

HCBS Strategies, Inc.

Proposed Plan for Implementing Community First Choice in Alaska

Developed for the Alaska Division of Senior and
Disabilities Services

HCBS Strategies Incorporated

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Proposed Plan for Implementing Community First Choice in Alaska

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Executive Summary

This report details the requirements and presents a proposed plan for implementing Community First Choice (CFC) so that the State of Alaska can make a decision regarding whether to proceed with developing the option. Alaska's Medicaid task force recommended considering replacing the current Personal Care Attendant (PCA) program with CFC, a new Medicaid option authorized under the Affordable Care Act (ACA), because the State could receive an enhanced federal match of 6%.

Developing a proposed plan required careful reviews of Alaska's current operations for providing home and community-based services (HCBS) and the draft and final federal regulations for CFC. HCBS Strategies, the contractor awarded a competitively bid contract to assist the Division of Senior and Disabilities Services (SDS), obtained extensive input from SDS staff; the Community First Choice Council (CFCC), which included a wide variety of stakeholders; and seven Community Forums. All work on this effort was conducted between November 2011 and June 2012.

It is important to note that on May 7, 2012 the Centers for Medicare and Medicaid Services (CMS) made a major change in publishing the final regulations for CFC that makes it impossible for Alaska to simply convert the PCA program to CFC. Specifically, these rules limited CFC to individuals who have impairments substantial enough that they would qualify for being in an institution, such as a nursing facility (i.e. meeting an institutional level of care (LOC) criteria). These eligibility criteria would exclude a large number of individuals who currently qualify for PCA.

To comply with these rules and offer a way for Alaska to consider moving forward with CFC, we have proposed that the State could establish an "umbrella" program that includes two new Medicaid funding authorities and uses consistent service definitions, processes for accessing services, rates and budget assignment procedures, etc. The State would operate these two Medicaid funding authorities as a single program to replace the current PCA program: (1) CFC would be used for people who meet an institutional LOC and (2) the State Plan HCBS option would be used to provide similar supports to people who do not meet the institutional LOC. The State Plan HCBS option, also known as 1915(i), was originally created under the Deficit Reduction Act of 2005, but was substantially modified under ACA. Under this authority, Alaska could offer a flexible benefit similar to what has been discussed under CFC but eligibility would not be tied to meeting an institutional LOC. The major difference is that the State would not receive enhanced match for these individuals through 1915(i).

Given the need to split PCA into two Medicaid authorities and the need to invest the resources to redesign core systems infrastructure necessary to meet other CFC requirements, we recommend that the State try to rebrand the new programs and HCBS Waivers as a unified program that we have tentatively named Alaska Community Choices (ACC). Rebranding these services could have the following benefits:

- A single program may be easier for Participants to understand. This could aid outreach and education efforts, such as through the ADRC.
- Having a single name for all programs should lead State staff and providers to view these funding streams as a single program and could create momentum for having shared processes

and tools. For example, State staff may be more likely to create separate quality management systems for Waivers versus PCA when viewed as separate programs rather than components of a single program.

We believe that these changes would be beneficial to the system and many are included in a 2008 report that contained recommendations for reforming Alaska's long term care system. In addition, the plans are consistent with direction that two other states, Maryland and Minnesota, are considering given the changes to the CFC regulations. However, due to the short time frame for developing the recommendations included in this report and the major federal twist that occurred late in the process of this effort, it is critical that SDS work closely with its stakeholders to ensure that there is sufficient support to move forward.

We received excellent support from SDS staff in developing this report. Their guidance was crucial in developing recommendations that could be implemented given Alaska's unique needs and service delivery infrastructure. We also received and incorporated extensive input from the Community First Choice Council and a series of Community Forums. We believe this input substantially strengthened the proposed plan.

The chapters of this report summarize the proposed plan including changes to processes for: 1) accessing services, including changes to the initial intake, assessment, and support planning processes; 2) processes for setting budgets and assigning resources; and 3) quality assurance strategies. We also include a draft plan for implementing the program and transitioning PCA to the new funding streams.

Chapter I: Background

Purpose of Project

The State of Alaska, Department of Health and Social Services, Division of Senior and Disabilities Services (SDS), led an effort to investigate the feasibility of, design and develop a new Community First Choice (CFC) option authorized under the Affordable Care Act (ACA), otherwise known as the health care reform law. CFC is a new Medicaid option that allows individuals who need long term supports and services (LTSS) to receive attendant care in their homes. ACA added CFC to the Social Security Act as section 1915(k). This project is the result of the recommendations from the governor-appointed Medicaid Task Force charged with reviewing and considering options for the State's Medicaid program. The Task Force recommended exploring the replacement of Alaska's current Personal Care Attendant (PCA) program with CFC.

On September 26, 2011, SDS issued a Request for Proposals (RFP) to select a contractor to assist in developing the design of a potential CFC program. On December 1, 2011, SDS executed a contract to HCBS Strategies Incorporated, a small consulting firm with extensive experience in helping states build and evaluate home and community-based services (HCBS) delivery systems. The contract required that the report be delivered by June 30, 2012. HCBS Strategies had developed a report with recommendations for improving Alaska's long term care system in 2008.

This report provides background information about Alaska's current PCA program and the CFC Option, presents the draft plan that has been reviewed by SDS and an advisory council, and includes a summary of feedback offered by attendees at community forums across Alaska.

It is important to note that on May 7, 2012 the Centers for Medicare and Medicaid Services (CMS) made a major change in publishing the final regulations for CFC that makes it impossible for Alaska to simply convert the PCA program to CFC. To comply with these rules, the proposed plan that would allow Alaska to move forward with implementing CFC requires substantial changes to State systems for accessing Medicaid funded HCBS that will also impact the Medicaid Waivers. We believe that these changes would be beneficial to the system and many are included in our 2008 recommendations. However, given the short time frame in which the recommendations included in this report were developed, especially given the major twist that occurred late in the process of this effort, it is critical that SDS work closely with its stakeholders to ensure that there is sufficient support to move forward.

In this document, we refer to individuals who are engaged with the SDS service delivery system as Participants. This language is consistent with the use in many CMS presentations and in other states. The term Participant is chosen over the more traditional term, Consumer, because labeling someone as Participant implies that they are actively participating in the process of directing his or her supports as opposed to passively consuming supports. Thus, once someone makes a request for supports, we label them as a Participant.

Current Medicaid Funded HCBS Options in Alaska

This section briefly describes the current Medicaid funded HCBS in Alaska. We believe it is important for the reader to have a basic familiarity with these programs in order to understand the rest of the report. These HCBS programs include the Personal Care Assistance program and the Medicaid waiver programs. It is important to note that the state also has several additional programs that are funded using state-only or federal funds.

Personal Care Assistance

The PCA program provides home-based services to Medicaid-eligible seniors and others eligible for assistance. The PCA program enables low-income, frail elderly Alaskans and functionally disabled, physically disabled, and frail Alaskans to live in their own homes and communities instead of being placed in a more costly and restrictive long term care institutions. The PCA program provides services that help individuals accomplish activities of daily living such as bathing, dressing and grooming, shopping, and other activities necessary for the person to live at home (e.g., cleaning, meal preparation, laundry, etc.).

Services are provided through two different Personal Care Assistance models. The agency-based PCA program (ABPCA) allows Participants to receive services through an agency in which a registered nurse oversees, manages, and supervises their care. This model has been operational for over 14 years.

The consumer-directed PCA program (CDPCA) allows the Participant to manage his or her own care by selecting, hiring, training, and supervising his or her own personal care attendant. The agency under CDPCA provides administrative support to the Participants and the personal care attendant. This model became operational in 2001. Unlike programs using the popular “cash and counseling” model where the Participant is the employer and receives a specific amount of money to cover a given time period, the CDPCA program in Alaska utilizes a PCA agency as the employer; while the Participant makes the decisions about who to hire and how to train that person, the worker turns in the timesheets to the agency that then bills Medicaid.

Medicaid Waivers

The Medicaid Waiver programs are designed to provide an alternative to institutional placement for low-income individuals certified as needing the services of an institution. They are called “waivers” because they allow a state to waive certain Medicaid requirements, including allowing states to provide many types of home and community-based services (HCBS) that could not be covered under the regular Medicaid program. HCBS waivers are also known as 1915(c) waivers because they are authorized under section 1915(c) of the Social Security Act. Under these waivers, the State can cap the number of people that are served and the amount of services any person will receive. Alaska has also taken advantage of the ability to allow individuals with higher incomes qualify for Medicaid if they are enrolled in a waiver. SDS, which is part of the single State Medicaid agency, operates four waivers that target the following populations:

- Children with Complex Medical Conditions (CCMC),
- Individuals with Mental Retardation/Developmental Disabilities (MRDD),

- Adults with Physical Disabilities (APD), and
- Older Alaskans (OA).

Each of the waivers offers a set of services, or service menu, designed for the population being served under the program. There is a great deal of consistency in the service menus, definitions and limits on services across the waivers. The common services across all waivers include respite, environmental modifications, specialized medical equipment, chore services, transportation, and meals. Each of the waivers also has a mechanism to pay for Assisted Living Home (ALH) care, though the actual Medicaid service is called either Residential Habilitation or Residential Supported Living services (RSL), depending upon the waiver and the needs of the individual. Residential Habilitation also includes services in the person's own home under the MRDD waiver and the CCMC waiver. Nursing is available in all waivers. Intensive Active Treatment services are available in all waivers except the OA or APD waiver.

All of the waivers also pay for and require care coordination services. Care coordination, which has traditionally been called case management, is designed to coordinate services and help ensure that the person is receiving appropriate supports and that there are no health or safety concerns. None of the waivers pay for personal care (defined as assistance with activities of daily living (ADLs), such as bathing, dressing or eating) for someone who does not live in an ALH. These services would be paid for through the PCA program described above. Thus, there is an assumption that for most people receiving waiver services outside an ALH, waiver and PCA supports will both be used.

HCBS Strategies Scope of Work

The original RFP identified the following scope of work:

"The contractor will be required to provide the following deliverables by June 30, 2012:

1. Provide consultation on all aspects of the Community First Choice Option development and implementation as needed.
2. Participate in no less than monthly calls with the Project Manager.
3. Serve as liaison with state and national experts on the Community First Choice Option as required.
4. Attend meetings and teleconferences in which expert evaluation input is needed. Report on the results of these meetings.
5. Attend a minimum of three (3), in-person meeting with the Project Manager in Anchorage, Alaska.
6. Develop a written plan and assist Senior and Disabilities Services in consideration of and the development of a Development and Implementation Council that includes a majority of members with disabilities, elderly individuals, and their representatives.
7. Conduct three (3) in-person stakeholder meetings, one each in Anchorage, Fairbanks, and Juneau, Alaska, which should include Development and Implementation Council members and interested members of the public.
8. Produce a written Detailed Program Design for all of the requirements in the attached Community First Choice Option proposed rules implementing Section 2401 of the Affordable

Care Act that includes both the contractor's and stakeholder's recommendations from meetings with the Development and Implementation Council, Senior and Disabilities Services, and Division of Health Care Services. Should any changes through a Final Rule happen during the contract period, they must be included in the final design. Major elements of the design will include:

- a. Transition plan for sun setting the PCA program and implementing the Community First Choice program;
- b. Eligibility criteria;
- c. Required services and billing codes;
- d. Assessment tool;
- e. Service plan and service budget;
- f. Support system;
- g. Service models and reimbursement rates;
- h. Provider qualifications;
- i. Data collection;
- j. Quality assurance System;
- k. Information collection requirements;
- l. Maintenance of effort and eligibility; and
- m. All recommended Management Information System (EIS, MMIS, DS3, etc.) changes."

HCBS Strategies staff recognized early on that complying with the requirements in CMS' proposed rules for CFC would likely require substantial changes to current operations. We were familiar with these operations from our 2008 work, but started this project by reviewing subsequent changes to regulations and operations. A core part of this work was updating a spreadsheet originally developed in 2008 that summarized information about key operations. A large portion of our first site visit was spent reviewing this information and having preliminary conversations about how CFC might impact these operations.

An early task was the development of the Community First Choice Council (CFCC). We provided SDS with recommendations regarding the structure of the CFCC and worked closely with SDS staff to identify potential Council members.

While the original scope only required monthly meetings with SDS staff, given the scope of work to be accomplished within seven months, we recommended weekly meetings. We held these meetings as web-enabled conference calls.

We recognized that while CMS' proposed rules had clarified much of the original statutory language, it raised many other questions. We developed a Microsoft Access database that identified core questions by components of the proposed regulations and reviewed draft questions for CMS with SDS staff and the CFCC. We led three conference calls with CMS and SDS staff to present and receive answers from CMS regarding these questions. These questions and CMS' responses are included as **Appendix A**. It is important to note that these questions are based on the draft regulations and we have more information now that the final rules have been published.

We held three in-person meetings and four web-enabled calls with the Community First Choice Council (CFCC), which we describe in greater detail below. To facilitate sharing of information with the CFCC and

increase the transparency of the project, we developed a website that had all materials provided to the CFCC (this information can be found at <http://akcfc.blogspot.com/>). We plan to hand over the control of that website to SDS after the conclusion of our role in this project. The CFCC provided feedback to proposed CFC policies and operations which greatly shaped the recommendations within this report.

Six community forums (three for Participants and three for providers) provided wider public input regarding the design of CFC. These forums took place in Juneau, Anchorage, and Fairbanks. The Anchorage events included a statewide call in using Go-To Meeting so that individuals unable to participate in one of the local forums could attend. Several major refinements to the plan resulted from comments and feedback occurring at these forums. **Appendix B** presents a summary of these forums.

CFC Council

The state established the (CFCC) to provide guidance in the development of Community First Choice. The CFCC provided important input and guidance to the state regarding the development and implementation of Community First Choice. The goals for the CFCC are to:

- To influence the design and implementation of Community First Choice to best meet the needs of individuals in Alaska.
- To assist the state with identifying and addressing issues related to the transition of services for individuals currently receiving PCA to CFC.
- To advise the state regarding the establishment of a quality management strategy that incorporates a continuous quality improvement design.
- To provide ongoing input into the operations of CFC.

The CFCC was established to include two levels of membership – voting and advisory members. Voting members include members of the community representing:

- Seniors with physical or medical disabilities
- Individuals with Alzheimer's disease or dementia
- Younger individuals with physical or medical disabilities
- Individuals with brain injury
- Individuals with developmental disabilities
- Children with disabilities

Advisory members represented including:

- Mental Health Trust
- PCA Provider Association
- Statewide Independent Living Council
- Alaska Native Tribal Health Consortium
- Alaska Geriatric Exchange Network (AGENET)
- Association on Developmental Disabilities

Decisions and recommendations formally adopted by the CFCC were determined only by voting members. While these decisions and recommendations are non-binding, the state has incorporated their guidance as part of this design process.

If this effort moves forward, SDS has proposed expanding the role of the CFCC and renaming it the Alaska Community Choice Council (ACC Council). This Council will consist entirely of Participants and their representatives. SDS will also establish an ACC Providers Council to supplement this effort. These Councils will serve as mechanisms for the state to receive input on the operations of the State's Medicaid-funded HCBS. The role and function of these Councils are discussed further in Chapter V, Quality Assurance.

Overview of Community First Choice

CFC is a new Medicaid state plan option introduced in Section 2401 of ACA and signed into law as section 1915(k) to the Social Security Act. The legislation allows a state option to provide "person-centered" home and community-based attendant services and supports. CMS issued proposed rules for this program on February 25, 2011 and published final rules on May 7, 2012.

The option expands on what can be provided under the Medicaid state plan by allowing states more flexibility for supporting individuals who meet certain income and functional criteria. Similar to PCA, there are no caps on caseload or expenditures, and approval is obtained through a State Plan amendment versus a waiver. Services provided under CFC may be provided through a traditional agency model or Participant-directed services similar to ABPCA and CDPCA, respectively. The service focus is similar to services provided under PCA, but offers attractive, flexible benefits not currently allowed under federal parameters for state plan PCA services.

These flexible benefits include an expanded service set, including options to pay for goods that substitute for personal assistance, emergency response systems, skills training, training for Participants regarding hiring/firing staff, and transition costs related to moving from a nursing facility to a community setting.

CFC also provides an enhanced 6 percent federal match above the current Federal Medical Assistance Percentage (FMAP). Given Alaska's current FMAP in which 50% of the costs of services are matched by the federal government, the federal government would cover 56% of the CFC service costs.

CFC permits states to provide supports through an agency model, a self-directed budget model, cash model, or voucher model. CFC provides other flexible options, such as using the individual's self-directed budget to purchase goods that substitute for human assistance. In order to qualify for CFC, individuals must meet certain income standards, and must have a need for assistance in certain functional areas (such as ADLs and IADLs).

A key requirement in CFC is that Participants must meet an institutional level care (LOC) for one of the following types of institutions: nursing facility, intermediate care facility-mental retardation (ICF-MR), or institutional psychiatric care for individuals under age 21. The nursing facility and ICF-MR institutional LOC criteria are the same criteria that are used for the HCBS waivers.

The final regulations include several other requirements that states must address in order to implement CFC and receive the enhanced FMAP. We have summarized selected components of these regulations and discussed the implications for the development of this plan in *Exhibit 1*. Meeting these requirements drove the proposed design described in the later chapters in this report.

Exhibit 1: Key Components of the Final CFC Rule

The following section provides selected language from the CMS final rule for the CFC option (*in italics*) and a brief discussion of the implications for the design of the CFC plan. We briefly discuss the implications for the design of a CFC option in Alaska following each section.

§441.510 Eligibility.

(c) Receive a determination, at least annually, that in the absence of the home and community-based attendant services and supports provided under this subpart, the individual would otherwise require the level of care furnished in a hospital, a nursing facility, an intermediate care facility for the mentally retarded, an institution providing psychiatric services for individuals under age 21, or an institution for mental diseases for individuals age 65 or over, if the cost could be reimbursed under the State plan.

Implications: The final regulations required that individuals must meet an institutional LOC in order to be enrolled in CFC (this was a substantial change from the earlier regulation). This change means that a large portion of the individuals currently enrolled in PCA would not be eligible for CFC.

§ 441.520 Included services.

(a) If a State elects to provide Community First Choice, the State must provide all of the following services:

- (1) Assistance with ADLs, IADLs, and health-related tasks through hands-on assistance, supervision, and/or cueing.*
- (2) Acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health-related tasks.*
- (3) Backup systems or mechanisms to ensure continuity of services and supports, as defined in §441.505 of this subpart.*
- (4) Voluntary training on how to select, manage and dismiss attendants.*

Implications: While the regulations clearly allow CFC to cover services currently provided under PCA, it is important to note that the State must also provide backup systems (such as personal emergency response systems) and voluntary training to Participants.

(b) *At the State's option, the State may provide permissible services and supports that are linked to an assessed need or goal in the individual's person-centered service plan. Permissible services and supports may include, but are not limited to, the following:*

- (1) *Expenditures for transition costs such as rent and utility deposits, first month's rent and utilities, bedding, basic kitchen supplies, and other necessities linked to an assessed need for an individual to transition from a nursing facility, institution for mental diseases, or intermediate care facility for the mentally retarded to a home and community-based setting where the individual resides;*
- (2) *Expenditures relating to a need identified in an individual's person-centered service plan that increases an individual's independence or substitutes for human assistance, to the extent that expenditures would otherwise be made for the human assistance.*

Implications: Under CFC, the State can offer two additional benefits:

- SDS can receive Medicaid match for costs similar to what SDS pays for using State-only funding under the Nursing Facility Transition program. It is important to note that these supports would also apply to individuals transitioning from an ICF-MR to the community. However, given Alaska's minimal use of ICF-MRs, these costs are likely to be minimal.
- The State can offer goods and services that substitute for human assistance. SDS and the CFC Council clearly supported offering these supports as long as these costs are compensated by a comparable reduction in spending on hours of services. The change in the final regulation requiring an institutional LOC late in this planning process creates an incentive for SDS to shift other Medicaid Waiver funded services to CFC so that the State can receive the enhanced match. Chapter IV provides details on these proposed plans.

§ 441.525 Excluded services.

Community First Choice may not include the following:

- (a) *Room and board costs for the individual, except for allowable transition services described in §441.520(b)(1) of this subpart.*
- (b) *Special education and related services provided under the Individuals with Disabilities Education Act that are related to education only, and vocational rehabilitation services provided under the Rehabilitation Act of 1973.*
- (c) *Assistive devices and assistive technology services, other than those defined in §441.520(a)(3) of this subpart, or those that meet the requirements at §441.520(b)(2) of this subpart.*
- (d) *Medical supplies and medical equipment, other than those that meet the requirements at §441.520(b)(2) of this subpart.*
- (e) *Home modifications, other than those that meet the requirements at §441.520(b) of this subpart.*

Implications: The regulations and the accompanying descriptions included in the preambles of the draft and final rules suggest that the State will have the ability to fund items identified in paragraphs (c) through (e) above as long as the meet the following conditions:

- The items must be included in the individuals Support Plan.
- The items must decrease the needs for assistance from a person or increase the Participant's independence.

§ 441.535 Assessment of functional need.

States must conduct a face-to-face assessment of the individual's needs, strengths, preferences, and goals for the services and supports provided under Community First Choice in accordance with the following:

§ 441.540 Person-centered service plan.

(a) Person-centered planning process. 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.*
- (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 they receive and from whom.*
- (7) Includes a method for the individual to request updates to the plan.*
- (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 Community First Choice, the plan must:

- (1) Reflect that the setting in which the individual resides is chosen by the individual.*
- (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 cannot supplant needed paid services unless the natural supports are unpaid supports that are provided voluntarily to the individual in lieu of an attendant.*
- (6) *Reflect risk factors and measures in place to minimize them, including individualized backup plans.*
- (7) *Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her.*
- (8) *Identify the individual and/or entity responsible for monitoring the plan.*
- (9) *Be finalized and agreed to in writing by the individual 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) *Incorporate the service plan requirements for the self-directed model with service budget at \$441.550, when applicable.*
- (12) *Prevent the provision of unnecessary or inappropriate care.*
- (13) *Other requirements as determined by the Secretary.*

§441.555 Support system.

For each service delivery model available, States must provide, or arrange for the provision of, a support system that meets all of the following conditions:

- (a) *Appropriately assesses and counsels an individual before enrollment.*
- (b) *Provides appropriate information, counseling, training, and assistance to ensure that an individual is able to manage the services and budgets if applicable.*
 - (1) *This information must be communicated to the individual in a manner and language understandable by the individual. To ensure that the information is communicated in an accessible manner, information should be communicated in plain language and needed auxiliary aids and services should be provided.*
 - (2) *The support activities must include at least the following:*
 - (i) *Person-centered planning and how it is applied.*
 - (ii) *Range and scope of individual choices and options.*
 - (iii) *Process for changing the person-centered service plan and, if applicable, service budget.*
 - (iv) *Grievance process.*
 - (v) *Information on the risks and responsibilities of self-direction.*
 - (vi) *The ability to freely choose from available home and community-based attendant providers, available service delivery models and if applicable, financial management*

entities.

- (vii) Individual rights, including appeal rights.*
- (viii) Reassessment and review schedules.*
- (ix) Defining goals, needs, and preferences of Community First Choice services and supports.*
- (x) Identifying and accessing services, supports, and resources.*
- (xi) Development of risk management agreements.*
 - (A) The State must specify in the State Plan amendment any tools or instruments used to mitigate identified risks.*
 - (B) States utilizing criminal or background checks as part of their risk management agreement will bear the costs of such activities.*
- (xii) Development of a personalized backup plan.*
- (xii) Recognizing and reporting critical events.*
- (xiii) Information about an advocate or advocacy systems available in the State and how an individual can access the advocate or advocacy systems.*

Implications: The regulations require the development of a person-centered assessment and support planning process. They also specify a number of specific requirements that must be included in the Support Plan. The proposed draft plan includes proposed changes to the assessment and support planning process that address these requirements.

There are two major implications for changes to how current programs operate. One, SDS will need to require a standardized format for Support Plans and this format will likely need to include Waiver services if an individual is enrolled in both CFC and a Waiver. Two, assessment tools and the new Support Plan will need to include several new sections that will likely result in both of these processes taking more time. This is especially true for the Support Plan, which will need to demonstrate how person-centered goals are driving the assignment of supports; as well as include risk management and back-up plans.

- (c) *Establishes conflict of interest standards for the assessments of functional need and the person-centered service plan development process that apply to all individuals and entities, public or private. At a minimum, these standards must ensure that the individuals or entities conducting the assessment of functional need and person-centered service plan development process are not:*
- (1) *Related by blood or marriage to the individual, or to any paid caregiver of the individual.*
 - (2) *Financially responsible for the individual.*
 - (3) *Empowered to make financial or health-related decisions on behalf of the individual.*
 - (4) *Individuals who would benefit financially from the provision of assessed needs and services.*
 - (5) *Providers of State plan HCBS for the individual, or those who have an interest in or are employed by a provider of State plan HCBS for the individual, except when the State demonstrates that the only willing and qualified entity/entities to perform assessments of functional need and develop person-centered service plans in a geographic area also provides HCBS, and the State devises conflict of interest protections including separation of assessment/planning and HCBS provider functions within provider entities, which are described in the State plan, and individuals are provided with a clear and accessible alternative dispute resolution process.*

Implications: The major challenge that this provision creates for Alaska is that it limits the ability of Care Coordinators and other staff who are employed by an agency that provides personal care services to the Participant from driving the support planning process. Because the assessment process is already being conducted by SDS staff, this process would be considered “conflict-free.”

