programs.

Standards for Person-Centered Planning

Overview of Person-Centered Planning

Underpinning successful HCBS is the importance of a complete and inclusive PCP process that addresses the person's array of HCBS needs in the context of personal goals, preferences, community and family supports, financial resources, and other areas important to the person. The process should result in the provision of appropriate services consistent with the efficient use of available resources.

To support the PCP process, some states are utilizing or developing a standardized comprehensive functional assessment process to determine eligibility for various programs through a "no wrong door" approach. Functional assessments are related to the PCP process, and must be undertaken using a person-centered approach. The functional assessment and the PCP should be used as a basis for service authorization, utilization review, budgeting, measuring goals and improving outcomes, and other purposes. However, the PCP process often results in quality-of-life goals that exceed the ability of any set of program-specific services and supports to fully meet them. Therefore, the PCP process must not be limited by program specific functional assessments. One of the functions of the PCP process is to help the person and the support team to develop innovative and non-traditional ways to meet the goals in the plan. The goals must not be restricted due to a lack of easily identified services or supports. Several initiatives in HHS support a standardized functional assessment process including the Balancing Incentive Program, (<http://www.balancingincentiveprogram.org/>), and the Aging and Disability Resource Centers (http://acl.gov/Programs/Integrated_Programs/ADRCs/Index.aspx).

Definition of Person-Centered Planning

Person-centered planning is a process directed by the person with LTSS needs. It may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. PCP should also include family members, legal guardians, friends, caregivers, and others the person or his/her representative wishes to include. PCP should involve the individuals receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs (medical and HCBS), and desired outcomes. The role of agency workers (e.g., options counselors, support brokers, social workers and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs, and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

Preferences may include, for example, the following concepts related to the person's experience and necessary supports:

- Family and friends

- Housing
- Employment
- Community integration
- Behavioral health
- Culture
- Social activities
- Recreation
- Vocational training
- Relationships
- Language and health literacy
- Other community living choices

PCP assists the person to construct and articulate a vision for the future, consider various paths, engage in decision-making and problem solving, monitor progress, and make needed adjustments to goals and HCBS in a timely manner. It highlights individual responsibility including taking appropriate risks (e.g. back-up staff, emergency planning). It also helps the team working with the individual to know the person better.

Person-Centered Planning Process

PCP must be implemented in a manner that supports the person, makes him or her central to the process, and recognizes the person as the expert on goals and needs. In order for this to occur there are certain process elements, consistent with statutory or regulatory provisions. These include:

1. The person or representative must have control over who is included in the planning process, as well as the authority to request meetings and revise the plan (and any related budget) whenever necessary.
2. The process is timely and occurs at times and locations of convenience to the person, his/her representative, family members, and others.
3. Necessary information and support is provided to ensure the person and/or representative is central to the process, and understands the information. This includes the provision of auxiliary aids and services when needed for effective communication.
4. A strengths-based approach to identifying the positive attributes of the person must be used, including an assessment of the person's strengths and needs. The person should be able to choose the specific PCP format or tool used for the PCP.
5. Personal preferences must be used to develop goals, and to meet the person's HCBS needs.
6. The person's cultural preferences must be acknowledged in the PCP process, and policies/practices should be consistent with the HHS Office on Minority Health Standards National Standards on Culturally and Linguistically Appropriate Services (CLAS) <http://www.minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15>.

7. The PCP process must provide meaningful access to participants and/or their representatives with limited English proficiency (LEP), including low literacy materials and interpreters.
8. People under guardianship or other legal assignment of individual rights, or who are being considered as candidates for these arrangements, should have the opportunity in the PCP process to address any concerns.
9. There must be mechanisms for solving conflict or disagreement within the process, including clear conflict of interest guidelines.
10. People must be offered information on the full range of HCBS available to support achievement of personally identified goals.
11. The person or representative must be central in determining what available HCBS are appropriate and will be used.
12. The person must be able to choose between providers or provider entities - including the option of SD services - when choice is available.
13. The PCP must be reviewed at least every twelve months or sooner, when the person's functional needs change, circumstances change, quality of life goals change, or at the person's request. There must be a clear process for individuals to request updates. The accountable entity must respond to such requests in a timely manner that does not jeopardize the person's health and safety.
14. PCP should not be constrained by any pre-conceived limits on the person's ability to make choices.
15. Employment and housing in integrated settings must be explored, and planning should be consistent with the individual's goals and preferences, including where the individual resides, and who they live with.