As there is a desire to allow Participants who are enrolled in both CFC and a Waiver to have a choice between an independent and an agency-based Care Coordinator, we have proposed a process that may allow for this. Under this proposal, if the Participant selects an agency-based Care Coordinator, SDS staff will perform key portions of the support planning process, but still allow the agency-based Care Coordinator to complete the detailed plan.

§441.565 Provider qualifications.

(a) For all service delivery models:

- (a) An individual retains the right to train attendant care providers in the specific areas of attendant care needed by the individual, and to have the attendant care provider perform the needed assistance in a manner that comports with the individual's personal, cultural, and/or religious preferences.
- (b) An individual retains the right to establish additional staff qualifications based on the individual's needs and preferences.
- (c) Individuals also have the right to access other training provided by or through the State so that their attendant care provider(s) can meet any additional qualifications required or desired by individuals.

(b) For the agency-provider model, the State must define in writing adequate qualifications for providers in the agency model of Community First Choice services and supports.

§441.570 State assurances.

A State must assure the following requirements are met:

- (a) Necessary safeguards have been taken to protect the health and welfare of enrollees in Community First Choice, including adherence to section 1903(i) of the Act that Medicaid payment shall not be made for items or services furnished by individuals or entities excluded from participating in the Medicaid Program.

Implications: Under CFC, the State would be taking greater responsibility for assuring a Participant's health and safety than under the current PCA program. Meeting this assurance is similar to a requirement for the HCBS Waivers. As has been the case for these Waivers, Alaska should be prepared to have more robust systems for ensuring that staff providing support are adequately trained and that appropriate monitoring occurs.

Because CDPCA is considered an Agency with Choice model under the provisions of the federal regulation, SDS will likely need to ensure that all CFC agencies meet a standard set of agency qualifications. This also means that SDS will need to consider enhancement of the qualifications for staff hired under this model. It is important to note that while the regulations require that Participants have the ability to train staff, this does not appear to prohibit a state from requiring standardized training that all staff receive - this standardized training may then be supplemented by training tailored to and directed by the Participant. The proposed plan attempts to retain strengths of the current CDPCA program, the flexibility to relatively quickly hire staff and allowing Participants to train staff, while strengthening the ability of the State to assure that all staff are well-trained and reasonable safeguards have been put in place to assure health and safety.

(b) For the first full 12 month period in which the State plan amendment is implemented, the State must maintain or exceed the level of State expenditures for home and community-based attendant services and supports provided under sections 1115, 1905(a), 1915, or otherwise under the Act, to individuals with disabilities or elderly individuals attributable to the preceding 12 month period.

Implications: The State will have to be very careful when implementing this program to ensure that other changes, especially those aimed at minimizing fraud and making the program more cost-effective do not drive down overall costs for HCBS during the first year after implementation.

§441.575 Development and Implementation Council.

(a) States must establish a Development and Implementation Council, the majority of which is comprised of individuals with disabilities, elderly individuals, and their representatives.

(b) States must consult and collaborate with the Council when developing and implementing a State plan amendment to provide Community First Choice services and supports.

Implications: SDS established the CFC Council to meet this requirement. To ensure that individuals with disabilities, elderly individuals, and their representatives constituted the majority of the Council while allowing participation from other stakeholders, SDS used a structure in which Participants and Participant representatives were voting members.

§441.585 Quality assurance system.

- (a) States must establish and maintain a comprehensive, continuous quality assurance system, described in the State plan amendment, which includes the following:
- (1) A quality improvement strategy.
 - (2) Methods to continuously monitor the health and welfare of each individual who receives home and community-based attendant services and supports, including a process for the mandatory reporting, investigation, and resolution of allegations of neglect, abuse, or exploitation in connection with the provision of such services and supports.
 - (3) Measures individual outcomes associated with the receipt of home and community-based attendant services and supports as set forth in the person centered service plan, particularly for the health and welfare of individuals receiving such services and supports. These measures must be reported to CMS upon request.
 - (4) Standards for all service delivery models for training, appeals for denials and reconsideration procedures for an individual's person-centered service plan.
 - (5) Other requirements as determined by the Secretary.
- (b) The State must ensure the quality assurance system will employ methods that maximizes individual independence and control, and provides information about the provisions of quality improvement and assurance to each individual receiving such services and supports.
- (c) The State must elicit and incorporate feedback from individuals and their representatives, disability organizations, providers, families of disabled or elderly individuals, members of the community and others to improve the quality of the community-based attendant services and supports benefit.

Implications: This section builds upon the requirements in the previous language about health and safety and provider qualifications that we discussed earlier. There are a couple of notable extensions. One, the State will likely need to expand and enhance its critical incident management system to meet the language in these rules. It is of note that the rules appear to be even more proscriptive than the rules for the 1915(c) Waivers. Two, the State will need to apply measureable performance indicators as a part of its quality assurance system. Three, person-centered outcomes will need to be a major component of this monitoring system and at least a portion of this information needs to be obtained directly from Participants.

§441.590 Increased Federal financial participation.

Beginning October 1, 2011, the FMAP applicable to the State will be increased by 6 percentage points, for the provision of Community First Choice services and supports, under an approved State plan amendment.

Implications: CFC is unique in that the enhanced match offered under the program continues for however long the State chooses to continue the program.

Other Factors Influencing the Proposed Program Design

In addition to considering the federal requirements for CFC, we also considered other relevant issues that SDS, members of the CFCC and other stakeholders identified at the beginning of the process:

- A number of the individuals needing HCBS are Alaska Natives and/or individuals living in remote areas under frontier conditions. Alaska's geographic size, limited accessibility and rugged conditions present obstacles to ensuring access to eligible program Participants. Traditional agency service delivery is not feasible in many of these remote areas. Similarly, access to services that are culturally appropriate for the state's diverse population or adapted to fit with the living conditions in small villages (e.g., harsh winter conditions, plane-only access, and lack of running water in homes) make Alaska's challenge unique.
- The growth in caseload and expenditures within the PCA program during the past ten years have been dramatic and difficult to manage; and, is expected to continue to cause challenges given the aging population in the state. The state has responded to this through a series of program integrity measures, including shifting functional assessment away from program providers to state staff and/or contractors, clarifying policies to reduce potential duplication in service provision, and placing limitations on the provision of services. These changes have resulted in a fair amount of change fatigue for all entities involved.
- There is growing need and pressure to address the service needs of individuals with cognitive limitations who may be able to physically perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs), but need cueing or supervision in order to complete tasks appropriately or in a safe manner (e.g., individuals with dementia or brain injury). The lack of PCA program inclusion for cueing and supervision is evidenced in state standards covering functional criteria for service eligibility and in the scope of services eligible for payment. The result is that the state's PCA program is not available for supporting individuals with cognitive needs unless there are other medical needs demonstrated.
- The state may wish to increase the flexibility of the current PCA program. CDPCA has helped the state to address access problems for individuals that formerly were unable to obtain services through traditional agencies, such as individuals living in remote areas of the state. However, unlike programs using the "cash and counseling" model where the consumer is the employer and receives a specific amount of money to cover a given time period, the CDPCA program in Alaska permits the individual to select and direct workers by utilizing a PCA agency as the employer. This model limits the flexibility typically enjoyed by individuals under other Participant-directed models - notably being able to use these funds for purposes beyond paying staff on an hourly basis.
- Although there is an implicit assumption that individuals living in the community who are not in an ALH will receive both Waiver services and PCA, the coordination of these supports has been problematic. Participants sometimes have separate assessments for Waiver and PCA. There is

also confusion regarding whether the Waiver Care Coordinator is responsible for developing a support plan for both Waiver and PCA services. While some Care Coordinators may do so, SDS staff and others reported that this does not occur in all cases.

- Alaska has limited systems in place for assisting all individuals seeking information about their options for long term supports and services (LTSS) and helping those individuals understand those options. While Alaska's Aging and Disability Resource Center (ADRC) effort continues to develop, it only covers a portion of the State. In addition, individuals who learn about a potential LTSS option from a provider (such as receiving outreach from a PCA agency) may only receive a brochure describing Waiver services.

Moving Forward with CFC Given CMS Regulations Limiting CFC to Individuals who Meet the Institutional Level of Care

CMS' final rule limiting CFC to individuals who meet an institutional LOC means that the original vision of the Medicaid Task force to use CFC to obtain additional federal funding for PCA with a minimal amount of change was not possible. Given this substantial change, we explored several possible choices with SDS:

- **Not moving forward with CFC:** The State could choose to abandon the effort and not move forward. It is important to note that in addition to forgoing the enhanced match, the State will continue to face pressure from CMS on several of the components included in the final CFC rules. CMS has indicated that they intend to create consistent rules for all Medicaid-funded HCBS to the extent practicable. Thus, the state will eventually be required to implement infrastructure in meeting those components. CMS will have the greatest ability to incorporate these requirements into revised regulations for the 1915(c) Waivers.
- **Changing the institutional LOC criteria for nursing facilities:** The State could lower the Medicaid nursing facility LOC criteria so that it was more consistent with the proposed criteria for CFC. Because one of the original purposes of this effort was to help increase federal funding for Medicaid HCBS and control state spending as the older adult population increases, we could not recommend this option as it could potentially lead to a sizeable increase in spending.
- **Moving forward with CFC and maintaining the current PCA program for individuals who do not meet LOC:** Under this option the state would maintain the current PCA program, but add CFC for individuals who do not meet an institutional LOC. We could not recommend this option because it would further fragment the system in a manner that could make it more confusing for potential Participants to understand their options and more challenging for SDS staff to administer. This option would also be more challenging for providers because the requirements for participating in the programs would likely differ.
- **Moving forward with CFC and utilizing another Medicaid authority to create a program that mirrors the structure and benefits of CFC by will cover individuals who do not meet an institutional LOC:** Under this proposal, the State would establish an "umbrella" program with consistent service definitions, processes for accessing services, rates and budget assignment procedures, etc. The State would apply two new Medicaid funding authorities into this single program: (1) CFC would be used for people who meet an institutional LOC and (2) the State Plan

HCBS option would be used to provide similar supports to people who do not meet the institutional LOC. The State Plan HCBS option, also known as 1915(i), was originally created under the Deficit Reduction Act of 2005, but was substantially modified under ACA. Under this authority, Alaska could offer a flexible benefit similar to what has been discussed under CFC but eligibility would not be tied to meeting an institutional LOC. The major downside is that the State would not receive enhanced match for these individuals through 1915(i).

After discussing the options with SDS, it appeared that the first option (not moving forward) and the last option (moving forward and establishing parallel CFC/1915(i) programs) were the most viable options. Our report presents a plan for the State to move forward and develop parallel programs to accomplish the state's initial goal of transforming the PCA program to CFC. This report will allow SDS and the stakeholders to fully understand the changes that must be made, and should facilitate the State's ability to make an informed decision regarding how to proceed.

Moving Toward and Integrated Medicaid Funded HCBS Delivery System

The report presents a plan for transforming the current PCA program into parallel CFC/1915(i) programs that are designed to appear seamless to Participants. It is important to note that the CMS regulations also include requirements and incentives for the State to better integrate these programs with supports provided under HCBS Waivers. Thus, if the State is going to invest the resources to redesign core systems infrastructure necessary to meet these requirements, we recommend that the State try to rebrand the new programs and HCBS Waivers as a unified program that we have tentatively named Alaska Community Choices (ACC). Rebranding these services could have the following benefits:

- A single program may be easier for Participants to understand. This could aid outreach and education efforts, such as through the ADRC.
- Having a single name for all programs should lead State staff and providers to view these funding streams as a single program and could create momentum for having shared processes and tools. For example, State staff may be more likely to create separate quality management systems for Waivers versus PCA if they are viewed as separate programs than if they were viewed as components of a single program.

Overview of the Proposed Plan

The subsequent chapters in this report present the proposed plan for moving forward with CFC as part of the ACC effort. We recognize that many of the changes we are proposing represent substantial changes to the way programs currently operate in Alaska. We attempted to minimize amount of change by preserving current systems infrastructure wherever possible. This includes:

- The proposed plan keeping the current assessment tool, the Consumer Assessment Tool (CAT), as the core of the tool under ACC.
- The plan proposing only minor modifications to the current process for assigning hours under PCA and the Waivers keeping the current core assignment methodology intact.
- Proposing a plan such that existing PCA providers should be able to become providers under ACC.

- The State not choosing to adopt an approach that would have allowed Participants to pay caregivers directly or through a fiscal intermediary potentially eliminating the need for agencies.

The remaining section of this report summarizes the proposed plan:

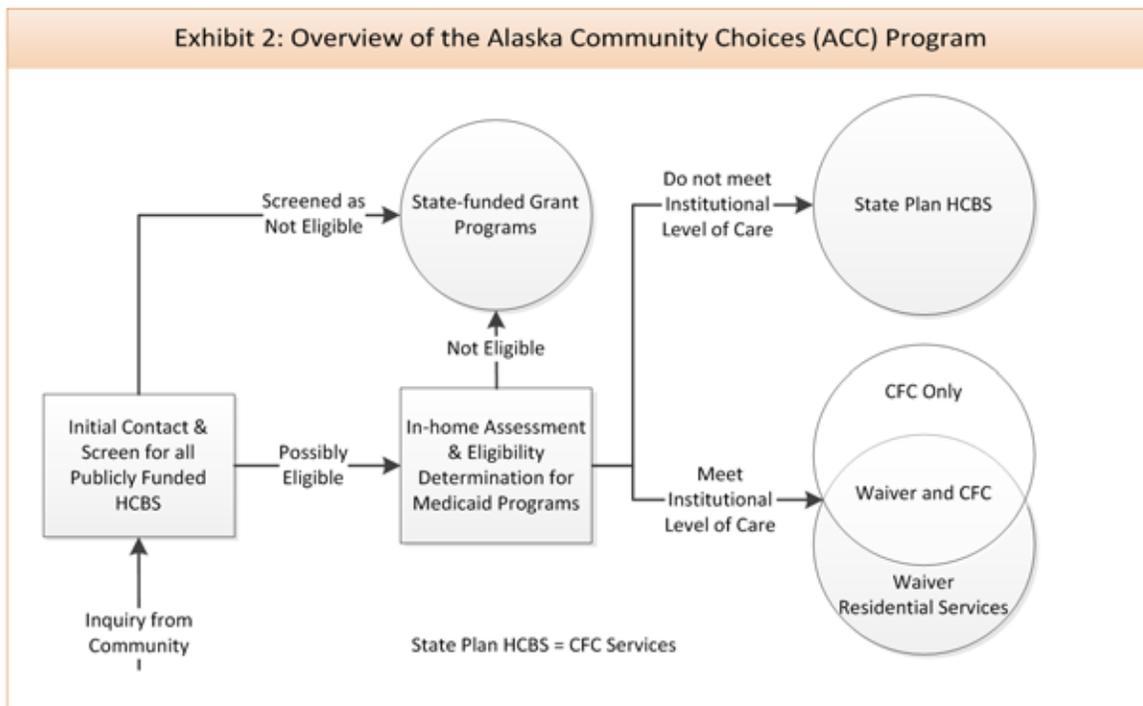
- Chapter II provides an overview of the proposed program and discusses the major components of the structure of the program.
- Chapter III describes the processes Participants will use to access services, including describing changes to the initial intake, assessment, and support planning processes.
- Chapter IV discusses the process for setting budgets and assigning resources.
- Chapter V lays out the proposed quality assurance strategy.
- Chapter VI discusses the estimated fiscal impact of the proposed changes.
- Chapter VII provides a plan for implementing the program and transitioning PCA to the new funding streams.

Chapter II: Program Framework

Alaska Community Choices—Design Overview

As explained toward the end of Chapter I, implementing CFC will require substantial changes to business operations supporting Medicaid-funded HCBS including splitting what is now paid for as part of PCA into two programs. Thus, the plan proposes integrating core components of all Medicaid-funded HCBS, including the Waivers under the ACC framework. The ACC effort integrates multiple Medicaid funding streams into a unified process of requesting, determining eligibility, and identifying HCBS supports. From the Participant perspective, ACC should feel like a single program. The ACC effort should also simplify the system for providers by aligning provider requirements including training and quality assurance protocols across Medicaid funding streams.

Exhibit 2 provides an overview of how ACC proposes to integrate CFC, State Plan HCBS (aka, the 1915(i) option) and HCBS waivers. The exhibit also shows how access to state grant funds for individuals who do not meet the eligibility criteria for Medicaid HCBS services may fit into this process. The proposed process for integrating these funding streams includes the components:



- ACC establishes a screening process that will occur when someone initially requests Medicaid-funded HCBS, including personal care and supports provided through a Waiver. The proposed screening process is discussed in greater detail in the next chapter. This process will screen out individuals who are clearly not eligible for Medicaid-funded HCBS. These individuals will be referred to State-funded grant programs for supports.
- As is the case for current programs, an in-home assessment will be performed by SDS staff on individuals who may be eligible for Medicaid-funded HCBS. ACC proposes to have a unified

assessment process that will determine eligibility for all Medicaid-funded HCBS programs. This will address a major challenge in the current process in which individuals may have separate assessments for PCA and a Waiver. Anyone determined not to be eligible for Medicaid-funded HCBS will be referred to State-funded grant programs. The proposed structure for this assessment process is described in greater detail in the next chapter.

- A single Support Plan will be developed for individuals determined eligible for Medicaid-funded HCBS. Support Plan is the term we are using to describe what may otherwise be referred to as a Service Plan or a Care Plan. The next chapter details the proposed components of this plan and who may complete the plan. Under the ACC proposal, SDS will require a single Support Plan that addresses all LTSS including supports provided under CFC, State Plan HCBS, a Waiver, other Medicaid-funded supports, supports paid for by a third party, and unpaid supports.
 - Individuals who do not meet an institutional LOC will only be eligible for Medicaid HCBS supports provided under the State Plan HCBS option.
 - Individuals who do meet an institutional LOC will have the following options:
 - § They may receive supports provided in an ALH. These supports will be funded using a Waiver.
 - § They may receive both Waiver and CFC supports if they are not in an ALH or other prohibited settings.
 - § They may receive only CFC supports.

In the remaining sections of this chapter, we describe the covered services and supports, who is eligible to participate in each of the ACC programs, models of service delivery and who is qualified to deliver services and supports. These components are an essential part of the plan the State will submit for federal approval, establishing the basis for how the CFC and State Plan HCBS option would operate under ACC.

Service Definition

This section describes the types of services that are proposed to be available under CFC and State Plan HCBS. The ACC proposal does not include changing any of the services that are available under the Waivers, however, some of the services may shift to CFC to allow the State to capture additional federal match (see Chapter IV for more information).

CMS Requirements

While we tried to incorporate existing PCA definitions wherever practicable, complying with CMS' final rules require some changes which are described in greater detail later in this chapter. These changes are driven primarily by the CFC rules rather than the draft State Plan HCBS rules because the CFC rules have more specific requirements.

CMS' rules for CFC rules require the State to include the following four types of services:

- 1) Assistance with ADLs, IADLs, and health related tasks;
- 2) Acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health related tasks;

- 3) Back-up systems and mechanisms; and
- 4) Voluntary training for hiring and managing support workers.

The CMS rules also allow for optional services that can be funded under CFC. Under the proposed plan, Alaska would offer the following services under CFC/State Plan HCBS:

- 1) Transition services; and,
- 2) Goods and services (replacing need for human assistance or increasing independence).

The proposed plan includes all of the required and optional services. This will allow the State to provide more flexibility to Participants and potentially draw down federal dollars that are currently financed with State-only funds.

Development of the Service Definitions

SDS sought input from members of the CFC Council regarding whether to include the two optional services and the general approach for providing the required services. The Council supported the inclusion of the optional services, with a recommendation to limit the amount of the individualized budget that could be diverted from worker assistance to pay for substitutes under goods and services.

HCBS Strategies staff developed draft definitions by cross-walking the CFC regulations and the existing Alaska PCA/CDPCA definitions. While we tried to maintain existing Alaska PCA regulations wherever possible, implementing CFC would require some relatively minor changes. For example, under CFC workers may provide ADL/IADL training activities that support skill acquisition. This type of activity is not currently covered by the State's PCA definitions. Additionally, the rules would need to be modified to include new services, such as Training and Supports for Participants to manage workers.

We used models from other states to propose new language that would need to be added to current PCA regulations. We reviewed the proposed definitions with SDS staff and the CFCC and modified the definitions to incorporate their input.

The State intends to use common service definitions for both CFC and State Plan HCBS to allow these programs to be seamlessly integrated into the ACC effort. There may be some minor distinctions in the two programs due to the differences in the level of need between the program Participants; CFC is tailored to people meeting institutional level of care, thus, they would have a richer service package. We note where those differences are likely to occur for relevant services later in this chapter.

The proposed service definitions could also be extended to the Waivers, though this was beyond the scope of this process. SDS would want to carefully examine the implications of making these changes and seek input before doing so.

Detailed Service Definitions

Below we provide a detailed description of the services that would be covered under CFC and State Plan HCBS. The State proposes to cover all of the required and optional CFC services identified earlier in this chapter section.

For each of the proposed services, we include: 1) a policy statement identifying the purpose for the service and the conditions necessary for the service to be authorized; and, 2) a description of activities or tasks that may be performed under the covered service.

1. Assistance with ADLs, IADLs, and Health Related Tasks

Proposed Policy

CFC and State Plan HCBS are designed to support individuals to be as independent as possible and are intended to be tailored to individual circumstances. A worker may provide hands-on assistance, cueing, or supervision for ADLs, IADLs, and health related tasks in the person's home or in other community settings under the following conditions:

- The need for services has been determined through the assessment process and has been authorized as part of the individual support plan
- The activities are for the sole benefit of the individual
- The activities are provided consistent with the stated preferences and outcomes in the individual support plan
- The individual directs the worker in the performance of support activities; if the individual is unable to direct activities, the support plan must specify how oversight will occur

Proposed Service Description

A worker may provide hands-on assistance, cueing, or supervision for the following.

ADL Activities

- Dressing and undressing – This includes the application or removal of clothing, special appliances (e.g., prosthetics, braces) or wraps.
- Grooming – This includes basic hair care (e.g., shampooing, drying, brushing, use of hair products), oral care, shaving, basic nail care, applying cosmetics and deodorant, care of eyeglasses, hearing aids, or other grooming activities associated with cultural practices.
- Bathing – This includes the following activities:
 - Preparation of bath area, including drawing water, setting out towels, or other tasks necessary for completing the activity
 - Performance of bath tasks, including washing and/or drying of individual
 - Clean-up of area after bath, including emptying water, removal of towels, cleaning sink, tub, or shower, wipe up of water
 - After bath care, such as care of skin (e.g., applying body lotions)

- Eating – This includes tasks needed to prepare and perform eating. Examples may include assisting with orthotics or adaptive equipment required by the person for eating, use of napkin, serving or preparing plate, cutting food, and wiping mouth or cleaning hands.
- Transfers – This includes support or assistance with moving or transferring the person from one seating or reclining area to another.
- Mobility - Assistance with ambulation.
- Positioning - Assistance with positioning or turning a person for necessary care and comfort.
- Toileting – This includes activities related to helping person with bowel or bladder elimination and care. Examples include assisting person to bathroom, transferring or positioning person onto toilet or other device (e.g., bedpan, toileting chair), care of feminine hygiene, use of toileting equipment or supplies, cleansing the perineal area, providing general hygiene care of a colostomy, an ileostomy, or an external catheter; performing digital stimulation, giving suppositories not containing medication, inspection of the skin, adjusting clothing, care of and disposal of incontinence supplies, disposal of waste (e.g., flushing, emptying pan), preparation and/or clean-up of equipment and area.

IADLs (individuals 18 and older)

- Accompany the individual on community outings; examples include outings for shopping and errands, activities related to maintaining health, or participation in activities related to socialization
- Assist with paying bills or organizing personal or financial papers
- Perform or assist with light housekeeping duties
- Perform or assist with shopping for food, clothing, or essential items
- Perform or assist individual in planning and preparing of meals
- Perform or assist individual with communications; examples include answering mail, communicating by telephone or internet

Health Related Tasks

Health related tasks include activities designed to maintain health. This includes the following tasks for traditional agency and agency with choice:

- Perform or assist individual with collection of health information and communication with health providers
- Assistance with self-administration of medication, including opening lids on medication bottles, reminders of medication schedule, and placing medication within reach of the individual
- Care of non-sterile dressings for uninfected post-operative or chronic conditions
- Prescribed foot care, excluding nail care for recipients who are diabetic or have poor circulation
- Application of elastic bandages and support hose

- Assistance with the use and minor maintenance of respiratory equipment and prescribed oxygen
- Assistance with putting on and removing a prosthetic device
- Assistance with walking and simple exercises prescribed by a physician, a physician assistant, an advanced nurse practitioner, or therapist, who is licensed in this state or practicing or employed in a federally or tribally owned or leased health facility in this state
- Assistance with prescribed range of motion or stretching exercises

Individuals receiving support under the agency-with-choice CFC options may direct workers to provide additional health maintenance activities. Examples include routine physical activities such as walking stretching and exercise designed to maintain health, movement and flexibility; urinary system management and/or bowel treatments; administration of medications; tube feeding; and, wound care when the following conditions are met:

- The activity is authorized in the support plan
- The worker's performance of the activity is directed by the individual or the individual's authorized representative
- The worker has been trained by the individual or the individual's authorized representative in performance of the health maintenance activity

2. Acquisition, Maintenance, and Enhancement of Skills Necessary for the Individual to Accomplish ADLS, IADLS, and Health Related Tasks

Proposed Policy

CFC and State Plan HCBS provide for skill training and maintenance activities related to ADLs, IADLs, and health related tasks as a means to increase independence, preserve functioning, and reduce dependency of the Participant. A worker may provide training and maintenance activities under the following conditions:

- The need for skill training or maintenance activities has been determined through the assessment process and has been authorized as part of the individual support plan
- The activities are for the sole benefit of the individual
- The activities are designed to preserve or enhance independence or slow/reduce the loss of independence when the person has a progressive medical condition
- The activities are provided consistent with the stated preferences and outcomes in the individual support plan
- The activities are provided concurrent with the performance of ADL, IADL, and health related tasks as described in the earlier section
- Training and skill maintenance activities that involve the management of behavior during the training of skills, must use positive reinforcement techniques

- The worker must receive training about appropriate techniques for skill training and maintenance activities. This training must also include instruction about unallowable techniques for skill training and maintenance (e.g., procedures involving techniques considered to be aversive or to involve resistive redirection)
- Companion service activities may be provided to maintain or address needs in the areas of socialization, community integration, personal safety, or activities designed to provide cognitive stimulation.

Proposed Service Description

Skill training and maintenance include activities designed to result in the acquisition of new skills, reacquisition of skills, and preservation of skills necessary for ADLs, IADLs, and health related tasks. For example, individuals may need to learn new skills or to relearn lost skills after a medical event (e.g., severe injury or stroke). Skill training and maintenance activities provided under CFC and State Plan HCBS do not include therapy (e.g., occupational, physical, communication therapy) or nursing services that must be performed by a licensed therapist or nurse, but may be used to complement therapy or nursing goals when authorized and coordinated through the support plan. Companion services may also be provided under this service as a means to maintain or address needs in the areas of socialization, community integration, personal safety, or activities designed to provide cognitive stimulation.

3. Back-up Systems or Mechanisms

Emergency Response Systems

Proposed Policy

CFC and State Plan HCBS cover back-up personal emergency response systems or mechanisms designed to ensure the health and welfare of the individual and must meet the following conditions:

- The need for services has been determined through the assessment process and has been authorized as part of the individual support plan
- The service is for the sole benefit of the individual
- The service is designed to preserve or enhance independence or slow/reduce the loss of independence, or to ensure the health and welfare of the individual

Proposed Service Description

Back-up systems or mechanism may include personal emergency response systems or other back-up systems/technology approved by the state. The back-up system or mechanism must be designed for obtaining assistance, and must be tailored to the individual's health and safety needs and mobility limitation.

Emergency Support for Unplanned Absence of Unpaid Caregiver

Proposed Policy

Supports may be provided to a participant in the event of the unplanned absence of an unpaid caregiver. Back up support may be provided under the following conditions (all conditions must be met):

- Emergency Support services are described and authorized as part of the support plan, or are approved by the Support Plan coordinator within 3 business days of an emergency event.
- Emergency Support services include one or both of the following activities:
 - Assistance with ADLs, IADLs, or health related tasks; or
 - Acquisition, maintenance or enhancement of skills necessary to perform ADLs, IADLs, or health related tasks.
- There is a need for one-time emergency supports due to the sudden, unexpected loss or absence of an unpaid caregiver. Emergency supports may not be performed simultaneously with providing other CFC or State Plan HCBS services and must be for the express purpose of replacing assistance provided by an unpaid caregiver.

Service Description

Agencies may provide replacement supports when the designated unpaid caregiver is not available to provide necessary support during a time in which CFC or State Plan HCBS is not scheduled. A CFC or State Plan HCBS worker may be designated to provide 1) assistance with ADLs, IADLs, or health related tasks or 2) skill training and maintenance activities when required for health and safety reasons. Reimbursement may include up to 8 hours on a one-time basis when there is a sudden, unexpected loss or absence of an unpaid caregiver.

Note: This service is not the same as developing a back-up for regularly scheduled CFC/State Plan HCBS workers who are unable to show up for their scheduled work. While the support plan should address what will happen if a scheduled worker is unavailable, the Back-up Support services are intended to cover the duties performed by an unpaid caregiver during an unplanned absence. If an unpaid caregiver is likely to be unable to resume supporting the Participant for some time or beyond the eight hours covered for emergency, the situation should be treated as a change in status with a corresponding change in the support plan.

4. Goods and Services

Proposed Policy

CFC/State Plan HCBS may cover the costs of goods and services designed to enhance independence when those goods or services meet the following conditions:

- The goods or services replace the need for human assistance or increase independence in areas of need identified in the assessment process
- The goods or services are authorized in the individual's support plan
- The goods or services are for the sole benefit of the individual

- The goods and services are consistent with the stated preferences and outcomes in the individual support plan

Proposed Service Description

Services and goods must help to increase or maintain independence, benefit the individual, and replace the need for human assistance. Individuals may use up to \$3000 per year from their service budget for the purchase of goods or services.

Goods and services must be used to meet ADL, IADL, or health related needs identified in the assessment or to increase independence in performing ADL, IADL or health related tasks. Purchases may include items or services from retailers, organizations, or businesses available to the general public. Purchases may also include environmental modifications.

Participants are allowed a great deal of flexibility in selecting goods and services that fit their needs and living situation. These purchases can be for maintaining or increasing independence in the home or in the community, including opportunities for greater community inclusion. The range of goods/services that might assist Participants will vary substantially; therefore the State will not adopt a definitive list. However, the purchase of goods and/or services must be tailored to the individual circumstances of the Participant and address goals identified in the Support Plan.

Examples of goods and services that could be obtained include purchases such as: home appliances (e.g., microwaves for reheating food prepared ahead of time), paying for a grocery delivery service instead of depending on a worker to perform food shopping, non-medical transportation, or technology and environmental changes that allow the person to be more independent (e.g., alarm systems to warn another about wandering behavior, grab-bars or ramps, safety devices to prevent stoves from being left on, motorized cart to help with mobility). The examples mentioned here are illustrative and are not meant to be an all-inclusive list.

Some items cannot be purchased with CFC/State Plan HCBS funds. Items or services not allowed include the following:

- Drugs or alcohol
- Firearms
- Items or services person is otherwise eligible to receive under Medicaid
- Items or services covered under Medicare (if person is on Medicare)
- Experimental treatments
- Room and board
- Special education services
- Services provided under the Rehabilitation Act
- Medical supplies and equipment that can be paid for under the regular Medicaid State Plan services

Environmental modifications may be paid for outside of the Participant allocation for CFC when approved by the State and within limits prescribed specifically for environmental modifications (e.g., current Waiver limits). Participants in State Plan HCBS will also be able to purchase environmental

modifications, but the purchase must come from their State Plan HCBS amount. These special conditions on environmental modifications are discussed in more detail as part of Chapter IV. The difference in how the State will treat costs related to environmental modifications has to do with moving existing Waiver services (for people meeting institutional level of care) under the CFC program.

The proposed process for paying for these goods and services is discussed in Chapter IV.

5. Voluntary Training for Hiring and Managing Workers

Participants using traditional agency services play a role in selecting their workers and are responsible to direct worker activities and Participants using the “agency with choice” model maintain joint employer responsibility with the CFC agency. To prepare Participants to fulfill these roles, the CFC rules require voluntary training to the Participant about his or her responsibilities and rights as a joint employer (if using agency with choice) and managing activities of the worker as described below.

Proposed Policy

All individuals receiving CFC or State Plan HCBS would be offered voluntary training for hiring, managing, and dismissing CFC workers. Training will be designed to provide the individual with skills, resources, and tools for selecting skilled workers, directing worker activities, and evaluating the performance of workers so that CFC supports achieve the desired outcomes.

Proposed Service Description

CFC and State Plan HCBS cover training and assistance for the following topics:

- Employer responsibilities and employee rights
- Worker job responsibilities
- Training and directing CFC/State Plan HCBS workers in performance of duties
- Scheduling, monitoring, and verifying worker time
- Evaluations of worker performance
- Dismissing workers for poor job performance
- Wage and hour requirements

Note on Service Delivery

The preferred method of delivery is through the SDS training unit. Participants will be able to access training through a variety of means, including written materials, phone, web based, and other means. Training will be scheduled on a regular basis. Participants will only need to notify SDS or sign up for a session that fits their schedule and need.

6. Transition Services

Proposed Policy

CFC may cover the costs associated with transition from institution to community under the following conditions:

- Transition costs are necessary for a person currently residing in an institution to be able to move to a the community

- The person or his/her authorized representative desires assistance through transition services
- Transition costs are authorized in the plan for discharge and movement to community
- The community setting is one of the allowed settings for CFC
- The individual is projected to be discharged from the institution within 6 months

Proposed Service Description

CFC will cover costs related to one or more of the following:

- Travel, room and board to bring caregivers in from a rural community to receive training
- Trial trips to the home where the person will be living after discharge
- Rent and security deposits
- First month's rent and utilities
- Furnishings necessary to set up a livable home
- Two week supply of groceries
- Transportation to the person's new home
- Temporary payment of a worker to learn necessary skills for providing CFC services to individual
- Other items or services that assist the person to transition from institution to the community if preapproved by SDS

Transition Services do not cover:

- Nonessential items, such as televisions, radios, CD or MP3 players, etc.
- Down payment or purchase of a home

The proposed process for paying for transition supports is presented in Chapter IV.

Eligibility

ACC Eligibility Process

The proposed ACC plan includes developing a unified assessment process that will determine program eligibility for all Medicaid-funded HCBS. This should be a seamless process from the perspective of individuals seeking services. The State would still use the CAT for determining functional eligibility for ACC programs (and/or the ICAP for individuals with intellectual disabilities), but the process would be streamlined so that the in-home assessment collects all the information necessary to determine eligibility for ACC programs.

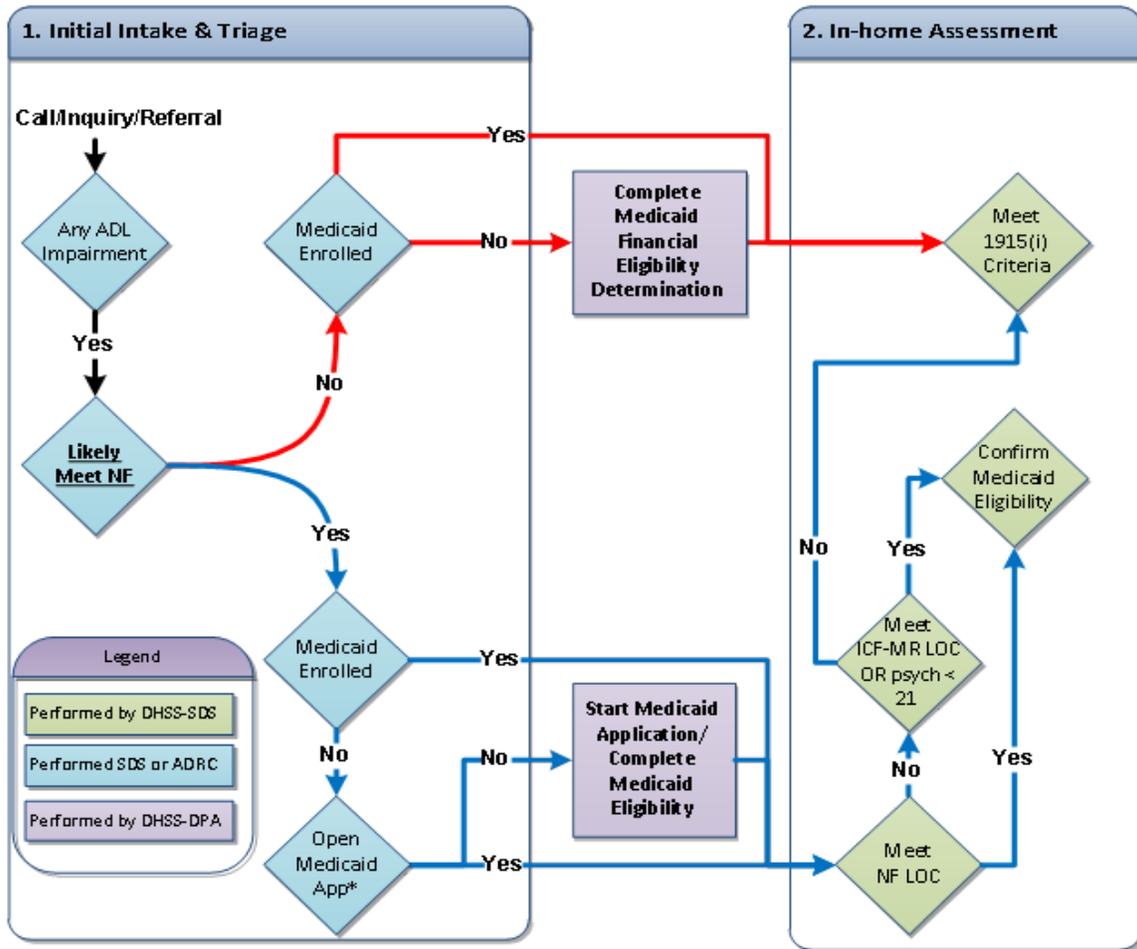
Exhibit 3 portrays the proposed eligibility determination process. The initial intake and triage process will help to determine whether the individual already has Medicaid eligibility and are potentially eligible for any ACC support, which would lead to an assessment. Once the in-home assessment is complete, eligibility for ACC programs would be determined and communicated to the individual.

The screen will also make a preliminary assessment regarding whether someone might meet an institutional LOC. Because individuals who meet LOC can potentially qualify for Medicaid with higher incomes, it is often necessary to have the functional eligibility determination completed before the Medicaid financial eligibility determination process can be completed. Thus, the SDS would require that

the Medicaid financial eligibility determination be completed only for individuals who are not likely to meet LOC. For other individuals, SDS would only require some evidence that the Medicaid financial eligibility determination process has been started (but not completed). Thus, for Participants potentially meeting LOC, an assessment can be scheduled if any of the following conditions have been met:

- A Medicaid application has been filed.
- A Participant is receiving General Relief
- A Participant is in the process of establishing a Miller Trust
- A Participant has been referred to SDS by either child or adult protective services.

Exhibit 3: Proposed ACC Eligibility Process



*Also if on GRA, Establishing Miller Trust, or Referred by Protective Services

Proposed ACC Eligibility Criteria

As stated earlier, as part of the shift to CFC, SDS recommended and the CFCC supported a change in the functional eligibility criteria that applies for the current PCA program. The current PCA program allows any Medicaid participant requiring hands-on assistance from another person with any ADL or IADL to receive PCA services. Before the publication of the final CMS CFC rules, the plan was to allow anyone who needed hand-on assistance or supervision *or* cueing with two or more ADLS to be eligible for CFC.

While the proposed change would exclude individuals who *only* require hands-on assistance with IADLs, such as shopping and meal preparation, it would allow individuals who only require supervision or cueing, such as those with Alzheimer’s Disease and Related Dementias (ADRD) or brain injuries, to qualify. Individuals only requiring IADL assistance would be referred to grant funded programs, while more individuals with ADRD or brain injury would receive Medicaid-funded HCBS.

The publication of CMS’ final rule for CFC that limited the option to individuals, who meet an institutional LOC, meant that a substantial portion of the existing PCA Participants and proposed Participants under CFC could not be included in CFC. Thus, as discussed in the last chapter, SDS is proposing to create a State Plan HCBS option that would cover individuals who do not meet LOC, but do need hands-on assistance, supervision, or cueing with two or more ADLs.

It is important to note that because of federal regulations, HCBS Waivers and/or CFC will be able to qualify for Medicaid at higher incomes than Participants enrolled in State Plan HCBS. Individuals who meet an institutional LOC and can therefore qualify for a Waiver can be eligible for Medicaid if their income is at or below an amount that is equivalent to 300% of the Supplemental Security Income (SSI). Individuals who meet the State Plan HCBS criteria, but do not meet LOC, must qualify for the regular Medicaid program and have countable income that is less than or equal to 150% of the federal poverty level (FPL).

Participant Living Arrangement

States allow for a broad array of living arrangements under their home and community based programs. In recent years CMS has been working to develop a common definition in order to address concerns that some arrangements may not meet the intent of home and community based services (e.g., size, location, participant control over routine).

The draft federal CFC regulations originally contained definitions of excluded settings. If individuals live in one of these settings, they would not be eligible for CFC funded supports. In the final rule, CMS elected to postpone the inclusion of these draft provisions. The rationale given by CMS for this decision is that CMS will be adopting new definitions for home and community services in the near future. These new definitions will apply to CFC, State Plan HCBS, and 1915(c) Waiver services. CMS indicated during a conference call with States, that States implementing CFC prior to the adoption of the living arrangement regulations will be given time (e.g., one year) to transition to the new requirements.

Excluded living arrangements generally encompass arrangements that are institutions, attached to institutions or congregate on the basis of disability. Many of these arrangements are managed by providers already receiving reimbursement to provide attendant type services, similar to what would be provided under CFC/State Plan HCBS.

Alaska currently excludes certain settings for providing PCA services. In order to proceed with CFC/State Plan HCBS, Alaska will need to define the settings in which people can reside and receive supports paid through CFC/State Plan HCBS. Based on our general understanding of the direction CMS is taking, the existing PCA provisions are likely to meet most, if not all, of the new CMS definitions. Therefore, it appears to make sense to apply the current exclusions to CFC and State Plan HCBS. The definition is described below.

DEFINITION:

CFC and State Plan HCBS will not be supplied to individuals in settings defined in Alaska Administrative Code, Title 7, Section 125.050(b). These excluded settings include:

1. A licensed skilled or intermediate care facility or hospital
2. A licensed intermediate care facility for the mentally retarded
3. A foster home licensed, except for recipients in a licensed foster home who are receiving residential habilitation services
4. An assisted living home
5. A residence where personal care services are already paid in a contractual agreement
6. A general acute care hospital

Service Models

The federal CFC regulations allow states to select one or more service models when offering CFC. The service models include agency, self-directed, cash, and voucher models. To help facilitate the decision about the service model(s) to adopt in Alaska, the state worked with us to review critical considerations including:

- current PCA/CDPCA infrastructure;
- operational process changes required by the new models;
- an analysis the likely impact of adopting new models at this time; and,
- how each of the allowed service models matched up with the objectives of the state.

Based on an assessment of the above factors and the desire to maintain core components of the current PCA program, including the CDPCA option, the state elected two variations of the agency model: a traditional agency model and an “Agency with Choice” model. The CFC rule defines the agency model as: *a model in which entities contract for or provide through their own employees the provision of services and supports, or act as the employer of record for attendant care providers selected by the individual participant.* The CFC agency model definition aligns well with both the existing PCA and CDPCA program. This decision will limit the administrative burden on the state and create the least amount of disruption to the current arrangements for providing services.

Traditional Agency Model

The traditional agency model under CFC/State Plan HCBS will be very similar to the traditional agency model currently used in Alaska for PCA. In this model, the Participant chooses an agency to provide supports. The agency is the sole employer of the worker and is responsible to hire, fire, and manage the schedule of its workers. CFC regulations specify that the individual must be allowed to have a significant role in the selection and dismissal of the providers of their choice, for the delivery of their specific care, and for the services and supports identified in their person-centered service plan. The Participant also directs the day to day activities performed by the worker while the worker is with the Participant and may be asked to provide the agency with feedback about satisfaction. However, the Participant does not have the ultimate authority to hire or fire individual workers.

The attractiveness of this model for many participants is that it does not require the Participant to manage workers. Also, worker scheduling and issue resolution can be managed by the agency. On the other hand, some individuals want more direct control over the scheduling and management of individual workers. For these participants, the agency with choice option may be more attractive.

Agency with Choice

The “Agency with Choice” is another variation of the agency model as defined by CFC regulations. Agency with Choice is similar to Alaska’s CDPCA option, with some important distinctions. Agency with Choice allows the provider agency and a Participant to share employer responsibilities. For example, the Participant may identify a worker to be hired and the agency will ensure that the worker meets minimum requirements (e.g., background checks). Participants generally will schedule and manage workers, direct their activities, and conduct performance reviews. Participants may also provide training and instruction necessary for workers to perform responsibilities, and approve/verify timesheets. The agency will perform payroll functions and file claims to the state for payment of services, and monitor for compliance with wage and hour laws.

The advantage of this model for many participants is that it provides considerable control of who performs support activities. It also allows many more people to participate in CFC, in that, frontier areas are not dependent on an agency being in close proximity. Agencies can be more regionally based because of the joint employer relationship.

Provider Qualifications & Training Requirements

It is important to note that under the federal requirements for CFC the state will be assuming greater responsibility for assuring the health and welfare of individuals enrolled in CFC than it currently does for individuals served by PCA. In addition, the draft federal regulations explicitly require the state to set minimum qualifications and training requirements for workers serving individuals under the agency model. Thus, while in developing the ACC plan, we maintained the core of the PCA provider qualifications and training requirements, we needed to supplement them to meet the more stringent requirements.

Provider qualifications include requirements necessary for an agency to enroll and receive certification as a CFC/State Plan HCBS provider. The State currently maintains a set of requirements for its PCA providers and will be adapting this basic set of Medicaid provider requirements to meet ACC needs. Examples of basic Medicaid provider requirements include standards covering legal entity requirements (e.g., business license), organizational structure and management requirements, recordkeeping, etc. As a Medicaid provider, CFC/State Plan HCBS agencies will need to meet all relevant Medicaid requirements in order to maintain standing as an enrolled CFC/State Plan HCBS provider. A second level of requirements concerns specific requirements relating directly to the service provided.

The existing PCA/CDPCA program standards treat agency and CDPCA workers differently. Traditional PCA agency workers must meet a set of specific State-set training requirements. CDPCA workers only need to have training in first aid, CPR and must successfully pass a background check. Other training for the CDPCA worker is specified by the individual participant. Because under CFC, Agency with Choice is considered by CMS to be another version of the Agency model, submitting a CFC plan that included only

the requirements for the current CDPCA model could be problematic. Therefore, under the ACC proposal, the State is proposing to make the standards for both the models more similar (though not identical).

In developing standards it was important to consider that Alaska has some unique challenges in implementing a set of qualification and training standards. Training access and the availability of workers are especially challenging in rural and frontier areas of the state. The State worked with the CFCC to try to find a balance between the need to ensure worker competency and concerns that the standards would affect the ability of providers and Participants to find workers. *Exhibit 4* provides the proposed standards and training for agencies and workers under both CFC and State Plan HCBS. These standards are not being applied to Waiver services at this time. The proposed standards included below were modified substantially based upon the input from members of the CFCC and we would anticipate that they would continue to evolve as the details of each component are developed.