Elements of the Person-Centered Plan

The person-centered service plan must identify the services and supports that are necessary to meet the person's identified needs, preferences, and quality of life goals. To the extent that PCPs are consistent with statutory and regulatory provisions, the PCP must have the following attributes:

1. Reflect that the setting where the person resides is chosen by the individual. The chosen setting must be integrated in and support full access 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 HCBS.
2. The plan must be prepared in person-first singular language and be understandable by the person and/or representative.
3. In order to be strengths-based, the positive attributes of the person must be considered and documented at the beginning of the plan.
4. The plan must identify risks, while considering the person's right to assume some degree of personal risk, and include measures available to reduce risks or identify alternate ways to achieve personal goals.

5. Goals must be documented in the person's and/or representative's own words, with clarity regarding the amount, duration, and scope of HCBS that will be provided to assist the person. Goals will consider the quality of life concepts important to the person.
6. The plan must describe the services and supports that will be necessary and specify what HCBS are to be provided through various resources including natural supports, to meet the goals in the PCP.
7. The specific person or persons, and/or provider agency or other entity providing services and supports must be documented.
8. The plan must assure the health and safety of the person.
9. Non-paid supports and items needed to achieve the goals must be documented.
10. The plan must include the signatures of everyone with responsibility for its implementation including the person and/or representative, his or her case manager, the support broker/agent (where applicable), and a timeline for review. The plan should be discussed with family/friends/caregivers designated by the individual so that they fully understand it and their role(s).
11. Any effort to restrict the right of a person to realize preferences or goals must be justified by a specific and individualized assessed safety need and documented in the PCP. The following requirements must be documented in the PCP when a safety need warrants such a restriction:
 - a. The specific and individualized assessed safety need.
 - b. The positive interventions and supports used prior to any modifications or additions to the PCP regarding safety needs.
 - c. Documentation of less intrusive methods of meeting the safety needs that have been tried, but were not successful.
 - d. A clear description of the condition that is directly proportionate to the specific assessed safety need.
 - e. A regular collection and review of data to measure the ongoing effectiveness of the safety modification.
 - f. Established time limits for periodic reviews to determine if the safety modification is still necessary or can be terminated.
 - g. Informed consent of the person to the proposed safety modification; and
 - h. An assurance that the modification itself will not cause harm to the person.
12. The plan must identify the person(s) and/or entity responsible for monitoring its implementation.
13. The plan must identify needed services, and prevent unnecessary or inappropriate services and supports.
14. An emergency back-up plan must be documented that encompasses a range of circumstances (e.g. weather, housing, staff).
15. The plan must address elements of SD (e.g. fiscal intermediary, support broker/agent, alternative services) whenever a self-directed service delivery system is chosen.
16. All persons directly involved in the planning process must receive a copy of the plan or portion of the plan, as determined by the participant or representative.

Person-Centered Planning Implementation

Implementing the person-centered plan requires monitoring progress to achieve identified goals, so that appropriate action is taken when necessary. This includes mechanisms to ensure all HCBS - paid and unpaid - are delivered, that the plan is reviewed according to the established timeline; there is a feedback mechanism for the person or representative to report on progress, issues and problems; and that changes can be made in an expedient manner. People receiving HCBS must be fully involved in the process to update their service plans based on their needs and preferences on an ongoing and regular basis, no less often than annually, based on the time the plan was created or last revisited.

Successful implementation for systems or accountable entities (e.g. state or local programs) requires policy, mission/vision statements, and operations documents at the federal, state, local, and person-level (for self-direction) aligned to incorporate PCP standards, and that staff involved in the PCP process have a consistent understanding of the process and implementation. In order for PCP principles to be fully realized leadership, administrative, and other staff are strongly encouraged to receive competency-based training in PCP. A process for monitoring PCP should be implemented at the federal, state, and local levels and incorporated as an integral component of quality improvement activities across HCBS programs.

For people using HCBS, this includes active engagement in the planning and service delivery process involving a number of support professionals. The person's input informs the quality of services and supports when he/she takes an active role in the PCP process by:

- Providing accurate information for eligibility and service planning.
- Actively identifying and engaging providers, case managers, family members, friends, direct support workers, support brokers, medical professionals, and others.
- Approving and signing only a plan that is developed and accepted by everyone involved.
- Participating fully after the approved plan is implemented (e.g., appearing timely for meetings and appointments, reviewing the plan regularly).
- Providing regular feedback on the HCBS provided.