In *Exhibit 4* requirements are described along the following dimensions:

- Required versus tailored: Some requirements or training are required for workers supporting all individuals, while others only apply to Participants who have a relevant need (i.e., “tailored”). When a training module is categories as tailored and the assessment indicates that training area may be relevant to the Participant (e.g., the basic nutrition and meal preparation model would be triggered for Participants assessed as needing support with meal preparation), the worker must receive this training under the Traditional Agency model. If a Participant selects the Agency with Choice model, the Participant may choose whether to have the worker take the State provided training, provide the training him or herself, or deem that the training is not necessary. However, SDS may require State-sponsored training if a demonstrated health and safety concern has occurred (e.g., a critical incident, emergency room or hospital visits) that is directly related to a worker not being properly trained.
- Timeframe for providing training: The exhibit also provides the proposed timeframe in which training must be provided, including: a) before the worker is hired; b) after hire, but before work is started; or c) at some point after the worker starts providing support

Exhibit 4: Proposed Qualifications and Training for CFC and State Plan HCBS

Requirement	Required or Tailored to Individual Need	Timeframe for Providing Training
Currently Required in Law/Statute (non-negotiable standards)		
Minimum age of 18		Before
Background Checks		Before
First Aid Training		Before unless Waived by SDS
CPR Training		Before unless Waived by SDS
Requirements		

Proposed Plan for Implementing the Community First Choice Option in Alaska

Requirement	Required or Tailored to Individual Need	Timeframe for Providing Training
Legal requirements such as record keeping program responsibilities, medical assistance fraud, waste and abuse, anti-solicitation and ethics (allowable marketing practices) and reporting of harm	Required	After hire but before starting care
TB testing	Required* *further work to be done in conjunction with ACC Advisory Council	Before
Pass the CFC-specific competency exam	Required* further work to be done in conjunction with ACC Advisory Council; some adjustments to be done in conjunction with voluntary training modules	Within 6 months of enrollment in Medicaid system or supporting a Participant with specific need
Confidentiality/data privacy (HIPAA)	Required	After hiring but before starting support of Participant
Critical incident reporting	Required	After hiring but before starting support of Participant
reporting to APS	Required	After hiring but before starting support of Participant
Person-centered principles/independent living philosophy	Required-after consultation with stakeholders on content	After—within 3 months
Assistance with self-administered medication	Tailored - Based on Participant Choice or demonstrated health or safety issues	After (a timeframe will be specified after training module is developed)
Practical knowledge of body systems, body mechanics, body disorders and diseases, and the observation of body functions	Tailored - Based on Participant Choice or demonstrated health or safety issues	After (a timeframe will be specified after training module is developed)

Proposed Plan for Implementing the Community First Choice Option in Alaska

Requirement	Required or Tailored to Individual Need	Timeframe for Providing Training
Understanding and working with children, the elderly, persons with physical or developmental disabilities, persons with communicable diseases, and persons with physical or mental illnesses	Tailored - Based on Participant Choice or demonstrated health or safety issues	After but prior to starting to work with Participant
Universal precautions; (i.e., infectious control precautions)	Required	After (a timeframe will be specified after training module is developed)
Bowel and bladder care	Tailored - Based on Participant Choice or demonstrated health or safety issues	After (a timeframe will be specified after training module is developed)
Basic nutrition and food planning and preparation	Tailored - Based on Participant Choice or demonstrated health or safety issues	After (a timeframe will be specified after training module is developed)
Practical skills and use of equipment necessary to perform tasks	Tailored - Based on Participant Choice or demonstrated health or safety issues	After (a timeframe will be specified after training module is developed)
Procedures for physical transfers, including emergency evacuation of physically disabled persons and non-ambulatory persons	Tailored - Based on Participant Choice or demonstrated health or safety issues	After (a timeframe will be specified after training module is developed)
Procedures for taking blood pressure, temperature, pulse, and respiration	Tailored - Based on Participant Choice or demonstrated health or safety issues	After (a timeframe will be specified after training module is developed)
Fall prevention	Tailored - Based on Participant Choice or demonstrated health or safety issues	After (a timeframe will be specified after training module is developed)
Behavior management	Tailored - Based on Participant Choice or demonstrated health or safety issues	After (a timeframe will be specified after training module is

Requirement	Required or Tailored to Individual Need	Timeframe for Providing Training
		developed)
Skin integrity	Tailored - Based on Participant Choice or demonstrated health or safety issues	After (a timeframe will be specified after training module is developed)
Monitoring medication side effects	Tailored - Based on Participant Choice or demonstrated health or safety issues	After (a timeframe will be specified after training module is developed)
Death and dying	Tailored - Based on Participant Choice or demonstrated health or safety issues	After (a timeframe will be specified after training module is developed)
Communicating with medical providers	Tailored - Based on Participant Choice or demonstrated health or safety issues	After (a timeframe will be specified after training module is developed)
Proper Lifting Techniques	Tailored - Based on Participant Choice or demonstrated health or safety issues	After (a timeframe will be specified after training module is developed)

One area of considerable discussion was how to address the interests of the State to establish a standard set of training requirements/curriculum while also addressing the interests of Participants to determine the training needs of workers they direct. The State attempted to find a reasonable middle ground by allowing many of the training areas to be at the discretion of the Participant. One exception to this included situations in which there is an identified health and safety concern. The State asserted that in those circumstances, it must have the flexibility to require training.

While the Council agreed to work with the State to implement the specified training in the above table, members also indicated a need to continue efforts to build in additional Participant controls over training of workers.

Training Support Infrastructure

In order to make training of CFC/State Plan HCBS workers widely available, the State will need to develop an adequate training infrastructure. SDS recognizes that it is not reasonable to simply ask agencies to take on the entire responsibility for the new training requirements. The plan as proposed requires that the State and providers engage in a collaborative effort to ensure workers have the training and skills necessary to perform the activities required.

During the planning for CFC/State Plan HCBS, SDS initiated discussions about a potential working partnership with The Alaska Trust Training Cooperative (TTC), currently under the direction of Lisa Cobble. The Alaska TTC appeared to be “a good fit” for assisting SDS with building the training infrastructure needed to successfully implement CFC/State Plan HCBS.

The training cooperative has the following stated goals.

- **Goal 1** – Leading and partnering with training entities
- **Goal 2** – Brokering and facilitating non-academic training based on identified training gaps and provider need
- **Goal 3** – Utilizing tools that assist with training delivery

The result of these discussions was agreement to move forward with crafting and implementing a plan for training workers using the TTC. Two of the potential benefits of this approach include 1) many of the curriculum components can be standardized, helping to ensure worker access to the most up-to-date information in building skills and knowledge; and, 2) worker access to training can be improved through the use of multiple modes of training.

Modes of Training

Several modes of training were discussed for potential development.

- Web based training – This may include online presentation or self-guided training curriculum
- In-person training – This includes training available through sources such as the provider agency, Participant, certified trainers (e.g., first aid, CPR), community education (e.g., community college, adult education, or other), SDS or other recognized agents
- Independent study – This includes other alternative training approved for worker training

The State also wants to require some type of demonstration of worker competency. Preliminary plans call for the observation of the worker in completing critical activities necessary to meet the needs of participants. This observation may be performed by the provider agency. Other arrangements may also include participant evaluation of work performance.

Training Tracking

Early discussions with TCC also included the goal of building capacity to track worker training on a statewide basis. A training tracking system would allow the State and providers to document and verify that workers had met the training requirements. The system would also create a permanent record that could follow a worker when moving to a new agency. This could assist provider agencies by reducing retraining costs and by tailoring training to the correct skill level of the worker (e.g., more advanced training could be provided rather than repeating basic training curriculum).

Chapter III: Program Access

This chapter describes how individuals would access services under ACC, and details the model and proposed infrastructure in which individuals would access services. We define the process to include the following steps:

- **Initial request for supports and the collection of initial information:** The major purpose of this step is to determine if a full assessment should be done to establish program eligibility and/or whether referrals to other points in the service delivery system are warranted. Currently, intake is done primarily by private sector agencies and the emerging ADRCs. Although some agencies have developed their own intake and/or screening tools, the State does not have a uniform tool based on functional eligibility requirements.
- **Assessment and eligibility determination:** In addition to making a determination about functional eligibility for programs, this process also intersects with the Medicaid financial eligibility determination process and, in the case of PCA, results in the assignment of the number of hours of support. For Medicaid-funded HCBS, SDS staff currently performs this function using the Consumer Assessment Tool (CAT). This tool collects information about ADLs, IADLs, and other functional and medical needs.
- **Support Planning:** The next step involves the development of a plan, often called a Service Plan or a Care Plan, describing the supports an individual needs. SDS does not currently require the use of a standardized format for this plan. Agency staff and/or Waiver Care Coordinators develop this plan. Although some Care Coordinators do develop a plan for both PCA and Waiver services for Participants who receive both, SDS currently does not require this. Individuals participating in the Community Forums and the focus groups conducted during our 2008 work indicated that a lack of coordination of these plans is an issue.

As outlined in Chapter I, the final CFC rules have a number of requirements that will require changes to how individuals currently access Medicaid-funded HCBS. These changes include requirements for:

- A person-centered process
- Mechanisms for counseling individuals about their choices prior to enrollment
- The ability to freely choose from among available providers
- A process that informs Participants about the risks and responsibilities of self-direction
- A plan that includes individual goals and outcomes and supports designed to help achieve these goals
- A plan that addresses all support including unpaid supports
- Recording that supports in other settings were discussed
- Mechanisms for mitigating risk
- Mechanisms to prevent duplication with other services

- A back-up plan for all individuals enrolled in CFC
- Conflict-free assessment and support planning processes

Incorporating Person-Centered Principles into Systems Operations

CMS, AoA, and other federal agencies are directing states to make systems more person-centered and, as noted above, incorporating person-centered principles is a major component of the final CFC rules. Incorporating person-centered principles into systems operations involves making the following changes to the process for accessing supports:

- Active involvement of Participants in all phases of the process
- Identifying Participant strengths and preferences, as well as needs
- Respecting the traditions and customs of the Participant
- Establishing personalized goals and outcomes to maximize control and independence and having these goals drive the development of the Support Plan
- Developing supports that are customized to the Participants' goals rather than simply reflecting a limited list of set services.

While many agencies have made efforts to adopt person-centered processes and tools, there has not been an extensive State led effort. In addition, states need to continuously consider the impact of the structure of systems operations from a person-centered perspective as these systems evolve and changes are made. Thus, person-centeredness should be viewed as a direction, not a destination. It is important to recognize that a person-centered framework needs to be applied to all components of systems operations that impact the individual.

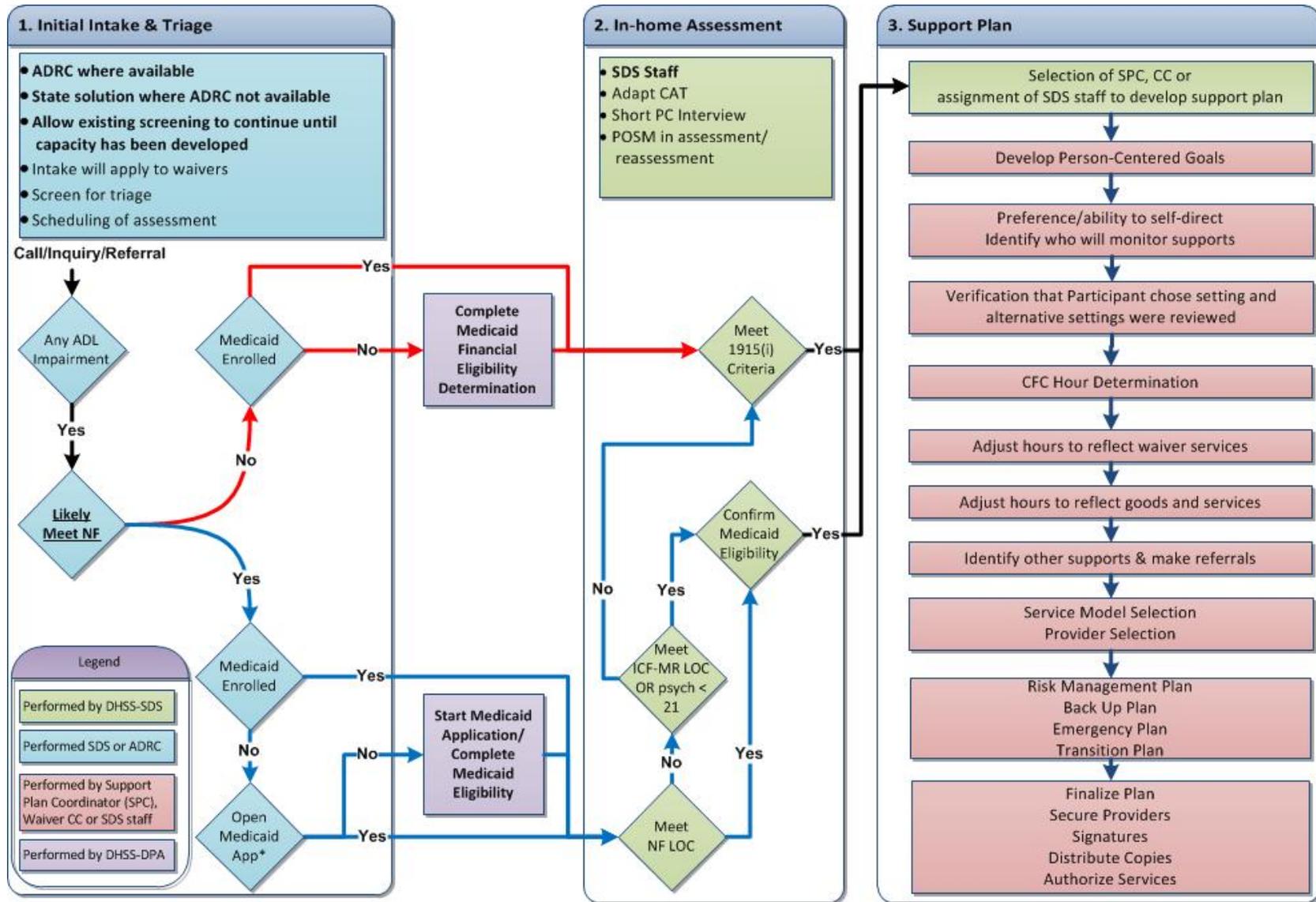
Overview of the Process of Accessing Alaska Community Choices

The proposed ACC effort attempts to integrate and transform PCA, which would be provided under CFC and State Plan HCBS, and the HCBS Waivers into an integrated program. The major goals of this effort are for Participants to be able to have:

- A single process to learn about all supports available to them.
- A single assessment protocol that determines eligibility for all services.
- One plan that outlines all of their supports

Exhibit 5 provides an overview of the process. *Exhibits 7* through *9*, which are placed later in the chapter, describe how this process may be altered to reflect whether an individual is enrolled in a Waiver and/or if the Care Coordinator is independent or agency-based.

Exhibit 5: Overview of the Process of Accessing HCBS Supports under ACC



*Also if on GRA, Establishing Miller Trust, or Referred by Protective Services

In *Exhibit 6*, we have broken down the process of accessing supports under ACC into three main activities:

- Intake & Triage
- Assessment
- Support Planning

Intake and Triage

Under the ACC effort, the State would apply a common intake and screening process for all Medicaid-funded HCBS. This process is consistent with a single point of entry/no wrong door system advocated by CMS and AoA. This type of a system is one of Alaska's goals that the State submitted to AoA as part of its ADRC five-year plan.

The ACC plan does not include requiring this process be used for nursing facilities or other LTSS, but Participants may be referred to these entities as part of the screen. We did not include this because it was not a necessary requirement for implementing CFC under the federal rules.

The majority of these intakes and screens would likely occur through a telephone call. However, some may be done in person, especially for populations that may be less likely to contact the State for supports (e.g., populations living in remote locations, non-English speaking individuals, etc.).

Under the proposed plan, ADRCs would be enhanced or expanded to support the intake and screening function. Because ADRCs are cataloguing available supports and building capacity to provide individuals with counseling about LTSS options, the ADRCs may be uniquely positioned to begin the process of supporting informed choice. If implemented, this process would likely increase the volume of calls and contacts for the ADRC and additional funding would likely be needed. However, because the ADRCs would be serving as the entry point for Medicaid-funded supports, their activities should be eligible for receiving Medicaid administrative federal financial participation (FFP), covering a substantial portion of costs. For example, Medicaid administrative FFP pays for more than one-third of the costs of the ADRCs in Wisconsin.

SDS will likely need to conduct initial screening and triage for some areas that are not covered by ADRCs or where the ADRCs have not built capacity. We recommend that SDS assign dedicated staff to fulfill this function.

During the Community Forums, providers made the argument that it would be very difficult for the ADRCs or the State to perform the outreach and screening to certain populations, such as individuals who do not speak English or live in remote areas. Based upon this input, the plan also allows for private sector entities to continue receiving reimbursement for screening in these situations. Under the proposed plan, the State and the ADRCs would work with the providers to determine what areas would benefit from the additional outreach and screening provided by other private sector entities.

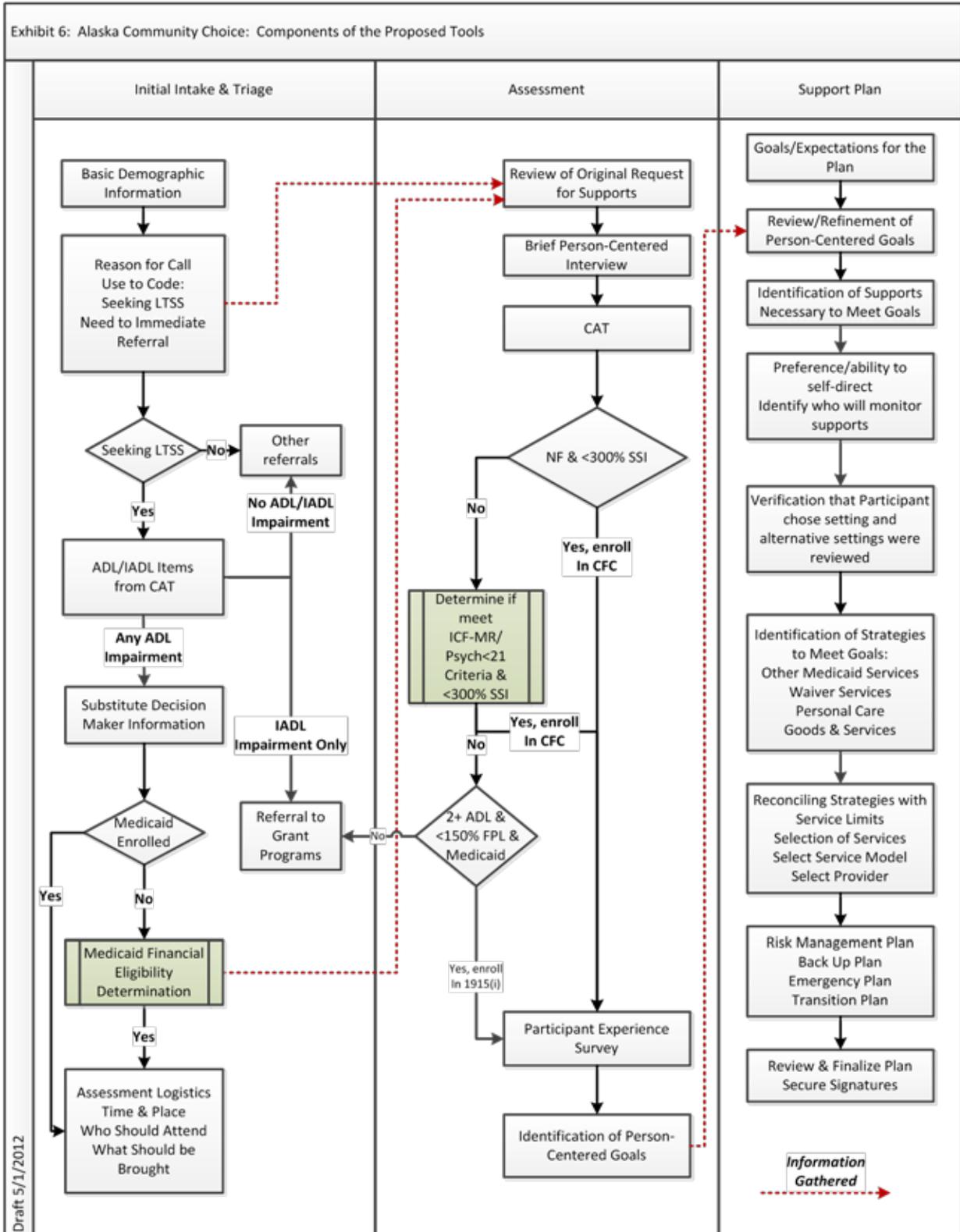
In order for the intake and triage to streamline the scheduling of the in-home assessment, the entity providing the screening should have the ability to set appointments for assessments. Achieving this goal for ADRCs and other private sector entities will likely be a logistical and technical challenge for SDS.

Careful consideration must be given to this issue during implementation. Additionally, the protocol should include an opportunity to talk with the individual about what to expect during the assessment and to provide a list of things that the individual should have ready when the worker comes to complete the assessment.

A common intake and screening protocol would be established. A draft version of this protocol is included as **Appendix C**. It is important to note that this version is a rough draft that has not been extensively reviewed by the State, nor has input been received from stakeholders. Thus, it should be viewed as a starting point or a potential example rather than a completed tool. The protocol included in this Appendix was developed based upon other similar screening tools developed for Maryland, Hawaii, and Minnesota. All entities performing screening would be required to use this tool to ensure consistency across the State.

Exhibit 6 presents an overview of the major components of the draft proposed intake and triage, assessment, and support planning protocols. The intake and triage protocol would help to differentiate among the following:

1. Individuals for whom there is no evidence of a need for support with either an ADL or IADL: These individuals would receive referrals to other supports if necessary.
2. Individuals who appear to need support with one or more IADLs, but do not require any assistance with any ADLs: These individuals would be referred to State-funded grant programs.
3. Individuals who may need support with one or more ADLs: An in-home assessment would be scheduled for these individuals.



For the last group, the proposed protocol differentiates between people who may potentially meet an institutional LOC for the following reasons:

- In these cases, a registered nurse (RN) would be assigned to conduct the assessment (in other cases, a RN would be preferred, but the actual assignment will depend upon SDS staffing). This is necessary because SDS requires that the Waiver LOC be established by a RN; Having a RN conduct the assessment will minimize the need to repeat the assessment if it is done by a non-RN.
- Because Participants who are enrolled in a Waiver can qualify for Medicaid at higher incomes than under the regular Medicaid program, the LOC determination must be made before the Medicaid financial eligibility determination can be completed, in some cases. Therefore, SDS will not require that the Medicaid financial eligibility determination process be completed prior to conducting an assessment for Participants who may meet LOC. However, one of the following must be met:
 - The financial eligibility determination process has been started,
 - The Participant is receiving General Relief (GR),
 - The Participant is in the process of establishing a Miller Trust, or
 - Either Child or Adult Protective Services has referred the Participant.

Assessment

Under the proposed ACC plan, SDS staff will continue to do assessments using the CAT. The major differences will be:

1. In most cases, a single assessment will determine eligibility for Waivers, State Plan HCBS and CFC.
2. A few additional modules will be added to the assessment. These modules are discussed below.

The effort to integrate assessments and screening process described in the earlier section should substantially reduce the volume of waiver assessments that SDS does. Currently, 33% of Older Adult Waiver and 39% of Adults with Physical Disabilities initial Waiver applications are determined to be ineligible. Some of the gains in saved staff time will likely be offset by the additional time it takes to complete the new modules. However, we are hopeful that these changes will ultimately reduce volume and allow assessments and eligibility determinations to occur in a timelier manner.

A major challenge in streamlining the eligibility process will be integrating the LOC determinations for institutions other than nursing facilities. While the CAT can be used to make a determination for nursing facility LOC and State Plan HCBS/CFC, a separate tool, the Inventory for Client and Agency Planning (ICAP) is used to establish whether someone meets the ICF-MR LOC. Verifying if someone meets the inpatient psychiatric for individuals under age 21 (LOC) could be met using information provided by the entity providing inpatient psychiatric services. Under the model, we propose to use a tiered approach that is similar to how the State approaches the TEFRA eligibility determinations for children who may qualify for Medicaid under several different LOC criteria.

Appendix D presents a rough draft of the proposed assessment under ACC. As was the case for the intake and screening protocol, this draft has not been extensively reviewed by SDS nor has input been

received from the CFCC (however, HCBS Strategies did present the models from other states on which the protocol is based to the Council). *Exhibit 6* identifies the major components of the proposed protocol.

To comply with the CFC requirement that the assessment must be person-centered, we have proposed starting the assessment with a brief person-centered interview. A workgroup that was supporting the Minnesota Department of Human Services' effort to build a unified comprehensive assessment strongly recommended starting the assessment process with a person-centered interview. They argued that one of the flaws of most assessment processes was that by the time the Participant was asked what he or she wanted, "the train had left the station and was arriving at the destination." Workgroup members pointed out that assessors typically started forming conclusions about what supports a person needed as they conducted the assessment. Because most assessment tools focus on identifying an individual's deficits, the tendency is to build a plan that focuses on addressing these deficits. The workgroup members thought that if the assessor asked what the Participant wanted at the beginning of the assessment, the assessor's thinking might change to consider both how to address deficits in addition to supporting the Participant in meeting her or his goals.

In the proposed protocol, the assessment would first begin with the assessor reviewing the original reason the Participant requested supports and then move into a brief person-centered assessment that is based on protocols used in Minnesota, Maryland, and Hawaii. This would then be followed by the current CAT.

The next proposed component is the Participant Outcomes and Status Measure (POSM) Participant Experience Survey. This is a tool developed by Mary James at the University of Michigan.¹ This is an empirically based tool with established reliability. The tool addresses domains that are likely to be relevant to the Participant, including:

- Availability of paid care/supports
- Relationship with support workers
- Activities and community integration
- Personal relationships
- Dignity/respect
- Autonomy
- Privacy
- Security

Incorporating the POSM as part of the assessment/reassessment process provides an objective way of collecting person-centered performance indicators. These indicators can be used on both the macro

¹ While the POSM does not require a license, a newer version of this tool has been copyrighted under the interRAI effort (see www.interRAI.org). To use this newer version of the tool, the State would need to develop a licensing agreement with interRAI.

(understanding how the system is performing) and micro (understanding how supports are working for a particular Participant) levels.

Under the proposed assessment process, SDS staff to work with the Participant and/or his or her representative to identify preliminary person-centered goals. Having SDS staff play this role should help ensure adoption of a person-centered approach to the assessment. In addition, it will put the staff in a stronger position to conduct a meaningful review of the final Support Plan.

SDS will need to establish capacity and aptitude among staff to conduct person-centered assessments. This change will likely occur over time and require periodic training of staff on person-centered planning.

Support Plan

The final CFC rules have large implications for the Support Plan process. According to these rules, the plan must be person-centered including supports that are driven by Participant identified goals. The rules also have several other requirements that are best addressed in the Support Plan process, to include ensuring that the individual chooses the setting in which they live, requirements for risk management, and backup plans.

The major components of the proposed Support Plan include the following (these steps are outlined in *Exhibit 6*):

1. The first step would be to clarify the goals and expectations for the plan. We envision this as a brief structured interview designed to ensure that the plan is consistent with the Participant's expectations. For example, the interview would ask the Participant to explain what differences he/she would like to see as a result of LTSS and whether he/she has particular preferences (e.g., traditions, culture, etc.) for how services would be provided.
2. The second proposed component is a review of other supports, such as unpaid caregivers the Participant has available to help. This component will help ensure coordination between formal and informal support needs.
3. Next, the Support Plan would identify the types of support that might be needed to meet a particular goal. In the proposed model, the Support Planning team would work to identify the general types of supports that a Participant needs to meet each of the person-centered goals. We have classified these supports into the following broad categories:
 - Personal assistance
 - Skill acquisition or maintenance
 - Caregiver support
 - Individual or caregiver training
 - Equipment/Assistive devices
 - Environmental modification
 - Referral

- Health Professional Monitoring
 - Professional Nursing Services/Skilled Therapies/Treatments
 - Behavioral Interventions
 - Home delivered Meals
 - Transportation
 - Adult Day Care
 - Other
4. The proposed plan includes a facilitated conversation aimed at assessing the Participant's preference and ability to self-direct and determining who will monitor supports. This effort will likely build off of SDS' current processes, which examine whether the individual has a cognitive impairment that may limit her or his ability to participate in CDPCA without a representative. This process will need to balance the program goal of maximizing the ability of Participants to self-direct with the need to assure health and safety and prevent fraud and abuse. (See proposed policy language contained in Chapter V.)
 5. The CFC rules explicitly require a verification that the Participant chose the setting in which he or she is living and that other settings were reviewed. We have not seen components of other Support Plans that explicitly do this and, therefore could be easily adapted for Alaska. However, we envision that the State could develop a brief structured interview that achieves this goal.
 6. The next step is to identify strategies and specific services to provide the supports identified in step 3. This process would consider unpaid sources of support as well as paid services. The Participant would also have the option of purchasing goods and/or services (see Chapter IV for more information on this).
 7. The strategies and specific services will need to be reconciled with limits on the types and amounts of services available through CFC/State Plan HCBS and/or a Waiver. In many cases, there may not be a paid or unpaid source of support available and this need would be categorized as "unmet." Collecting information about unmet need will be important to: a) inform a risk management plan so that the Participant can make an informed choice and b) provide information about potential weaknesses in the current system.

We envision that this might be the phase in which it would make the most sense for the Participant to select whether personal care would be provided under the Traditional Agency or Agency with Choice model and select actual providers. However, in many cases, the Participant may choose to make this selection earlier in the process.

8. To comply with the CFC rules, the Support Plan would need to include a Risk Management Plan and Back-up Plan. From our perspective working with other States, we believe that it is useful to break the Back-up Plan into two components: a) a plan for what will occur when the primary caregiver(s) are not available or do not show up and b) a plan for what will happen in the event of some sort of emergency (the two major categories being when a Participant is dependent

upon some sort of technology and power is lost and an emergency that requires relocating the Participant (e.g., fire or major earthquake). Because the proposed plan will also offer supports for a Participant moving from an institution to the community, we recommend including a Transition Plan module for these Participants.

9. The final step would be for SDS to review and approve the plan. The CFC rules require collecting signatures from all providers involved in implementing the plan, however, services should be able to begin upon SDS approval and not need to wait for signatures.

We have included examples of modules pulled from other state's Support Plans that correspond to these components as **Appendix E**. If the State is to move forward, these components could serve as building blocks for developing a draft Support Plan.

While we envision that in many if not most cases, a team will develop the Support Plan that is chosen by the Participant, there will need to be one individual facilitating this process. While the CFC rules stated that the individual facilitating the development of the Support Plan must be "conflict-free," in developing this plan, we recognized that many current Participants have Care Coordinators who are employed by provider agencies and many of these Participants would want the ability to choose to keep the current Care Coordinator. Thus, we have outlined three scenarios for the development of the Support Plan.

Exhibit 7 shows the proposed process for individuals who are not enrolled in a Waiver. While we envision that most of these individuals would be enrolled in State Plan HCBS, a portion may be in CFC (i.e., Participants who meet LOC but who chose not to enroll in a Waiver or cannot because a Care Coordinator is not available). The flow of **Exhibit 7** is very similar to that shown in **Exhibit 5** with the following modifications:

- Because the Participant is not enrolled in a Waiver, another individual, who we have labeled as Support Plan Coordinator (SPC), must facilitate the development of the Support Plan. We envision that this may be private sector individuals or agencies that are not connected to a personal care service provider (e.g., an independent Care Coordinator. The SPC may also be staff from SDS.
- The development of the Support Plan is simpler because the SPC will not need to consider the provision of Waiver services.

Exhibit 7: Proposed Plan for Developing a Support Plan if the Individual is Not Enrolled in a Waiver

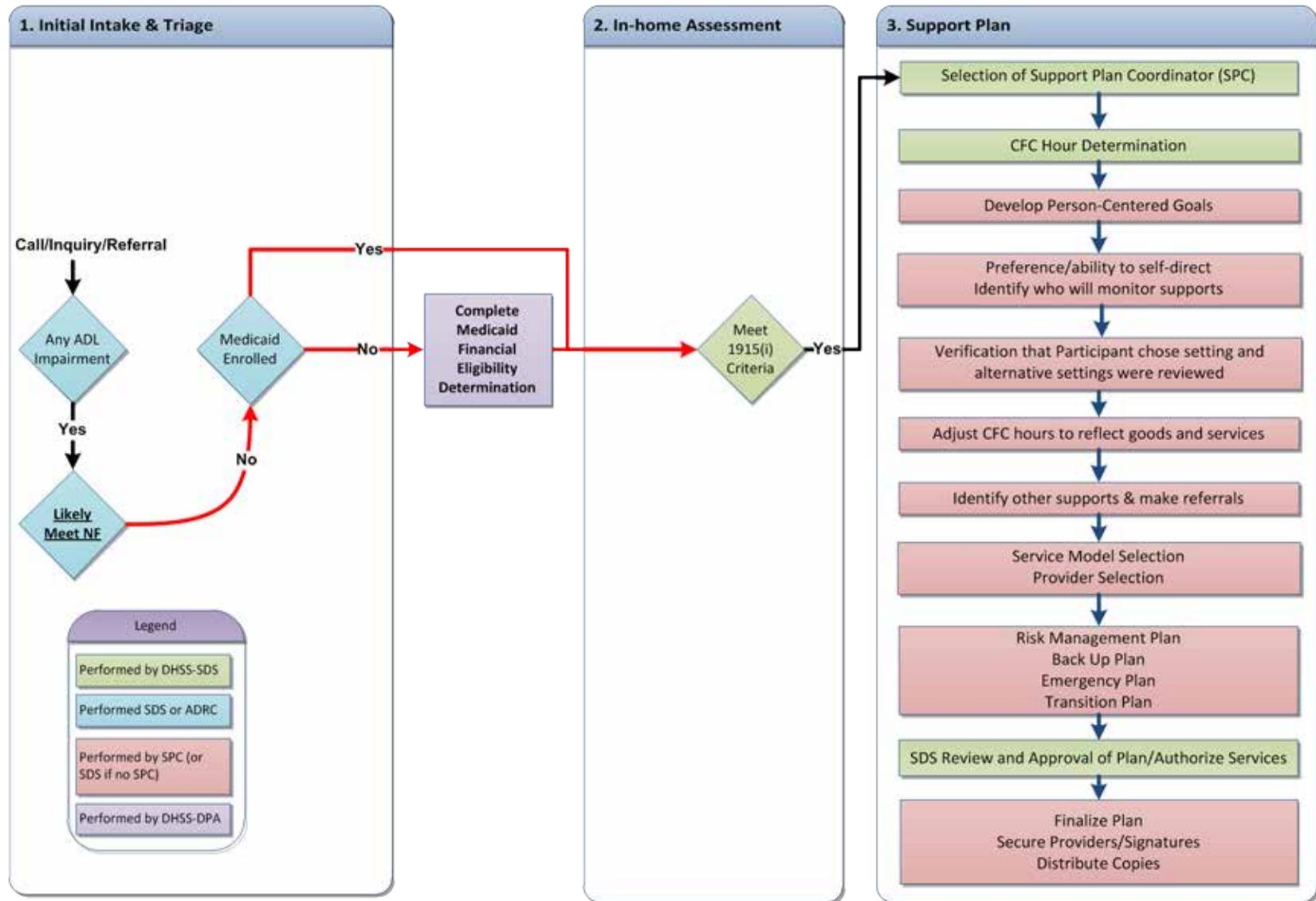
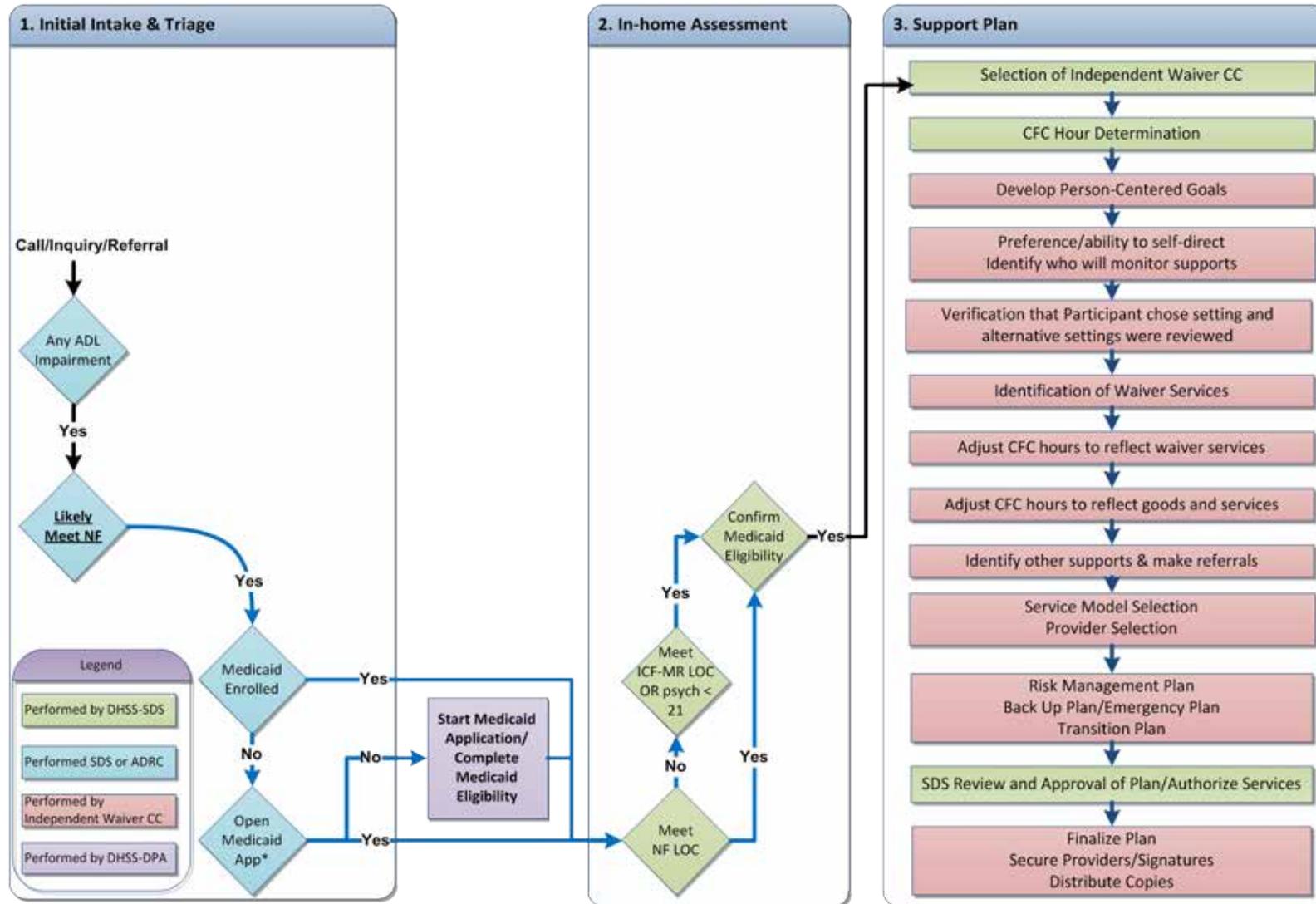


Exhibit 8 shows the proposed flow of developing a Support Plan for Participants who are enrolled in both CFC and a Waiver and have an Independent Care Coordinator. This process will be very similar to the process outlined in *Exhibit 5*.

Exhibit 8: Proposed Plan for Developing a Support Plan if the Individual is Enrolled in both CFC and a Waiver and has an Independent Care Coordinator



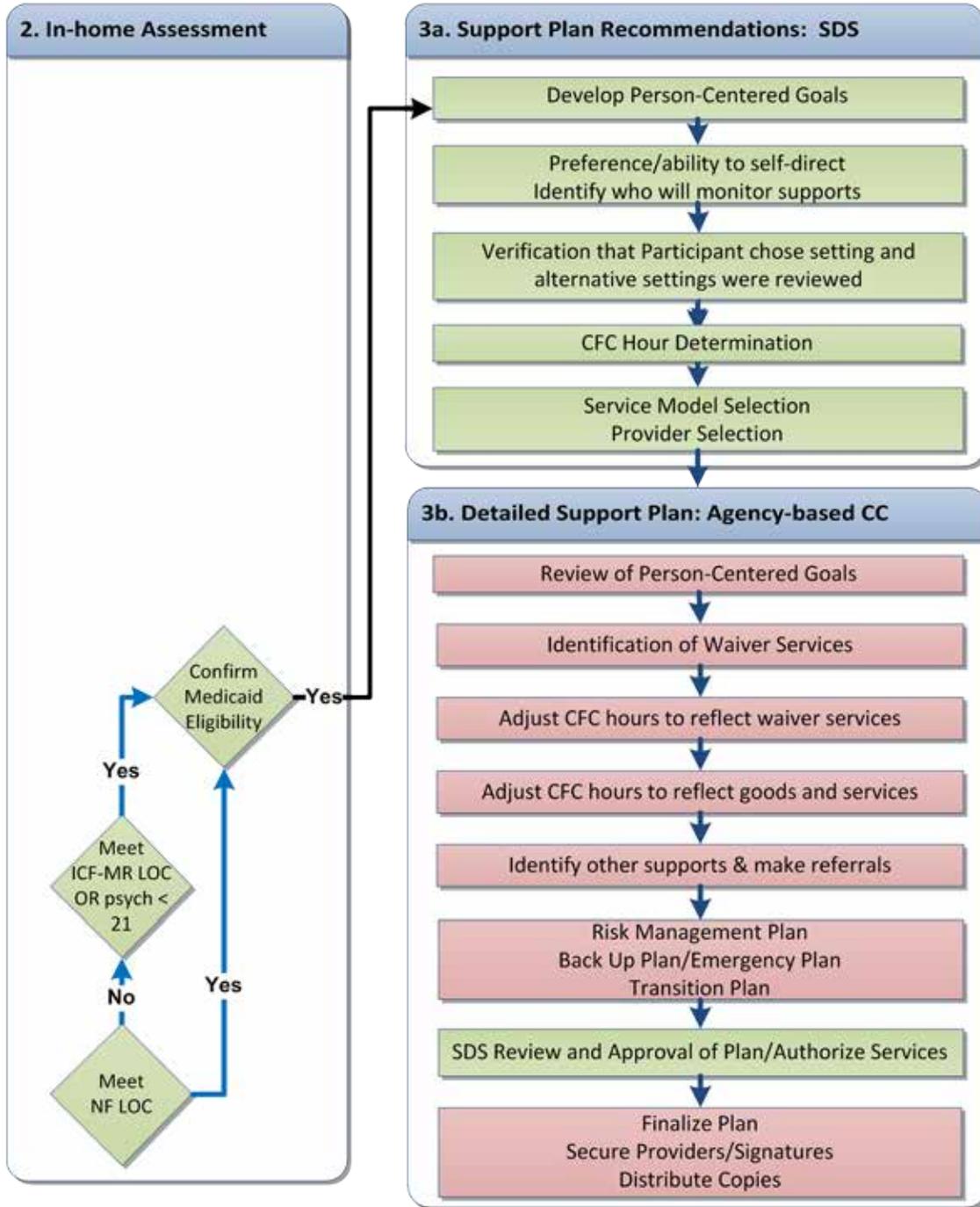
*Also if on GRA, Establishing Miller Trust, or Referred by Protective Services

Exhibit 9 presents the most complicated scenario. For Participants enrolled in both CFC and a Waiver who choose to have an agency-employed Care Coordinator, we have constructed a proposed process in which SDS staff would play a larger role in establishing person-centered goals and other key components of the proposed Support Plan that are most vulnerable to potential conflicts of interest. Thus, in this flow, we propose that SDS staff perform the following functions:

- Develop the person-centered goals
- Discuss the Participant's preference and ability to self-direct and who will monitor supports
- Verify that the Participant chose the setting
- Select the service model and service provider

The agency-based Care Coordinator would be charged with developing the core of the Support Plan. The proposed plan envisions that the Care Coordinator would start this process by reviewing the person-centered goals established by the Participant and SDS. The next step would be for the Participant working with the Care Coordinator and others on the Support Planning team to decide how goals will be met and to refine the goals if needed. When SDS staff review the final plan, a key component of that review would likely include comparing the original to the final goals, and the SDS reviewer may ask clarifying questions if there are major changes.

Exhibit 9: Proposed Plan for Developing a Support Plan if the Individual is Enrolled in both CFC and a Waiver and has an Agency-employed Care Coordinator



Chapter IV: Assigning Budgets and Hours

Under the ACC proposal, SDS proposes to maintain the current approach for assigning hours under PCA and the waivers to the extent practicable. The modifications will be to increase flexibility and comply with federal requirements.

Changes to the Approach for Setting Time under PCA

Currently, under PCA, individuals are allocated minutes of service based upon their assessed need using the Personal Care Assistance Level Computation (PCALC) formula developed by SDS. This formula considers ADLs (e.g., bathing, dressing) and IADLs (e.g., meal preparation) for which assistance is needed and the intensity of assistance needed as scored by the Consumer Assessment Tool (CAT). The methodology also assigns minutes for certain other tasks, such as sterile wound care, oxygen maintenance, and escorting individuals to appointments.

For ADLs, minutes are assigned if the individual is scored as needing limited or extensive assistance or being totally dependent. For IADLs, minutes are assigned if the individual is classified having difficulty performing a task independently. For both ADLs and IADLs, more minutes are assigned for greater dependency.

It is important to note that under the current methodology minutes are generally not assigned for ADLs for which an individual only requires supervision or cueing and does not require any physical assistance.² Individuals only requiring cueing or supervision with an IADL would be scored under the "Assistance/Done with Help" category, which falls in the middle in terms of the number of minutes assigned.

Because the new ACC eligibility definition allows individuals who only need supervision and cueing to be eligible for ACC supports, it will be necessary to modify the approach to assign time related to ADLs for individuals who only require supervision and cueing. We have proposed treating scores of supervision or cueing on an ADL the same as if the individual had scored as needing limited assistance.

Currently, under PCA, hours are assigned on a weekly basis so that hours that are not used within a particular week are not available in the next week. To increase flexibility under AAC, another proposed change is to allow Participants to hold in reserve a certain number of their hours so that they have this time available to compensate for when unpaid caregivers may not be available. For example, adult children who keep a parent in her home by combining ACC hours with their own unpaid time could use this reserve to provide greater support when they planned to take an annual vacation. Likewise, reserve hours could also be used when an unpaid caregiver is sick.

It is important to note that SDS has had limited capacity to ensure that hours are used within the proscribed timeframe within PCA. Thus, some Participants may have been shifting hours across time periods, unaware that this was in violation of program policies. SDS has been working on strengthening its MIS so that it can be able to detect and potentially not pay claims that are in violation of SDS policy.

² The current methodology does allow assignment of a limited number of minutes to assist supervision of eating or taking medication if chewing or swallowing issues are identified in the assessment.

The proposed change under CFC and State Plan HCBS formally allows individuals to “bank” some hours and defines the condition of that banking. This will allow individuals to have a reasonable amount of freedom to shift hours and ensure that all Participants can take advantage of this flexibility without violating program rules.

We propose that individuals be able to bank up to 10% of their hours within any plan year. Unused banked hours will not rollover into the next plan year.

We recommend that the amount of hours to be banked and the plan for using these hours be incorporated into the Support Plan. However, Participants should be able to modify these plans without needing to update the Support Plan.

SDS will need to ensure that its prior authorization system can track both the base number of hours and the carry over hours.

Changes to the Approach for Allocating Waiver Services

Alaska’s HCBS Waivers provide a range of services that can broadly be put into three buckets: 1) Care Coordination; 2) Supports in residential settings/Assisted Living Facilities; and 3) Supports that help individuals remain in their own home or the home of a family member. All Waiver Participants receive Care Coordination. Waiver Participants in Assisted Living Facilities are generally not eligible for the home-based supports or PCA.

Waiver Participants who are not in an Assisted Living Facility (typically they are living their own home or with a family member) are eligible for a number of waiver services. It is important to note that none of the Waivers covers personal care because the State assumes a Participant will receive this through the PCA program. However, there are a number of Waiver services that potentially overlap with PCA, including:³

- Day Habilitation
- Chore
- Respite
- Meals
- Specialized Private Duty Nursing
- Adult day services
- Shared-care services
- Supported-living services

These individuals may also be eligible for other Waiver services that are more clearly delineated from PCA, including:

- Supported Employment
- environmental modifications
- intensive active treatment

³ Actual services differ somewhat by Waiver type.

- Specialized Medical Equipment and Supplies
- transportation
- Nursing Oversight and Care Management

It is important to note that SDS does not use an impairment based calculation to assign units of Waiver services as it does for PCA. Thus, for most services, individuals are assigned a number of hours up to a certain cap. In most cases, this cap is higher than the comparable number of minutes that would be assigned using the PCA formula for similar tasks (e.g., the number of chore hours would be greater than the PCA time assigned for housework and laundry IADLs).

SDS has been engaged in a process to prevent duplication of Waiver and PCA services and has been clarifying policies to better define what Participants who are enrolled in both a Waiver and PCA are eligible to receive.

CMS regulations for CFC require that a Support Plan prevent duplication of services. To meet this requirement, SDS will need to clarify these policies. Thus, in *Exhibit 10* we have included a proposed breakdown of how the computation of PCA and Waiver service will be adjusted to reflect the choice in service by the Participant.