Standards for Self-Direction

Overview of Self-Direction

Section 2402(a) of the ACA emphasizes the importance of allocating resources to enable people to maximize their independence including by employing LTSS providers directly, designing an individualized, self-directed, community supported life, and using an accurate, fair, and flexible system for individual budget determinations. This service delivery model is referred to as self-direction, participant-direction, consumer-direction, and cash and counseling. Although PCP must be at the center of planning for all individuals receiving HCBS, SD may not be desired, or may not be available, to those who seek or are receiving HCBS. Longstanding evidence from demonstrations and programs such as "Cash and Counseling" and CMS's "Independence Plus" program indicate better outcomes and cost savings result through the use of SD. The concept of

SD may also be integrated into the traditional service delivery system through a focus on gradual transfer of control and the provision of regular opportunities to make choices in many contexts and settings, permitting the person to experience self-directed opportunities absent an established self-directed service delivery system. These types of precursor activities may be useful for people who are not, for whatever reason, able to experience the full benefits of a self-directed service delivery model.

Self-direction is a service delivery model where HCBS are planned, budgeted, and directly controlled by the person receiving services. Self-direction should involve the individuals receiving HCBS to the maximum extent possible and include family members, guardians, or other legal representatives as applicable. Through SD, the person can maximize independence and control over needed HCBS, including for example, choosing and discharging personal care staff. Often SD services are provided in the person's own home. SD typically involves a fiscal intermediary or financial management service, that performs tasks such as payroll processing and tax withholding. Many people who choose to self-direct also use the services of a support broker or agent, to assist them in managing the self-directed HCBS and associated tasks. Often family members and the HCBS consumer are trained as support brokers/agents, although they may not perform the associated tasks. People who self-direct their HCBS may have varying levels of control over a flexible budget, which is required to be sufficient to meet their needs appropriately in the community, and maintain health and safety.

The principles and processes described below are used to ensure consistent standards for SD across public programs. Program features that create the ideal environment for successful SD include:

- A common understanding of SD among case managers, direct service workers, support broker/agents, individuals and their families, any agency-based staff, and others.
- Consistent and effective implementation of the SD model structure and related functions such as support broker/agent, and financial management service/fiscal intermediary.
- The option to use a SD model is made available to all individuals who receive HCBS.
- Clear rules and procedures are established for people to manage their direct service workers (e.g., hiring and firing, staff responsibilities, conflict resolution, salary, supervision, scheduling, etc.).
- A budget process is in place that assures appropriate and timely HCBS are provided based on the person's needs as specified in the PCP. The team-based budget formulation and approval process is used to address the person's assessed individual needs (e.g. not associated with any particular residential setting, "one size fits all" rubric, or other arbitrary methodology disassociated from the individual); is flexible; permits for timely, straightforward modifications and adjustments; and maintains the person's health and safety in the community.

Definition of Self-Direction

SD means a consumer-controlled method of selecting and using services and supports that allow the person maximum control over his or her HCBS including the amount, duration, and

scope of services and supports as well as choice of provider(s). Often, in addition to the typical range of HCBS, self-directed delivery systems permit the person to purchase alternative goods and supports (where authorized by statute or regulation) that may not be available in traditional HCBS service delivery systems. Alternatively, some services available in traditional services delivery (e.g. respite care, day programs, criminal background checks, drug and alcohol screens, training) may not be available in a self-directed service delivery model. There are also various administrative arrangements that apply specifically to SD. For example, the person may act as the “employer of record” with the necessary supports to perform that function, and/or have a significant and meaningful role in the supervision of direct service worker(s). Some people may use a representative to direct their HCBS, and family members or legal guardians may have a role to assist people under guardianship, or un-emancipated minors. People who are self-directing their services should be given as much responsibility as they desire to hire, train, supervise, schedule, determine duties, and dismiss the providers or direct service workers whom they employ directly, or for whom they may share employment responsibilities with an agency. Many people use the services of a support broker or agent to assist them in these and other duties, with the support broker/agent included as distinct service in the person’s PCP.

Payment of SD HCBS could be through the provision of vouchers, direct cash payments, or use of a fiscal agent or fiscal intermediary to assist in paying for services and making certain all necessary payroll functions, including the payment of taxes, are performed. Fiscal agents/intermediaries may also provide regular service and payment summaries to the person receiving HCBS, and issue payment to providers, direct service workers, and support brokers/agents through electronic or paper methods. In some self-directed models, fiscal agency fees are based on a monthly or utilization basis, and are included in the person’s HCBS budget. Self-directed models exist in both traditional fee for service and managed care delivery systems.

Required Elements of Self-Direction

HCBS programs that provide SD must incorporate the following elements, to the extent they are consistent with statutory and regulatory provisions:

1. SD service delivery models must meet the PCP standards described in this document.
2. SD, when offered within programs, should be available to all individuals regardless of age, disability, diagnosis, functional limitations, cognitive status, sex, sexual orientation, race, ethnicity, physical characteristics, national origin, religion, and other such factors.
3. When representatives are required, they must be freely chosen when circumstances permit.
4. HCBS consumers must have access to information and counseling and information on self-direction through a variety of sources as needed or desired, so they can make an informed decision when choosing a SD service delivery model.
5. Case managers and administrative staff should have training in SD. This includes training, for example, on recruitment and education of direct service workers, budget processing, how the PCP relates to the SD budget, needed alternative supports, housing search, etc.