Exhibit 10: Identification of Waiver Services that Potentially Overlap with CFC Supports and Proposed Changes to the PCA Time Calculation

Waiver Service	Potential overlap with CFC	Description of Potential Overlap	Current Restrictions/Limitations Related PCA	Implications for CFC Service Definition
Care Coordination (CC)	Y	Under CFC, Waiver CCs would have responsibility for developing a Support Plan that addresses both Waiver and CFC supports. This Support Plan would need to be person-centered and contain additional components, such as a back-up plan. This may increase the time necessary to develop a plan.	None. Individuals on PCA and a Waiver receive Waiver CC	The cost basis for the Plan of Care Development should be reexamined once an estimate of the amount of time necessary to develop the combined Waiver/CFC Support Plan is developed.
Day Habilitation	Y	Would be allowable under the CFC service definition	Cannot receive at same time as PCA	Adjust assignment of minutes under CFC to account for all ADLs and IADLs support that would be expected to occur when someone was receiving day habilitation.
Supported Employment	N			
Chore	Y	Would be allowable under the CFC service definition	Cannot receive PCA time for IADL assistance if receiving chore	Make sure only included on one funding stream.
Respite	Y	Would be allowable under the CFC service definition	Can have at same time, but no double dipping	Review of the Support Plan will need to examine the potential for double dipping, but no automatic reduction of CFC time.
Environmental Modifications	Y	May potentially be paid under CFC is included in person-centered plan and decreases need for hands on assistance or increases independence.	None	Require that if this service can be paid under CFC, CFC will be used. Will not count against hours.
Intensive active treatment	N			
Meals	Y	Should not pay for meals if paying for someone to make meals under PCA	None	Reduce meal preparation IADL from time for task
Residential supported living	N			

Proposed Plan for Implementing the Community First Choice Option in Alaska

Waiver Service	Potential overlap with CFC	Description of Potential Overlap	Current Restrictions/Limitations Related PCA	Implications for CFC Service Definition
Specialized Medical Equipment and Supplies	Y	Backup systems, other items related support plan	None	Require that if this service can be paid under CFC, CFC will be used. Will not count against hours under CFC.
Specialized Private Duty Nursing	Y	Determination of whether private duty nurse should also do PCA tasks	None	Adjust assignment of minutes to account for all ADLs & IADLs that would be provided when receiving service
transportation	N			
Nursing Oversight and Care Management	Y	Could be used for monitoring	None	May want to allow nursing oversight and care for individuals with complex medical needs.
Adult day services	Y	Should not receive as the same time as PCA	Can have at same time, but no double dipping	Adjust frequency to account for all ADLs & IADLs that would be provided when receiving service
Adult Family Habilitation Home Services	N			
Child family habilitation home services/Shared care	Y	Would be allowable under the CFC service definition	Can have at same time, but no double dipping	Adjust frequency to account for all ADLs & IADLs that would be provided when receiving service in a licensed foster home, except when a 2 person assist is required. Would need to be documented in Support Plan.
Supported-living services (18+)	Y	Would be allowable under the CFC service definition	Can have at same time, but no double dipping	Review of the Support Plan will need to examine the potential for double dipping, but no automatic reduction of CFC time.
Group-home Habilitation Services	N			
In-home support services-supported living	N			

Paying for Goods/Services

As part of the ACC effort, Participants eligible for either State Plan HCBS or CFC could potentially exchange a portion of their hours to pay for good and/or services that reduce the need for hands on assistance or increase independence.

These goods and services must meet the following conditions:

- The goods or services replace the need for human assistance or increase an individual's independence
- The goods or services are authorized in the individual's support plan
- The goods or services are for the sole benefit of the individual
- The goods and services are consistent with the stated preferences and outcomes in the individual support plan

Services and goods must help to maintain independence, benefit the individual, and replace the need for human assistance. Individuals may use up to \$3000 per year for the purchase of goods or services.

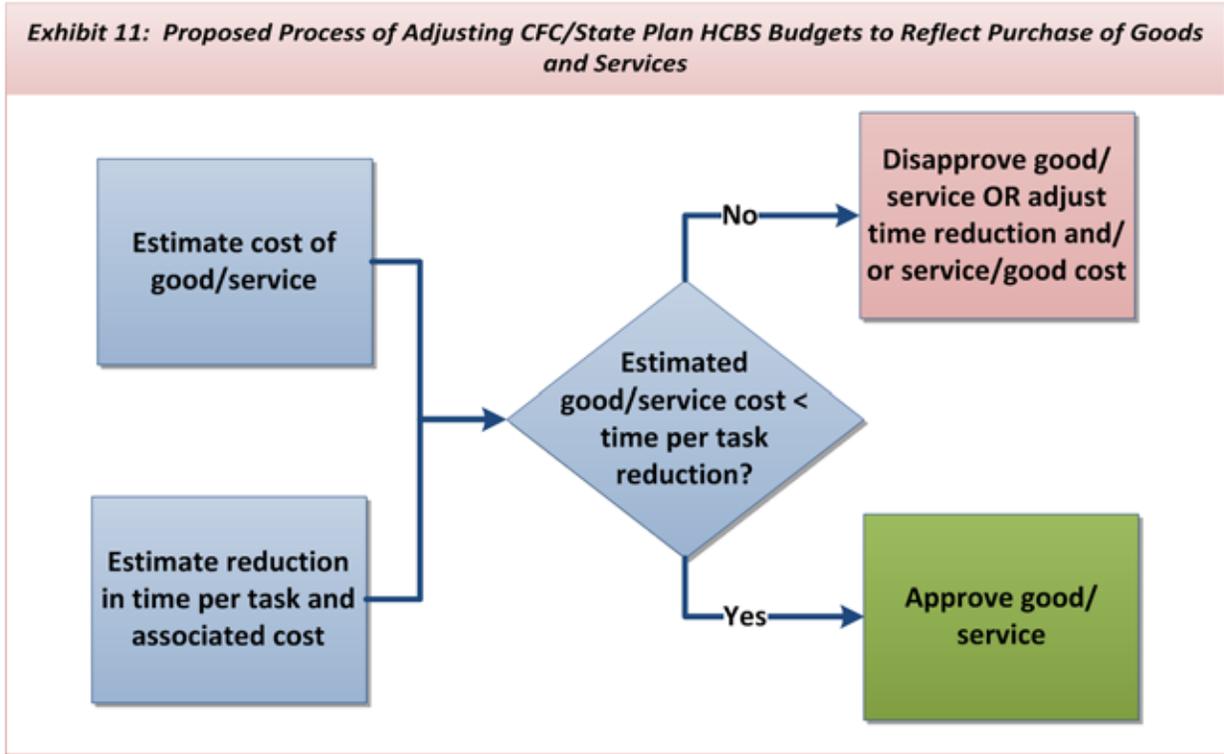
Goods and services must be used to meet ADL, IADL, or health related needs identified in the assessment. Purchases may include items or services from retailers, organizations, or businesses available to the general public.

Items or services not allowed under CFC include the following:

- Drugs or alcohol
- Firearms
- Items or services person is otherwise eligible to receive under Medicaid
- Items or services covered under Medicare (if person is on Medicare)
- Experimental treatments
- Room and board
- Special education services
- Services provided under the Rehabilitation Act
- Medical supplies and equipment

In most cases, the funds used to purchase goods and services must be paid for by reducing the number of hours of worker support the Participant receives under State Plan HCBS or CFC. However, environmental modifications and specialized equipment and supplies that meet all of the requirements identified above will not count against hours if the Participant is enrolled in CFC, but will count against hours if the individual is enrolled in State Plan HCBS. Thus, Participants who meet an institutional level of care (and are hence eligible for CFC and a Waiver) will receive an enhanced benefit that will be modeled after the current Environmental Modifications and Specialized Equipment and Supplies services included in the Waivers. Shifting these services from the Waivers to CFC will allow the state to obtain the enhanced federal match. It will also allow Participants who are not enrolled in a Waiver (such as those living in an area not covered by a Care Coordinator, but who meet an institutional level of care to receive these supports. The definition for these services under the Waivers will be amended to require that CFC be used to fund these supports if applicable.

Exhibit 11 portrays the process by which the number of State Plan HCBS or CFC hours will be adjusted to reflect the decision to purchase goods or services. Under this proposal, hours are translated into a dollar amount by multiplying the time by the hourly rate that applies for that particular individual.⁴



Participants may be able to make more of their hours available to convert to dollars to pay for goods and services if: 1) an argument can be made that the goods or services reduce the need for assistance or 2) an unpaid caregiver who will provide some of the hours that would have been provided by paid staff is identified. The individual assisting in developing the Support Plan and the SDS staff reviewing and approving the request to shift hours to pay for goods and services will need to consider whether the reduction in the number of hours may reduce the level of support to such a degree that it compromises the Participant’s health or safety. These determinations will need to be made on a case-by-case basis.

A key decision point in this process will be determining the timeframe over which hours are reduced to compensate for the costs of goods and services. Obviously, the cost for an ongoing service would result in a comparable ongoing reduction in hours. In other cases, this timeframe could be selected on a case-by-case basis. For example,

- Participants proposing relatively large purchases may choose to spread the reduction over the entire year to minimize the impact.

⁴ In some remote locations, individuals receive higher hourly rates. This may help offset higher costs for goods or services in these locations.

- If a cost is relatively minor, a Participant might wish to have the reduction be taken over a relatively short period of time.
- Some Participants may choose to take the reductions as large chunks of time that correspond to time periods in which friends, family or other unpaid caregivers are available. An example would be concentrating the reduction in hours in the summer months when an adult child who is a teacher has more time available to provide unpaid supports.

The plan proposes that the goods or services be purchased through the agencies providing State Plan HCBS or CFC supports. SDS anticipates that the agencies will be able to attach an administrative fee to the cost of purchasing these goods or services. This fee will be added to the actual costs of the goods or services if the good or service is counted against the Participant's budget. SDS will work with representatives from the provider community to determine the most appropriate structure for this administrative fee.

Paying for Transition Costs

CFC funds can be used for costs that are necessary to allow someone to transition from an institution, such as a nursing facility, to the community. Examples of these costs include furniture and rental deposits. SDS will base the parameters for this program on its state-funded nursing facility transition program. These funds would not count against the assignment of hours. (See service description in Chapter II, Program Framework.)

The process for paying for transition costs will be similar to the process used for the purchase of goods and services. Purchases will be managed through CFC provider agencies. The agency will issue purchase orders or otherwise arrange for payment based on an authorized plan. Transition purchases may occur prior to the Participant leaving the institution. The provider agency will oversee the purchase and delivery of the transition goods/services in a manner similar to what was proposed in the earlier section on the purchase of goods and services.

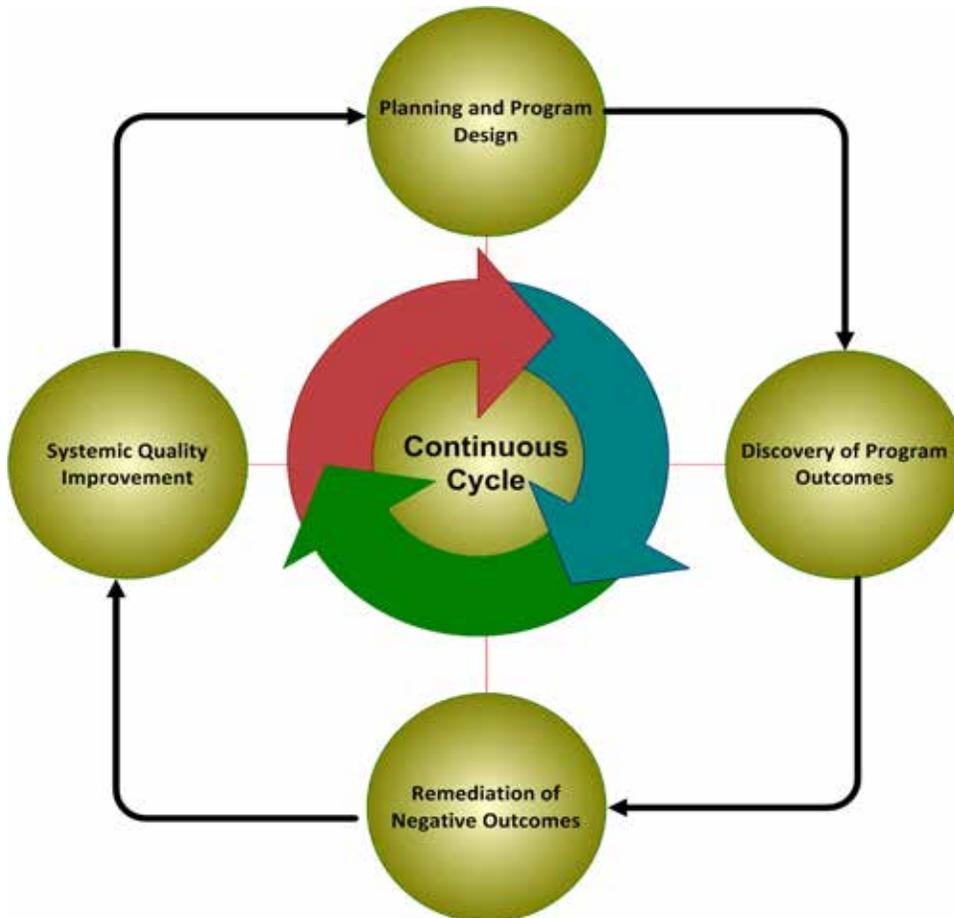
Chapter V: Quality Assurance

Overview of HCBS Continuous Quality Improvement Approach

As services offered under the HCBS umbrella grew in variety and flexibility, states needed effective strategies to assure quality related to individual needs, freedom to choose, health and welfare, and financial integrity. The Centers for Medicare & Medicaid (CMS) began to focus more attention to quality initiatives, requiring states to demonstrate discovery, remediation, and improvement processes sufficient to assure compliance with requirements in these areas. While states can still design a plan to work within individual state structures, the activities and strategies must fit within the context of the federal assurances.

As part of the state’s Medicaid State Plan submission for CFC and State Plan HCBS, Alaska must present a plan for how it will oversee and manage the quality of its services. Alaska’s quality strategy will be based on the continuous quality improvement process using the CMS federal framework for HCBS services. This process includes: 1) design; 2) discovery; 3) remediation, and; 4) improvement. *Exhibit 12* provides a diagram for how this looks.

Exhibit 12: Quality Framework



The *design* element of this continuous process includes defining what constitutes quality and sets a threshold for acceptable levels of performance in various outcome areas. Alaska has selected quality measures for eight areas:

- Intake and Triage
- Assessment and Eligibility Determination
- Support Planning
- Service Initiation
- Participant Experience
- Health and Welfare
- Provider Qualifications
- Program Integrity

In the *discovery* step of the quality process, Alaska defines how it will collect and report performance data in the selected areas. The strategy for data collection and aggregation builds off existing platforms, such as the DS3 system, critical incident reporting systems, the assessment process or other mechanisms used in the administration and oversight of services. Discovery will include organizing data to highlight areas of excellence and identify areas that require *remediation*.

The format selected for viewing performance under CFC will include a series of management reports tailored specifically for each partner of the system: SDS managers, assessors, support plan coordinators/care coordinators, and providers. The use of regular, tailored management reports constitutes an enhancement to Alaska's quality strategy, providing a powerful evidentiary tool on which to base actions for improving performance.

The final element of the quality process is *system improvement*. System improvement includes recognizing and building upon excellent performance. It also includes instituting tools and processes to assist all partners at all levels to be able to identify problems or excellence and to use the information to cause improved performance.

The following is a partial list of some of the proposed new tools and enhancements recommended for inclusion in the state's quality strategy:

- Clearly defined performance measures in eight quality areas
- Management reports to be issued on a quarterly basis
- Training tracking system available to provider agencies for documenting or verifying employee training
- Participant survey processes for collecting information about service outcomes and experience
- Standardized provider surveys for collecting Participant satisfaction information

Role of System Partners in Quality Management

The quality management strategy depends on the involvement of system partners. System partners include those HCBS system stakeholders who have influence on quality. Engagement at all levels is critical to home and community systems. Below we briefly discuss the role of the major partners.

The Role of SDS as a Medicaid Administrator in Quality Management

SDS is responsible to ensure system-wide quality by establishing the policies, procedures, and tools to track and communicate what is occurring within its services. This involves establishing performance measures, tracking performance and events, remediating problems discovered, and changing policies and/or procedures to support improved system-wide performance. Although SDS holds the responsibility for what occurs in a program, it accomplishes this through its partnerships with others, including other state agencies/units, providers, and participants and their families. Finally, SDS also has the primary responsibility to report data and discuss improvement strategies for programs.

The Role of Assessors and Support Plan Coordinators in Quality Management

SDS assessors and support plan coordinators have an important role and influence in the quality assurance system. It begins with assessing what the Participant needs for support in the home and community. Correct identification of needs and good support planning are important to the health and welfare of the consumer, and help determine whether a person can safely remain at home and retain his/her independence.

Assessors and support plan coordinators are also the eyes and ears of SDS to discover and remediate problems. Their biggest influence is directly at the consumer level through the evaluation of service effectiveness and consumer well-being, and reassessment of the situation when the status of an individual changes. They may also respond to and find solutions when a Participant has a complaint or reports a problem.

Having assessors and care coordinators as partners is important to assuring quality services at the system level as well. The information known to assessors and support plan coordinators provides essential data for remediating poor performance and improving the system. Assessors and support plan coordinators are in a unique position to help determine how well the policies and procedures of the program perform in adding value to the provision of services.

Role of Providers in Quality Management

Service providers represent “ground zero” for program success. Without good service providers, the program is unsuccessful. Provider agencies must maintain trained and talented staff capable of relating directly to Participants and their families. Ensuring high quality services that support the health and welfare of individual participants is a central function. Providers work to monitor and improve the performance of their agencies through various internal QA activities. These activities may include participant satisfaction surveys, peer review, complaint resolution, staff development planning, mentoring and supervision, and open communications with participants, families, and partner agencies.

Role of Participants and Families in Quality Management

Participants and families have an important role in assuring and influencing the quality of services provided. This is where quality is most personally experienced and where the difference in poor versus good quality dramatically affects the quality of life for an individual. Some of the most important things a Participant can do include becoming informed, being engaged, and speaking up about service provision. Individuals who actively participate in decisions are more likely to influence the quality of

their services. Active participation can sometimes be difficult, because people frequently seek services only after their situation has deteriorated. However, this is exactly when it is critical to be involved.

The updated quality plan addresses consumer involvement in several ways: consumer surveys and consumer reports about quality. SDS additionally will make reporting of events (incidents and complaints) more streamlined and efficient. The objective of this is to have the “system” be more effective and responsive in dealing with problems in a timely manner.

Using Performance Measures to Improve Quality

This section of the chapter discusses the critical components involved in a continuous quality improvement infrastructure.

Design and Discovery

A first step toward enhancing the state’s quality management approach is to establish a design that defines quality through a set of performance indicators and establishes a means to discover how well system partners perform. In this way, the indicators provide a way for the State to gauge how well the system performs and to take action when necessary.

The process to create a list of measures included a review of federal requirements, current state statutes/regulations, a review of existing resources in place for collecting data about performance, and a discussion of what the state needed and wanted to achieve. The creation of draft performance measures also considered the following.

- Measures should reflect critical aspects of the system (measure what is important)
- Measures should reflect a high but attainable standard of performance
- Each measure should have clearly defined threshold for when remedial action will occur (perfection is a rarity)
- Not all measures have to be implemented right away (consider phase-in over time)
- Existing systems and processes should be used for collecting data about the selected measures (enhance use of existing systems and processes, don’t start with having to build something new)
- Measures or thresholds of acceptable performance can be changed if needed

A complete set of draft indicators was developed. These draft indicators will be finalized prior to implementation with input from the Council. It is not necessary to apply all performance measures as part of the initial phase of the CFC/State Plan HCBS rollout. It makes sense to consider a phase in of measures and to add more as the state is able or identifies a need for a new measure. For purposes of this report, we include a summary of all of the draft indicators as ***Exhibit 13***.

Exhibit 13: Draft Performance Indicators

Intake and Triage

- ž All CFC enrollments come through triage process
- ž Percentage of intakes proceeding to assessment

- ž Percentage of individuals with ADL impairments verified in assessment
- ž All in-home assessments are scheduled within __ business day of screen.

Assessment

- ž All assessments will be completed within __ business days after screen.
- ž Individuals notified of eligibility for CFC within __ business days after assessment
- ž All CFC participants will be reassessed at least annually
- ž A review of assessed needs will occur within __ business days of a report of change in status.
- ž Scoring of CAT items will be consistent (95% inter-rater reliability)

Support Planning

- ž Each person will be provided choice of CFC or other HCBS services (if eligible)
- ž Initial support plan will be completed within xx business days of assessment.
- ž Each support plan will be reviewed and updated on at least an annual basis.
- ž CFC participants receive choice of 1) CFC model; 2) other CFC optional services; and 3) choice of provider.
- ž Participants indicate an average score of at least 4 when asked about availability of paid care and supports using the POSM survey.

Service Initiation

- ž CFC services are authorized within __ business days of the support plan submission
- ž Services are initiated within __ business days of service authorization

Participant Experience

Participants indicate (using the POSM survey):

- ž An average score of at least 4 when asked about privacy.
- ž An average score of at least 4 regarding their relationship with workers.
- ž An average of 4 when asked about personal relationships.
- ž An average of 4 on the scale when asked about opportunities for activities and community integration.
- ž An average score of at least 4 when asked about being treated with dignity and respect.

Health and Welfare

- ž Participants indicate an average score of at least 4 when asked about security (using the POSM survey).
- ž All support plans reviews of risks to health and safety and have a plan for minimizing risks.
- ž Critical incidents are reported within __ business day
- ž Corrective action is initiated within __ days after a critical incident

- ž All CFC workers have a completed background check

Provider Qualifications

- ž All provider agencies are in substantial compliance with all CFC requirements
- ž Workers meet training requirements for CFC.

Program Integrity

- ž Units of services provided under agency with choice are verified by the CFC participant.
- ž Percentage of plans that include goods and services (descriptive)
- ž Percentage of dollars spend on goods and services if included in plan (descriptive)
- ž Percentage of Budget Used (descriptive)
- ž Percentage of participants who use less than 50% of their budget

Remediation and Improvement Activities

SDS will create a series of quarterly management reports that report how well system partners are doing with respect to performance measures. The management reports will be tailored to system partners, making these a meaningful tool for managing quality at all levels. Management reports will be developed at each of the following levels.

- SDS Management
- SDS Assessor
- Support Plan Coordinators/Care Coordinators
- CFC/State Plan HCBS Providers
- ACC Advisory Council

The intention behind the management reports is to give partners an opportunity to manage quality at their levels by integrating continuous quality improvement activities into regular activities. The use of performance reports is both a means to recognize good practices and to identify problem areas needing attention. For example, provider agencies will receive regular information about their specific agency on the relevant measures, seeing how they performed in comparison to the established threshold for each measure and to an aggregate picture of other providers. Each provider agency can then use its own internal processes to remediate areas of low performance and to promote areas of excellence. From a state level, the partnership of the State with assessors, support plan coordinators and providers is especially important as a means to make quality management a sustainable effort, with the first line of remediation response being at the local level.

The management reports are also an important accountability tool for broad system management. Trends emerging from the regular collection of data may bring focus to problems with policy implementation or resource gaps. Decisions and actions taken to address these trends will be

supported by data collected in the management reports and from follow-up performed by the state and partners.

Exhibit 14 provides examples of action steps resulting from the review and discussion of management reports about performance.

Exhibit 14: Examples of Quality Improvement Action Steps

Finding	Possible Action (not limited to these actions)
Problematic Trend	<ul style="list-style-type: none"> • Review/modification of relevant State level policy and procedures • Provision of training and technical assistance • Publication of policy/procedure clarification • Investigation into pertinent factors impacting performance • Programmatic review or financial audit of service impacted
Excellence/Promising Practice	<ul style="list-style-type: none"> • Recognition and acknowledgement • Use as example in training and technical assistance • Use of voluntary peer mentoring • Replication of model or approach as a promising practice • Incorporation of practice into State procedure manuals
Poor Performance	<ul style="list-style-type: none"> • Require implementation of a plan of correction • Provision of training and technical assistance • Sanctions

Special Issues Relating to Remediation Efforts

This section discusses two specific areas that will require additional focus by SDS in developing its quality management approach. The State currently has structures in place for each of these areas, but will need to enhance or modify practices when implementing CFC/State Plan HCBS.

Critical Incident Reporting and Follow-up

The State will be required to provide CMS with assurances about how it monitors and ensures the health and welfare of CFC/State Plan HCBS Participants. Critical incident reporting and follow-up is an essential component. The existing incident reporting system can be improved to streamline the reporting process, track the status of any follow-up, and document actions taken. The State also needs a way to better track the reporting and substantiation of events.

We recognize that critical incident reporting needs to be coordinated with adult and/or child protection units responsible to investigate incidents of abuse, neglect or exploitation involving Participants. However, SDS has responsibility under federal requirements to ensure health and welfare during the process of investigation. It would also be helpful to coordinate reporting between the program administration unit and the protection unit to the extent allowed under Alaska statutes, so that persons making reports can provide a complete set of information one time.

Another area of consideration involves incidents that may not rise to the State's definition for involvement of adult and/or child protection (usually abuse, neglect or exploitation) but are critical events in the health and welfare of the Participant. For example, many states include requirements for reporting events such as unplanned hospitalizations, damage to property, medication errors, involvement of law enforcement, complaints and other incidents. These areas should be clearly defined and a process for reporting and follow-up established. The optimal situation would be for the state to use an automated system for reporting, tracking, and documenting the outcome of each critical event.

Service Model Disenrollment and Transition

After the provision of service is initiated, Participants may elect to move from traditional agency services to agency with choice, or vice versa. The state should have a process to safeguard continuity of services and assure health and welfare during any transition in model. In the following subsection we discuss two scenarios for disenrollment: voluntary and involuntary.

Voluntary Disenrollment

In a voluntary disenrollment the Participant may elect to do one of the following.

- Leave CFC/State Plan HCBS services
- Move from traditional agency CFC services to agency with choice
- Move from agency with choice to traditional agency CFC services

Leaving CFC/State Plan HCBS Services

Participants leaving CFC/State Plan HCBS services may do so for a variety of reasons, including moving to another state, moving into a different living arrangement such as assisted living or nursing facility, or other reasons. In cases where the person is exiting for a different type of support service, the state should take actions that will facilitate a smooth transition. Depending upon the circumstances under which the Participant leaves, the actions needed may include one or more of the following.

- Reassessment to determine eligibility and needs in new services
- Discussion with Participant to inform choice and ensure an understanding of options (options counseling)
- If person leaves due to loss of Medicaid eligibility, referral to other services for which person is interested and may be eligible
- Modification of the support plan to include any transition steps needed for transition to new service or living arrangement (if applicable)
- If applicable, arrange to provide necessary information about the individual to new providers (may require new release of information forms to be completed prior to change)

It may also be a benefit to ask for a discussion about the experiences of the Participant under CFC/State Plan HCBS. The purpose of this would be to help determine what, if any, design elements resulted in the exit to other services/arrangements. The state may wish to standardize an exit interview protocol and incorporate this into its quality management framework.

Moving From Traditional Agency to Agency with Choice

Participants wishing to move from a traditional agency model to agency with choice may be able to do so without a full reassessment, unless there are changes in status (e.g., medical condition, access to unpaid caregiver, etc.) that would otherwise trigger a full reassessment. One critical component related to reassessment includes an evaluation of the ability of the person to carry out the additional employer responsibilities under agency with choice. The assessment should help to identify needs for support or training in this regard.

The Support Plan Coordinator should also assist with the transition by completing the following action steps.

- Have a discussion with the Participant to inform choice and to ensure the person understands his/her options
- Modify the support plan, including the identification of
 - Authorized budget for worker activities
 - CFC/State Plan HCBS agency with which Participant will work
 - Individual worker and proposed schedule (e.g., hrs. per week)
 - Worker training (re-verify needs or identify any new training needs)
 - Goods or services to be purchased
 - Stop date for traditional agency services and start date for agency with choice
 - Identify and ensure provision of any Participant training requested that relates to new responsibilities under the agency with choice model

Moving from Agency with Choice to Traditional Agency CFC/State Plan HCBS

Participants wishing to move from agency with choice to the traditional agency model may be able to do so without a full reassessment, unless there are changes in status (e.g., medical condition, access to unpaid caregiver, etc.) that would otherwise trigger a full reassessment. The Support Plan Coordinator should assist with the transition through the following action steps.

- Have a discussion with the Participant to inform choice and to ensure the person understands his/her options
- Modify the support plan, including the identification of
 - Authorized units of service under traditional agency
 - CFC/State Plan HCBS agency that will provide support services
 - Proposed schedule based on needs (e.g., help needed with morning routine, help needed at specific times)
 - Worker training (re-verify needs or identify any new training needs)
 - Goods or services to be purchased
 - Stop date for agency with choice and start date for traditional agency services

The state may also want the support plan coordinator to ask the Participant about the reasons he/she wants to transfer from agency with choice to traditional agency services. A standard question or two

about the experience of the Participant can provide useful information about potential areas for improvement.

Involuntary Disenrollment

The agency with choice option requires the Participant to assume responsibilities for hiring and managing workers and firing or taking corrective action when needed. The provider agency will share employment and provide payroll support, but the Participant carries the majority of the responsibility for a worker's day-to-day activities. Given this scenario, it is critical that the state be able to address two concerns: 1) health and welfare of individuals who may be extremely vulnerable and/or unable to perform the above responsibilities; and 2) program integrity (protection from fraud or misuse of public funds).

It is recommended that the state establish criteria for when a Participant would be "dis-enrolled" from agency with choice and required to use the traditional agency model in order to receive services. In these cases, safeguards to ensure service continuity and health and welfare would be needed. The following recommendations summarize criteria that should be considered.

Under current CDPCA rules, the state requires a person to have cognitive capability to manage care OR to have a legal representative who is able to direct care provided by the CDPCA worker.

7 AAC 125.140

(e) If a recipient is found to be cognitively incapable of managing the recipient's own care as shown in the assessment under 7 AAC [125.020](#), the recipient may receive personal care services from an agency-based program only. To receive or continue receiving personal care services from a consumer-directed program, a recipient must obtain a legal representative or submit, on a form provided by the department, documentation from a licensed medical provider stating that the recipient is able to meet the requirements for managing the recipient's own care.

Given the requirements mentioned above for the state to make assurances for the health and welfare of the Participant, and the program integrity standards, it is recommended for the state to modify its current standard to include broader authority to require dis-enrollment under certain conditions.

Proposed Policy

Participants electing to use Agency with Choice must be offered training and information related to his/her rights and responsibilities in directing and managing CFC workers. If a participant is assessed to have additional support needs for managing and directing his/her own care or worker activities, the support plan must identify 1) the type of support to be provided; and 2) who will provide the support. The individual or individuals designated to act on behalf of the participant in managing CFC services must be a legally authorized representative who has authority to make healthcare-related decisions and may not have any financial interest in the provision of the participant's CFC or waiver services.

*For some participants, there may be a significant risk to health and welfare, or a demonstrated inability to manage responsibilities under Agency with Choice. The state **may** require CFC*

participants to use traditional agency CFC services in lieu of Agency with Choice services in the following circumstances:

- (1) The Participant is a victim of substantiated abuse, neglect or exploitation by a support provider agency or worker; or,*
- (2) The Participant is a victim of substantiated abuse, neglect or exploitation by the individual designated to provide assistance with directing and managing support workers; or,*
- (3) The Participant responsible for managing services under Agency with Choice, or his/her legal representative is found to have*
 - a. knowingly falsified information concerning the provision of CFC/State Plan HCBS; or,*
 - b. been verbally or physically abusive to or harassed workers hired to provide CFC/State Plan HCBS services; or,*
 - c. exploited a worker, such as requiring workers to perform activities not covered by CFC/State Plan HCBS or authorized in the support plan in order to maintain employment; or,*
 - d. knowingly provided false information concerning eligibility for CFC/State Plan HCBS services.*

The state must ensure Participant access to CFC/State Plan HCBS traditional agency services for which the person is eligible when taking any action to involuntarily dis-enroll a participant from the Agency with Choice variation of the agency model.

The above policy is defined in a limited way; the assumption is that most participants, if provided with appropriate support, can appropriately use the Agency with Choice option. In all except a few cases, the state should provide for additional support and training as the first step to remediate the situation.

We did not complete a legal review of Alaska's Medicaid program to determine the right of the individual to appeal an involuntary disenrollment from Agency with Choice. Appeal rights typically cover termination, reduction, or suspension of services, and some states extend this further to include other quality issues related to provision of services. The proposed policy covering involuntary disenrollment from Agency with Choice should not reduce, terminate, or suspend CFC/State Plan HCBS services; it does, however, affect the right to choose between the two variations of the CFC/State Plan HCBS model (agency) and may have some effect on how and when services can be delivered. In some locations where traditional agency services have not been developed, the end result could essentially be a loss of services. Thus, the state will need to consult with its legal counsel to determine the scope of rights or any clarifications needed within statute or rule to make it feasible for the state to take reasonable action to protect against fraud or dangers to the health and welfare of a participant, but to also protect the participant's right to service access and choice.

Participants moving from agency with choice to the traditional agency model may be able to do so without a full reassessment, unless there are changes in status (e.g., medical condition, access to unpaid

caregiver, etc.) that would otherwise trigger a full reassessment. The Support Plan Coordinator should assist with the transition through the following action steps.

- Discussion to inform the person about his/her choices under Medicaid
- Modification of the support plan, including the identification of
 - Authorized units of service under traditional agency
 - CFC/State Plan HCBS agency that will provide support services
 - Proposed schedule based on needs (e.g., help needed with morning routine, help needed at specific times)
 - Worker training (re-verify needs or identify any new training needs)
 - Goods or services to be purchased
 - Stop date for agency with choice and start date for traditional agency services

Stakeholder Input

The state will continue to use a council of stakeholders to maintain an open dialogue on the ACC options. Based on experience with the CFCC, including direct feedback received from CFC Council members, the state will make some modifications to the council structure. In addition, the state will expand its outreach to the broader community through new and existing channels. The following recommendations provide an initial roadmap for stakeholder input as an ongoing quality management strategy for implementation and ongoing management of programs.

1. **Expand the scope of the Council.**
 - It makes sense to expand the scope of the council to include CFC and related programs such as waiver programs and other home and community based services under the ACC structure. CFC and waiver programs both serve individuals meeting institutional risk criteria, and many Participants will receive supports from both programs. The state will also consider the State Plan HCBS option as a means to provide supports to individuals with ADL deficits but who do not meet institutional level of care. In order to make the system as seamless as possible, the state will need to maintain consistency across programs.
2. **Use the Council to provide advice concerning the ADRC.**
 - The recommendation for ACC includes use of the state's ADRC to fulfill an intake and triage role for individuals seeking access to HCBS services. The ADRC will also provide information and assistance about programs and services and can act as an independent resource about available providers.
3. **Expand support to and number of voting members on the Council.**
 - Council members representing consumers are frequently at a disadvantage when discussions involve complex policy issues. Consumer representatives do not necessarily have a lot of time or opportunity to develop an in-depth knowledge of all the issues involved. While the state has a responsibility to develop agendas that do not place undue burden on council members, it is difficult to talk about redesign of Medicaid programs without having a discussion about complex policies.
 - One of the changes that could help to address this problem is to expand membership to include consumer focused organizations that could help to identify additional consumer

members and who would have staff available to assist members with the issues and materials discussed at council meetings. The following organizations should be invited to assist SDS with an expanded consumer role on the council.

- Governor's Council on Disabilities and Special Education
 - DD and Child Consumer Representatives
- AK Commission on Aging
 - Older Adult and ADRD Consumer Representatives
- AK Brain Injury Network
 - BI Consumer Representative
- State Independent Living Committee
 - Younger Adult with Physical or Medical Disability Consumer Representative
- AK Mental Health Board

4. Expand advisory membership (non-voting) on the Council.

- The following organizations should be invited to participate as advisory members of the Council.
 - Agenet
 - PCA Association
 - Disability Law Center of AK
 - Association of Developmental Disabilities
 - Mental Health Trust
 - Medical Care Advisory Committee
 - Assisted Living Home Association
 - Filipino-American Assisted Living Home Association
 - Tribal Health

5. Arrange multiple means to collect ongoing input regarding Alaska's programs.

- The development process for the ACC model reflected in this report depended heavily on input of Council members. A brief series of community forums to present ideas to a more general stakeholder group were also held. Council meetings and community forums were held in person and via online tools. Moving forward, the state will need a more sustainable strategy for soliciting input. In addition to membership changes, the state should consider various means to collect input from council members and broader stakeholders. This should include the following.
 - Council will be used to provide direct input through the implementation process and ongoing program operations
 - Direct participant input will be collected through surveys or other means
 - This should include at least a regular collection of participant experience surveys concerning assessment and support planning and should be linked to other quality management activities
 - Provider feedback will occur through regular channels, such as meetings with associations

Chapter VI: Overview of Potential Management Information Systems (MIS) Changes

In building the capacity necessary for CFC and the broader ACC effort, the State will need to map out the infrastructure requirements of a MIS that will support new operational processes and management of the programs. New functions include assisting staff to guide Participants in accessing supports and services, an automated in-home assessment and support plan, and enabling the efficient collection and analyses of performance measurements as part of a continuous quality improvement strategy. The MIS recommendations in this chapter are included in the implementation plan and timeline exhibited in Chapter VIII.

Automation of the Initial Intake

In the proposed approach, Participants are able to access publicly funded LTSS through a common intake process that includes a screen to determine if a Participant may be eligible for ACC. Using a standardized protocol ensures a consistent process and allows for the collection of common data elements captured from the contacts being made no matter who performs the intake.

While a standardized intake protocol could be developed as a paper-based tool or script, the ability to electronically automate a protocol makes the process more efficient and ensures consistency in how contacts are handled. An automated tool can skip questions or require questions to be answered, while paper-based tools are limited in providing a structured environment to complete a task. Built-in, automated guides for staff potentially reduce the need for extensive staff training, as business rules can be incorporated into the tool. For example, an automated tool may include help functions to provide workers with program information. The result is a better and more consistent experience for individuals calling in to request information or assistance.

An automated intake tool supported through a MIS offers the ability to distribute the tool virtually to authorized users. Authorized users can access the intake protocol from other locations, while the data is stored onto a centralized data center. ADRC, SDS staff, or partner organizations can be trained and authorized as a gateway for Participants to access ACC. This could allow the State to augment its intake capacity, while maintaining the consistency of the intake process and having information captured to the State's MIS.

An intake tool automated on a centralized MIS also allows changes or modifications to be made to the protocol and instantly distributed to all authorized users conducting intakes. A paper-based tool would require a new protocol to be distributed and likely require additional training. In addition, there is always the potential for staff to inadvertently use an older paper-based protocol.

Automation of the In-home Assessment

The in-home assessment component includes a needs assessment and a determination about eligibility during an in-home visit to the Participant. We have proposed adopting a standardized protocol that addresses changes required by CFC and helps streamline the assessment process. While the Consumer

Assessment Tool (CAT) will continue to provide the basis for program eligibility, new person-centered components will be added to aid in the development of the Support Plan.

Currently, the State has a MIS to score the CAT, but the tool itself is still completed manually. The State should consider either building the ACC assessment automation on the current MIS infrastructure or adopting the CAT onto a new MIS. In either approach, the State will be able to incorporate and modify the CAT algorithms in the automation of the ACC in-home assessment. The MIS should also be able to incorporate and manage additional algorithms so that changes can be added and updated modularly. The MIS should be updatable in modules; analogous to being able to change an engine part as opposed to having to rebuild the entire automobile to get it to run again. Program requirements and policies change, and therefore the MIS support infrastructure must be flexible to support such updates.

Similar to the benefits of an automated intake, an automated in-home assessment tool helps create more consistency in generating assessment results and in determining eligibility for programs. While the accuracy of an assessment also relies on the skills and knowledge of the assessor, an automated assessment tool helps minimize that variation through guided prompts. For example, an assessor may overlook a particular IADL during an assessment, but the automation support would flag that IADL item as incomplete, prompting the assessor to complete it. An automated assessment that is comprehensive and is contained in a structured environment of a MIS is less likely to have deviations or errors as compared to a tool that is paper-based and/or tabulated manually. Programmatic deviations can still occur in a MIS, but can be corrected if the data is available on a centralized MIS database.

A centralized MIS where the system is able to communicate between processes will be important in helping the State build capacity and reduce the duplication of effort and data entry. For example, Participant demographic and contact information already gathered during the intake need only be verified for accuracy during the in-home assessment. Information that has been verified such as Medicaid eligibility can be tracked on a MIS, potentially preventing delays in authorizing services to the Participant. Staff members are able to save valuable time from additional duplicative data entry in an automated MIS. The information gathered during the in-home assessment will add to the Participant record, allowing the complete record to be seamlessly accessed during the support planning process. The ability for the MIS to be transparent in the flow of information among the various steps required (e.g., intake, assessment, support planning, service authorization, etc.) will result in a streamlined experience for the Participant and create administrative efficiencies.

Information can also be used during reassessments to review status changes from previous assessments. The MIS can simply automate and operationalize the process of reviewing a Participant's records prior to reassessment. Information from previous assessments can prompt the assessor to prepare and check for changes in specific areas during the reassessment.

Automation of the Support Plan

The support planning process connects the information gathered from the in-home assessment into the actual planning and implementation of a Participant's supports. The MIS enhances the ability to tie all these activities together into an integrated plan. The MIS should populate forward Participant information following upstream business flow activities. The Support Plan has information collected

from the initial intake and in-home assessment. A support planner works with that information to develop a plan of care with the Participant.

There are many components to a Participant's supports. These components range from the identified support needs, the available supports, the authorization of supports, to the emergency and backup plans. In ACC, the State will need to develop a support plan that is driven by person-centered principles – such that the automation of the Support Plan can be linked back to the expressed goals and preferences of the Participant. To do that, the MIS needs to be able to connect the available supports, minimize the gaps in information, and have the flexibility to include the Participant in a transparent process.

The automated Support Plan should:

- Compile the Participant's goals collected during the assessment and discussion of the Support Plan
- Help to identify and document the Participant's needed supports
- Document the plan for monitoring and oversight of the Participant's supports
- Check and assure that all support plan requirements have been satisfied
- Document and store all records, receipts, and signatures of authorizations

The Support Plan in the MIS should contain a comprehensive record for each Participant that allows the State to readily access information and respond to status changes affecting any Participant. For example, should there be an emergency when a support or service becomes unavailable to a Participant, the State may react more readily with a comprehensive picture of a Participant's support need electronically on file. The MIS should store and maintain all past support plans to enhance the capacity in monitoring changes of a Participant's needs and aide in developing future support plans for the Participant.

The MIS also becomes a centralized location that ties a Participant's support needs together and allows that support plan (or portions thereof) to be distributed to respective providers of those supports – creating an efficient means to manage, authorize and communicate about supports from a centralized system.

While a centralized data system allows for accuracy in maintaining and sharing information, it also enhances the control of the Participant's information, such that information can be securely captured and the distribution of the Participant's information can be monitored. Additionally, the ability to transmit Participant information about the provision of supports to authorized providers in a streamlined process will reduce the delay Participants experience in waiting to receive supports.

The MIS should summarize the detail and complexity of a Support Plan into a readable, user-friendly Participant print out. The Participant version of the Support Plan should provide a summary and connect the identified supports to the goals and preferences of the Participant. This process empowers the Participant to be more involved in the support planning process in a transparent framework – the MIS should strive for that end goal.

Automation of the Budget Calculations in the Support Plan

A key activity in the support planning process is the automation of the authorized budget calculation. The MIS should support the ability to extract information captured from the in-home assessment and apply this information to the calculation of the authorized budget hours. The tabulation of the budget hours is complicated and thus susceptible to calculation errors when manually calculated. Therefore, automation of this process will enhance the State's ability to maintain accuracy in allocating budgets to all ACC Participants.

Automation of Management Reports

The MIS is critical to supporting a data-driven quality management strategy. Chapter V discusses the quality assurance activities and proposed performance measures for ACC. The ability to generate reports and provide programmatic dashboards on the quality and utilization of supports enables the State to be more proactive in the management of ACC. Management reports can help to track aggregate trends as well as pulling detailed information such as the demographics of Participants served, timeliness of ACC activities, or performance related to specific indicators. This capacity is essential in supporting the State's ability to identify areas needing improvement.

In designing the MIS, the State will need to consider how the data is captured and how it is pulled into the management reports. For example, data may be qualitative or quantitative, may be Participant data or operational data, or raw data or pre-calculated data. These considerations need to be taken when implementing the automation of the intake, in-home assessment, and support planning processes. In a centralized MIS, all the information collected is automated and flows forward for the oversight and management reporting processes.

Integration of the MIS

In implementing the MIS, the State will need to determine if it is capable of building the MIS capacity on an existing system, developing of a new MIS that supports the core functions of ACC and support functions, or explore the procurement of a customizable commercial product/service.

The MIS should be able to interact with other data systems and support other functions across the State. For example, with the ADRC being identified as the primary resource that would conduct the intake, the State should consider how its MIS could integrate with or support the functions of the ADRC. The MIS should support access to outside stakeholders including providers, other state agencies, and to the Participants – access can be limited, but it should add value for the stakeholders that support the ACC infrastructure. As policies and requirements change the MIS must be modular enough to support those changes and be designed with that flexibility in mind.

The MIS can be a centralized system or integrated in parts; but regardless, the process should support a streamlined and seamless experience for the Participant from the intake to the in-home assessment to the support planning. The MIS should enable authorized users to access a Participant's complete record at any point of accessing ACC.

The MIS should automate the operations and business flow of the ACC by streamlining operations through guided automated protocols. These protocols from the initial intake, in-home assessment, through the support plan should provide guides that prompt for required tasks, skip non-applicable ones, and provide inline instructions and descriptions – reducing the likeliness for errors and improving consistency.

In addition to streamlined processes, a MIS support system results in a data driven approach to monitoring and managing operations. The wealth of data that is captured can be analyzed to provide continuous quality improvements and support the State in its policy reviews and development.

Additional Changes Needed to EIS/MMIS

So far this chapter has discussed some of the new MIS needs resulting from the proposed design. The decision to implement new ACC components will also require some basic changes or updates to the State's existing Eligibility Information System (EIS) and/or Medicaid Management Information System (MMIS). Below we provide a broad discussion of some of the potential changes that should be anticipated. Policy decisions made during implementation planning will further influence the nature and scope of changes to the existing EIS and MMIS systems.

New procedure/program codes for CFC and State Plan HCBS will need to replace the existing PCA/CDPCA procedures codes. The procedure codes allow the State to authorize and track enrollment into CFC or State Plan HCBS. The State also needs a way to track the type of service unit authorized and paid. This may be done by developing modifiers for each of the procedure/program codes that specify which services are authorized (e.g., personal assistance, goods and services, transition costs, etc.).

Because the State will enroll Participants into both CFC and Waiver services, it may also need to have system "edits" that assist with 1) ensuring that authorizations cannot exceed any service limits adopted for specific services (e.g., not to exceed amounts for environmental modifications), and 2) ensuring non-duplication of services for Participants receiving services under both CFC and Waiver. An example of the latter includes having an edit to block the authorization of some CFC services such as *personal assistance with IADLs* if a Participant chooses to receive *chore* services under a Waiver. While these edits can be manually lifted to allow authorization of services, the State would receive a "flag" to indicate that a review of the proposed service request is needed prior to authorization of the Support Plan.

ACC will also require refinements to the EIS so that the State can track individual-level eligibility for the specific programs (CFC or State Plan HCBS).

- CFC includes two new service eligibility groups, Participants meeting the Psych under 21 LOC and adults meeting IMD level of care. Other CFC eligibility groups are already defined under the State's waiver programs (e.g., NF or ICF/MR level of care) but will need to be incorporated into CFC service eligibility.
- State Plan HCBS includes a new service eligibility group, Participants with needs in at least 2 ADLs but not meeting institutional level of care.

As stated earlier, the decisions made during the next phase of implementation planning will shape the extent to which changes in the systems are required. The existing EIS and MMIS systems should have

the capability of handling the changes discussed in this section, as the types of changes discussed in this section are not atypical. However, we recommend that EIS and MMIS programmers/functional analysts for EIS and MMIS be included during the implementation planning phase discussion.

Chapter VII: Maintenance of Effort Analysis

This chapter examines the impact of the proposed CFC design on the current PCA Participants. Under the CFC maintenance of effort requirement, the State must not reduce its total expenditures for Medicaid-funded attendant care in the first year of implementation. This analysis uses data provided by the State to project the potential impact of the ACC program. If projected spending is less than current spending, the State will need to evaluate how to cover such gaps and maintain expenditures.

The specific CFC regulation pertaining to the maintenance of effort is as follows:

“For the first full 12 month period in which the State plan amendment is implemented, the State must maintain or exceed the level of State expenditures for home and community-based attendant services and supports provided under sections 1115, 1905(a), 1915, or otherwise under the Act, to individuals with disabilities or elderly individuals attributable to the preceding 12 month period.”

Because the design of the ACC effort maintains core components of the current system, costs should be relatively consistent. The main drivers of changes in cost are likely to be:

- Eligibility for the more limited benefit offered under the State Plan HCBS option will differ from the current PCA program. Under PCA, any individual requiring hands-on assistance with any ADL or IADL will qualify. Under ACC, an individual must need hands-on assistance, supervision or cueing with two or more ADLs. To estimate the impact of this, we needed to compare the number of individuals eligible under the current and proposed criteria.
- We have proposed altering the current methodology for allocating hours to assign time for ADLs and IADLs for which the Participant only requires supervision or cueing. Currently, with a few exceptions, Participants only receive time if they require hands-on assistance. To estimate the impact of this change, we needed to apply both the current and proposed algorithms for assigning time.
- The ACC plan also proposes to add a limited benefit for back-up supports (8 hours per year) and to provide emergency response systems (Waiver Participants can currently receive this).
- For services funded under the CFC component of ACC, the State will receive an enhanced match of 6%. This will reduce the share the State must pay on each dollar used to fund service.

By applying both the proposed eligibility and service budget methodology changes for each Participant, we were able to estimate the overall change in costs for the State. We also needed to determine if a Participant meets an institutional LOC to be eligible for the enhanced federal match under CFC.

Data Sample and Analysis

The State provided a sample of over 2000 active PCA Participants (identification by ID numbers only) linked to their respective Participant eligibility and budget calculations. The sample represents approximately one-half of the approximately 4000 active PCA Participants. SDS has programmatic algorithms that determine eligibility and assign support time. We were able to identify how these algorithms would change and had SDS run estimated numbers based on these modified algorithms.

We used the sample data to develop a modeling file that included eligibility status under the current and proposed functional eligibility criteria; nursing facility LOC status; and estimated hours under current and proposed methodologies. The proposed approach for assigning support time allocates 50% of the

maximum support time for ADLs and IADLs that are identified as requiring supervision or cueing (this is the same amount of time that is assigned for Participants requiring limited hands on assistance). The current PCA service budget methodology does not provide any support time for supervision or cueing. Maintaining the existing service budget allowance, ADLs and IADLs that require more assistance are calculated on 75% and 100% of the maximum time based on the Participant's assessed dependence, respectively. In addition, Participants would also be allocated 8 hours a year for emergency support hours in the event of unexpected loss or absence of an unpaid caregiver.