6. When a person chooses SD, an assessment of the supports needed to be successful should be conducted. People who choose SD must have access, for example, to culturally-linguistically sensitive information, training in issues specific to self-direction, financial/fiscal management services, and support brokers/agents, to assist them in the successful management of their HCBS.
7. In addition, the following information and support should be provided:
 - a. PCP and how it is applied through SD.
 - b. Use of and access to the grievance process.
 - c. Individual rights, including appeal rights.
 - d. Reassessment and review schedules for PCP, budgeting, etc.
8. The SD PCP must specify the following:
 - a. The HCBS the individual will be responsible for self-directing.
 - b. The methods by which the person will plan, direct or control services, including whether authority will be exercised over the employment of service providers and/or authority over expenditures from the individualized budget.
 - c. Appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in SD, and assure the continued appropriateness of the PCP and budget based upon the resources and support needs of the person.
 - d. The process for facilitating voluntary (and involuntary) transition from self-direction to a traditional service delivery model or other arrangement (e.g. institutional setting). There must be procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods or provider types.
 - e. Financial/fiscal management supports to be provided.
 - f. Support broker/agent services, irrespective of payment method (fee for service, managed care). If there is no support broker/agent required or chosen, the person must have training in acting as his/her own support broker.
9. If the PCP includes the employer authority to select, manage, or dismiss providers, it must specify the authority to be exercised by the person, any limits to the authority, and the parties responsible for functions outside the authority of the person.
10. If the PCP includes budget authority (which identifies the dollar value of the HCBS under the control and direction of the person), the SD PCP must meet the following requirements:
 - a. Outline the method(s) for calculating the dollar values and/or categories in the budget, based on reliable costs and service utilization.
 - b. Define a flexible and easily accessible process for making timely adjustments in dollar values to reflect changes in the person's SD PCP, particularly to support health and safety.
 - c. Provide for a regular procedure to evaluate expenditures under the budget, including those outlined in the SD PCP.
11. The SD planning process must be conducted in a manner and language understandable to the person and his/her representative(s). Individuals and/or their representatives must be provided with auxiliary aids and services if necessary for effective

communication. The SD process must provide meaningful access to people and/or their representatives who have limited English proficiency.

12. SD program entities must explicitly outline and make transparent to all stakeholders enrollment requirements such as limitations based on geography, demographic factors, residential arrangements, etc.
13. People must have the flexibility to choose the needed services and supports that best meet their needs and preferences within the context of a PCP process that includes the development of an agreed upon, multi-lateral, and approved funding allocation/budget amount for the projected SD HCBS.
14. People must have the flexibility to choose how funds will be used based on the HCBS identified in the PCP, consistent with the requirements of the funding authority, in a transparent manner, including (where appropriate), the ability to move funds categorically as needed.
15. People must have the flexibility to expeditiously and seamlessly change their service plans and budget allocations, based on different needs and preferences, with an assurance of health and safety.
16. People must be able to choose their paid and unpaid direct care workers and/or medical support staff, may include family and friends based on administrative policies, so long as they meet agreed upon guidelines and qualifications for the position, and are willing to perform the duties.
17. People must be allowed to direct the training of their workers in a manner consistent with applicable program requirements, and receive financial support to accomplish critical training needs as appropriate and available.
18. People must be provided with opportunities to participate in defining quality, such as the determination of worker qualifications and training, personal goal setting, and performance measures.
19. People must be supported in taking risks associated with pursuing their goals. There must be a back-up plan for assumed risks, and for a variety of emergency situations.
20. People must have the opportunity, as identified in the PCP and budget, to allocate or set aside funds for emergency needs (e.g., more costly emergency back-up workers, alternative emergency housing) to the extent authorized by applicable law and regulations.
21. People must have the opportunity, as identified in their PCP and budget, to allocate or set aside funds for, and where authorized, specialized purchases made timely such as necessary home or vehicle modifications to support independence and avoid unnecessary institutionalization.
22. People who need assistance with decision-making and do not have an authorized representative must have the option to choose an informal representative to assist them in selecting or managing services and supports, and/or have a person authorized to make personal or health decisions for them. People must also have access to one-on-one assistance as needed or requested with selecting or changing their informal representative.
23. The finalized SD PCP must be signed by the person or his/her legal representative, and a written copy of the plan and budget should be provided to all relevant parties.