We also needed to develop an estimate of the growth in Medicaid-funded attendant care that would have occurred regardless of the implementation of ACC. Because the Maintenance of Effort requirement only looks at the change from one year to the next, this growth is used to calculate the baseline increase in expenditures. SDS provided us with data from 2008 to 2012 on relevant services, which includes PCA and Waiver services that could be considered as a form of attendant care.⁵ Based on this data, we calculated that the annualized growth rate was 10.5%.

Findings

Exhibit 15 provides a summary of the projected costs and the State's share of the cost from our maintenance of effort analysis.

⁵ Under the CFC regulations, the definition of "attendant care" is relatively broad and potentially vague. In Alaska's case, we counted all PCA and the following Waiver services: a) respite care, b) day habilitation, c) supported employment, d) chore services, and e) meals.

Exhibit 15: Summary of Findings of Maintenance of Effort Analyses

	%	Total	State Share
1. Baseline Year 0 Medicaid Attendant Care		\$151,449,993	\$75,724,997
2. Baseline Year 0 PCA Services		\$99,648,705	\$49,824,352
3. Impact of Changes in Eligibility (% change)	-4.1%	\$(4,053,392)	\$(2,026,696)
4. Impact of Changes in Liberalizing Assignment of Hours (% change)	2.6%	\$2,480,749	\$1,183,219
5. Savings to State from ACC Participants eligible for CFC (applying 6% enhanced match to 38.4% of Participants eligible for ACC)			\$(2,259,650)
6. Impact of lines 3-5		\$(1,572,643)	\$(3,103,127)
7. Estimated Year 0 Medicaid Attendant Care Costs Under ACC		\$149,877,350	\$72,679,025
8. Estimated Year 1 Medicaid Attendant Care Costs under Baseline (Year 0 inflated by 10.5%)	10.5%	\$167,352,242	\$83,676,121
9. Projected Year 1 Medicaid Attendant Care Costs Under ACC	10.5%	\$165,608,862	\$80,307,602
10. Difference from Baseline Year 0		\$ 14,158,869	\$ 4,582,605
11. Difference from Baseline Year 1		\$ (1,742,380)	\$(3,368,519)
12. Net increase in State Dollars from CFC Enhanced Match			\$ 2,496,829

The analysis compares expenditures under the Baseline scenario which reflects the current structure of programs in Alaska against estimate expenditures if the State were to implement the ACC effort. Because we needed to account for growth in expenditures that would likely occur in the absence of implementing the ACC effort, we compare estimates across two years (Year 0 and Year 1).

Line 1 presents the Baseline costs for Medicaid Attendant Care (including PCA) in Year 0; this estimate is based on actual 2012 numbers provided by SDS. To meet the federal CFC Maintenance of Effort Requirement, State expenditures will need to meet or exceed \$75 million for all Medicaid attendant care services in the Year 1 estimates.

Line 2 presents the baseline PCA expenditures in Year 0 (these are based on actual expenditures in 2012). This is a subset of the total Medicaid Attendant Care from the previous line. Total expenditures for PCA Services in the 2012 fiscal year were approximately \$100 million of which \$50 million was State dollars.

We next examined the impact of the proposed change in eligibility. The data suggested that there would be a 17% reduction in the number of people eligible for ACC (either State Plan HCBS or CFC) than are eligible for PCA. Because the individuals no longer eligible have lower levels of impairment and lower costs (they were authorized only 6 hours per week on average) while the individuals added had

substantially greater needs, this change translated into a reduction in expenditures of only 4.1% (Line 3). This translates into a reduction of \$4.05 million, of which \$2.03 million are State dollars.

In Line 4, we estimated the impact of liberalizing the budget methodology (allowing for allocation of paid time for supervision or cueing) by assigning hours to Participants who only needed supervision or cueing. We also added relatively small amounts to the budget to reflect additional benefits, such as the 8 hours annually of back-up support and personal emergency response systems for Participants not covered by a Waiver. This increased costs by an estimated 2.6% or \$2.48 million in total and \$1.18 million in State dollars.

Of those eligible for ACC, 38.4% met the nursing facility LOC and were, therefore, eligible for CFC and the associated 6% increase in federal matching dollars. We estimated that this would result in an additional federal match of \$2.26 million. This is shown as a reduction in State dollars in Line 5.

The net impact of Line Items 3-5 to the baseline Year 0 PCA Services is a savings of \$1.57 million in total expenditures and a State savings of \$3.10 million (Line 6).

Therefore, the estimated Year 0 total Medicaid attendant care expenditures under ACC (Line 7) is the net of the baseline Year 0 Medicaid attendant care (Line Item 1) and the impact of the proposed changes (Line Item 6). The estimated Year 0 total Medicaid attendant care expenditures under ACC would be \$149.88 million including a State contribution of \$72.68 million.

To evaluate the impact of expected growth in spending, we used the annualized growth rate of 10.5% from 2008-2012 to estimate the Year 0 to Year 1 Medicaid attendant care costs under baseline (Line 8) and the Year 0 to Year 1 Medicaid attendant care costs under ACC (Line 9).

Because the projected State contribution under ACC is \$4.58 million more than current expenditures (Line 10), the State should be able to meet the Maintenance of Effort requirement assuming that cost increase in a similar manner as they did between 2008 and 2012.

As Line 11 shows, adopting the ACC approach should decrease overall costs moderately. While overall costs are projected to decrease by \$1.74 million, because of the enhanced match, the State spending is estimated to decrease by \$3.37 million; the enhanced match under CFC accounts for \$2.50 million (Line 12) of these savings.

Caveats

In conducting this analysis certain assumptions and caveats must be considered.

The data sample only includes active PCA Participants. This excludes individuals who are not eligible for PCA, but would be eligible under the ACC eligibility criteria. However, SDS provided information about initial applications under PCA that included people who applied for PCA but were deemed not eligible. From these data, we estimated that including for these individuals would result in a 0.5% increase in the number of people eligible. We adjusted our estimates to reflect this assumption.

The current PCA service budget methodology is being updated and we have used a snapshot of the current methodology as our baseline. Our estimates are relative to that baseline. Thus, the estimates would likely change somewhat as the methodology is refined.

We estimated annual increases in expenditures based on the 2008-2012 trends in expenditures. While the 10.5% rate was calculated over the four year period, there was substantial variation in the year-to-year changes. It is possible that the rate of growth could be substantially lower during the first year after implementation of CFC. However, it is important to note that even if the growth rate was half the historical growth rate; the State should still be able to meet the Maintenance of Effort requirement.

The greater flexibility offered under CFC could result in Participants using a larger portion of their allocated hours/budget than under the current approach. While this would not create a Maintenance of Effort issue, it could cause expenses to be higher than predicted. However, it is important to note that the proposed resource allocation approach would not allow anything beyond minor increases in expenses.

SDS is engaged in a number of efforts to clarify policies and reduce fraud. In many cases, these efforts may impact the number of people eligible and the amount of support they receive. Our model could not account for the impact of these changes. If these changes are implemented during the first year of CFC, this could create a Maintenance of Effort issue.

These estimates only include increased federal dollars associated with shifting PCA Participants to CFC. Because the final CMS rule limited CFC to individuals meeting LOC, the State could shift spending for certain Waiver services to CFC. For example, if SDS were to shift spending for respite, chore, and meals from the Waivers to CFC, the State would receive \$1.35 million in enhanced federal match. These dollars would be in addition to the savings associated with shifting PCA to CFC.

Estimating the Costs of Infrastructure Changes

As stated earlier, implementing the ACC initiative will require substantial changes to current LTSS operations infrastructure. These costs will offset many of the savings that are projected above.

Much of these costs will be one-time costs, while the savings will continue and should grow as overall expenditures grow. The one-time costs include the development of tools, protocols, processes, and changes to MIS. These tasks are outlined in the implementation plan. We have not developed a line item budget for each of these tasks, but a ballpark estimate would be around \$500,000 for developing the intake, assessment, support planning, and quality management tools. SDS should be able to receive Medicaid administrative FFP, lowering the State costs to around \$250,000. SDS would also need to make changes to its MIS and would likely want to contribute training to the TTC to support the effort to enhance the training infrastructure. These costs would also be eligible for Medicaid administrative FFP of at least 50%.

Ongoing costs include paying entities to perform the upfront screening and the additional time necessary to conduct person-centered assessments and develop Support Plans. In addition, the State is likely to need a limited number of new staff to help manage the program. These staffing costs will be offset by reductions in the total number of in-person assessments resulting from performing the initial screen and reducing the number of duplicate PCA/Waiver assessments. SDS may also want to provide ongoing funding to the TTC to support training

It is challenging to develop estimates of the ongoing costs because estimates of the additional time necessary and reductions in assessment cannot be developed until the actual tools are developed and piloted (these are steps in the proposed work plan). All of these tasks are eligible for Medicaid administrative FFP of either 50% or 75%. In addition, many of these changes are consistent with existing State initiatives, such as the ADRC and enhancing training especially in rural populations. It is important to note that by including these efforts under the ACC umbrella, they become eligible for Medicaid administrative FFP.

Chapter VIII: Implementation and Transition Plan

This chapter describes the steps necessary to implement the ACC effort including transitioning the current PCA program to ACC. *Exhibit 16* lists the key tasks. Work on a number of tasks may occur concurrently. However, some tasks are dependent on the deliverables of an earlier task. The column labeled “Predecessors” identifies other tasks that should be completed prior to listed task. In the table we also list those tasks for which we propose that SDS seeks input from Council members. The role of the Council will be to provide input regarding the policies, procedures or tools involved in implementing ACC. The only tasks for which we have not proposed obtaining input from Council members are those that involve: 1) the technical implementation of infrastructure for which core decisions were made in an earlier task and 2) processes that are internal to SDS or DHS, such as making staff management decisions or obtaining internal consensus or approvals.

We have divided the proposed work plan into the following major tasks:

- **Policies, Procedures and Tool Development:** The effort would start with a collaborative planning effort under which SDS would work with stakeholders to develop detailed policies, procedures, and plans for other infrastructure necessary to operate ACC. In many cases, these operations infrastructure would have to be submitted to CMS prior to receiving approval for a CFC application.
- **Approvals:** SDS would need to obtain approval from the Alaska Executive and Legislative branches and CMS. SDS would also need to promulgate rules for new programs and changes to existing programs.
- **Operations Infrastructure Development:** These tasks translate the policies, procedures, and tools developed earlier in the effort into the actual infrastructure necessary to operate the ACC programs.
- **Implementation:** This includes training and enrolling providers and transitioning current PCA participants to ACC.

Exhibit 16: Draft Implementation and Transition Tasks

Task Number	Task Name	Council Input	Predecessors
1	ACC Draft Plan		

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Task Number	Task Name	Council Input	Predecessors
2	SDS Decision whether to proceed		1
3	ACC Detailed Planning Effort		
3.1	Restructuring ACC Council	Y	2
3.2	Integration of ACC Plan with ADRC Plan and Long Term Care Reform Plan	Y	3.1
3.3	Review integration of ACA Navigator and other relevant components	Y	3.1
3.4	Policies, Procedures, and Tool Development		
3.4.1	Intake & Screening	Y	
3.4.1.1	Qualification & training requirements for staff conducting intake & screening	Y	2
3.4.1.2	Identification of who will perform screening	Y	
3.4.1.2.1	Requirements for ADRC	Y	
3.4.1.2.1.1	Payment	Y	3.4.1.1
3.4.1.2.1.2	Infrastructure for obtaining Medicaid Administrative FFP	Y	3.4.1.2.1.1
3.4.1.2.1.3	MIS - ability to complete tool and schedule assessments	Y	3.4.1.2.1.2
3.4.1.2.1.4	Other contractual requirements	Y	3.4.1.2.1.3
3.4.1.2.2	Requirements for Other Private Sector Organizations Performing Screening	Y	
3.4.1.2.2.1	Setting parameters for when private sector screening will be reimbursed	Y	3.4.1.1
3.4.1.2.2.2	Payment	Y	3.4.1.2.2.1
3.4.1.2.2.3	Infrastructure for obtaining Medicaid Administrative FFP	Y	3.4.1.2.2.2
3.4.1.2.2.4	MIS - ability to complete tool and schedule assessments	Y	3.4.1.2.2.3
3.4.1.2.2.5	Other contractual requirements	Y	3.4.1.2.2.4
3.4.1.2.3	Requirements for Referrals from Hospital Discharge Planners	Y	
3.4.1.2.3.1	Establishing a web-based and/or phone-based referral protocol	Y	3.4.1.1
3.4.1.2.3.2	Decision regarding when & whether additional screening will be necessary prior to assessment	Y	3.4.1.2.3.1
3.4.1.2.4	Requirements for SDS staff performing intake & screening		
3.4.1.2.4.1	Establishing staffing need		3.4.1.1
3.4.1.2.4.2	Infrastructure for obtaining Medicaid Administrative FFP		3.4.1.2.4.1
3.4.1.2.4.3	MIS - ability to complete tool and schedule assessments		3.4.1.2.4.2

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Task Number	Task Name	Council Input	Predecessors
3.4.1.3	Outreach and education plan	Y	3.4.1.2.1/3.4.1.2.2/ 3.4.1.2.3/3.4.1.2.4
3.4.1.4	Plan for routing intakes	Y	3.4.1.3
3.4.1.5	Development of intake & screening tool	Y	3.4.1.4
3.4.1.6	Development of intake & screening training materials	Y	3.4.1.5
3.4.1.7	Development of automation plan		3.4.1.6
3.4.1.8	Revision and refinement of Intake & Screening Performance Indicators	Y	3.4.1.7
3.4.2	Assessment		
3.4.2.1	Development of assessment tool	Y	3.4.1.5
3.4.2.2	Development of staff training requirements	Y	3.4.2.1
3.4.2.3	Development of assessment training materials	Y	3.4.2.2
3.4.2.4	Development of automation plan	Y	3.4.2.3
3.4.2.5	Revision and refinement of Assessment Performance Indicators	Y	3.4.2.4
3.4.3	Support Plan		
3.4.3.1	Development of Support Planning tool	Y	3.4.2.1
3.4.3.2	Protocol for information sharing & handoff of Support Planning	Y	3.4.3.1
3.4.3.3	Development of staff qualification & training requirements	Y	3.4.3.2
3.4.3.4	Development of Support Planning training materials	Y	3.4.3.3
3.4.3.5	Development of automation plan	Y	3.4.3.4
3.4.3.6	Revision and refinement of Support Planning Performance Indicators	Y	3.4.3.5
3.4.4	Participant Support Infrastructure	Y	
3.4.4.1	Identify specific tools to be developed	Y	3.4.3.4
3.4.4.2	Determine who will develop tools	Y	3.4.4.1
3.4.4.3	Determine who will be responsible for updating tools	Y	3.4.4.2
3.4.4.4	Plan for drawing down administrative FFP	Y	3.4.4.3
3.4.5	CFC/State Plan HCBS Worker Training Requirements & Infrastructure	Y	
3.4.5.1	Detailed training requirements	Y	2
3.4.5.2	Plan for developing State capacity for offering training through the TTC	Y	
3.4.5.2.1	Plan for drawing down administrative FFP	Y	3.4.5.1

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Task Number	Task Name	Council Input	Predecessors
3.4.5.2.2	Plan for developing training content	Y	3.4.5.2.1
3.4.5.2.3	Plan for developing competency measures	Y	3.4.5.2.2
3.4.5.2.4	Plan for delivering training in remote areas and non-English speaking populations	Y	3.4.5.2.3
3.4.5.2.5	Plan for tracking training compliance	Y	3.4.5.2.4
3.4.5.3	Protocol for approving alternatives to State-offered training	Y	3.4.5.2
3.4.5.4	Protocol for grandfathering existing staff	Y	3.4.5.3
3.4.5.5	Plan for phase-in of requirements based upon when TTC infrastructure will be in place	Y	3.4.5.4
3.4.5.6	Revision and refinement of Worker Training Performance Indicators	Y	3.4.5.5
3.4.6	Continuous Quality Improvement Infrastructure	Y	
3.4.6.1	Integration of ACC Performance Indicators with Waiver Performance Indicators	Y	3.4.1.8/3.4.2.5/ 3.4.3.6/3.4.5.6
3.4.6.2	Refinement of Management Reports	Y	3.4.6.1
3.4.6.3	Automation plan for populating Management Reports		3.4.6.2
3.4.6.4	Remediation Plan	Y	3.4.6.2
3.4.6.5	Processes for Quality Improvement Meetings among Provider, State, and ACC advisory councils	Y	3.4.6.3
3.4.6.6	Process for phasing in CQI efforts	Y	3.4.6.5
3.5	Community Outreach	Y	
3.5.1	Outreach Plan	Y	3.4.6.5
3.5.2	Outreach logistics	Y	3.5.1
3.5.3	Outreach events	Y	3.5.2
3.5.4	Outreach website	Y	3.5.3
3.6	Update and Provide Details for the Remaining Portion of the Implementation Plan	Y	3.5
4	Approvals and Rules		
4.1	State Approval		
4.1.1	Obtain approval with the Department to proceed		3.6
4.1.2	Obtain legislative approval		4.1.1
4.1.3	Receive State Approval to Proceed		4.1.2
4.2	CMS Approval		
4.2.1	Draft State Plan Amendments	Y	4.1.3
4.2.2	Submit State Plan Amendments to CMS		4.2.1

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Task Number	Task Name	Council Input	Predecessors
4.2.3	CMS Review Process		4.2.2
4.2.4	Receive CMS Approval to Proceed		4.2.3
4.3	Adopt Rule Changes		
4.3.1	Determine if changes are necessary to Overall Medicaid statutes		4.1.3
4.3.2	New rules for CFC and 1915(i)	Y	4.3.1
4.3.3	Changing Waiver Rules	Y	4.3.1
4.3.4	Publish Proposed Rules		4.3.2 4.3.3
4.3.5	Receive and Incorporate Public Input	Y	4.3.4
4.3.6	Publish Final Rules		4.3.5
5	Operations Infrastructure Development		
5.1	Implement Automation of Core Tools		4.1.3
5.2	Tool Piloting		
5.2.1	Develop pilot plan		
5.2.2	Clarify pilot approach	Y	4.1.3
5.2.3	Select pilot participants		5.2.2
5.2.4	Training pilot participants		5.2.3 5.1
5.2.5	Obtain input from pilot participants		5.2.4
5.2.6	Analyze data on time per tool		5.2.5
5.2.7	Refinement to tool and training materials based on pilot	Y	5.2.6
5.3	Adjusting SDS staffing capacity		
5.3.1	Estimate changes in SDS staff work		
5.3.1.1	Number of screens & time per screen from pilot		5.2.7
5.3.1.2	Change of volume of assessment from pilot		5.2.7
5.3.1.3	Amount of SDS staff time per assessment from pilot		5.2.7
5.3.2	Reallocate reduce/increase SDS staff		5.3.1
5.4	Implementing Private Sector Infrastructure Support		
5.4.1	ADRC RFP & Contract		4.1.3
5.4.2	Independent Support Plan Coordinator RFP & Contract		4.1.3
5.4.3	Refinement to administrative contracts that pay for screening		4.1.3
5.5	Altering the roles of Waiver Care Coordinators		
5.5.1	Reviewing reimbursement for Support Plan		5.3.1

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Task Number	Task Name	Council Input	Predecessors
	development given new requirements		
5.5.2	Defining Role of Support Coordinator		5.5.1
5.6	Establish Mechanisms for Individualized Budgets/Hour Assignments		
5.6.1	Adapt eligibility determination and hour assignment algorithms		5.1
5.6.2	Purchase of goods and services (including transition costs)		
5.6.2.1	Establish administrative rates		5.1
5.6.2.2	Policies - documentation requirements, limitations	Y	5.6.2.1
5.6.2.3	Develop form/automation	Y	5.6.2.2
5.6.3	Establish review process		5.6.2
5.7	Build Participant Support Infrastructure	Y	4.1.3
5.8	Build Quality Management Infrastructure		
5.8.1	Automating Management Reports		4.1.3
5.8.2	Implementing COI Meetings		5.8.1
5.9	Build Training Infrastructure for Direct Care Staff		
5.9.1	Administrative Contract to Training Trust to Develop Training Modules and Infrastructure		4.1.3
5.9.2	Development of Training Infrastructure	Y	5.9.1
5.9.3	Implementation of Training Infrastructure		5.9.2
6	ACC Implementation		
6.1	Communication with Participants and Providers		
6.1.1	Develop communication plan	Y	5.2/5.3/5.4/5.5/ 5.6/5.8
6.2	Develop materials that communicate program changes		
6.2.1	PowerPoint presentation	Y	6.1.1
6.2.2	Community Forums and Provider Presentations	Y	6.2.1
6.2.3	Letters to Providers	Y	6.2.1
6.2.4	Letters to Participants	Y	6.2.1
6.3	Enrolling Providers		
6.3.1	Technical assistance to providers	Y	6.2
6.3.2	Provider enrollment	Y	6.3.1
6.4	Transitioning Participants		
6.4.1	Keep current plan until next scheduled assessment, change of status assessment, or within 6 months		6.3.2

Task Number	Task Name	Council Input	Predecessors
	(whichever is sooner)		

Tasks 1-2: Proposed Plan, State Decision

The submission of this report marks the completion of the first task: The development of the proposed plan for ACC. Next, the State will need to decide whether to proceed with ACC. If the State decides to proceed, the next step would be to restructure the Council so that members will be available from the earliest stages of implementation planning. Chapter V describes the proposed changes in Council structure under the section regarding stakeholder input.

The ACC planning should be coordinated with other State planning efforts to include:

- The ADRC 5-Year Plan that was submitted to AoA: The ADRC is an integral part for how Intake and Screening will be handled in ACC; thus this planning effort would need to subsume the ADRC planning effort.
- Alaska’s broader LTSS system reform plan: SDS has been engaging stakeholders in a separate initiative to restructure the broader LTSS system. These plans will need to be aligned.
- Affordable Care Act initiatives: Implementation of ACA requirements, notably the requirement to have a “Navigator” who will assist individuals; especially those with a disability in choosing among health insurance options (including traditional Medicaid), may impact or benefit from integration with this initiative.

Task 3: Development of Detail Plan Related to Policies, Procedures and Tools

Under task 3, we have proposed that SDS work with stakeholders to develop the details of the proposed plans included in this document. This includes the development of all the policies, procedures and tools required for the main components of ACC.

Outreach to stakeholders is a critical component of this phase. The proposed implementation plan includes a variety of opportunities to solicit input, including events (e.g., forums and informational sessions), website, or other opportunities identified by the State and Council.

The main components and activities for Task 3 items are as follows.

- **Intake and Screening:** As discussed in earlier chapters, intake and screening will change considerably under the ACC process. A new, common intake and screening protocol will be developed, along with establishing common data elements and definitions. The intention will be to automate the protocol and tools so that workers can reliably and efficiently provide information and assistance about HCBS, and SDS can track the types of requests and the timeliness of responses. This will require changes to the MIS.

Another critical element for implementing intake and screening is the identification of the entity/entities that will serve as intake agencies in each region of the state. The State will develop agreements about the expected performance standards and staff competencies. SDS

will also be developing reporting mechanisms so that it can claim Medicaid administrative FFP for a portion of the activities performed by intake workers.

- **Assessment:** The in-home assessment protocol will need to be modified to establish functional eligibility for all components of ACC. Although the CAT will continue to provide the basis for determining functional needs, the proposed plans add person centered components to the assessment, such as a person centered interview and quality of life assessment/survey.

Automation of the entire assessment protocol will assist SDS in its management of the assessment process. This automation could incorporate much of the training information directly into the automated tool, thereby improving the reliability of the tool. The planning process should also identify the specific data elements to be used for performance indicators related to Participant status, health and welfare, timeliness of assessment and the correlation between need and services provided.

- **Support Plan:** While this document identified components from other states that could be adapted to be the Support Plan tool, we did not create a draft tool. Thus, the first task would be to develop a workable tool that meets Alaska's needs. This tool would need to meet the CFC rule requirements, such as being person-centered and including risk management and back-up plans. The protocol process must also be designed to engage the Participant in active decision-making about the model of service preferred and who will deliver supports.

SDS would also need to develop the processes for handing off the development of the Support Plan when the responsibility for leading the process shifts. For example, when a Participant is enrolled in both CFC and a Waiver and has an agency-employed Care Coordinator, responsibility for different components of the plan is proposed to be split between that Care Coordinator and SDS staff. The division of labor and sharing of information among these two individuals must be clear.

SDS will need to define the qualifications and develop agreements with the independent support plan coordinators. They would also need to modify requirements and guidance for Waiver Care Coordinators to reflect the new processes.

The tool should also be automated to the extent practicable. This automation may be more complicated than previous efforts because fully automating the tool would include incorporating several work flow requirements. This may require more sophisticated programming or the use of a different platform.

SDS would also want to revisit the draft performance indicators related to support planning included in this document to ensure that these measures are feasible and the tool can easily obtain quantifiable data for each of the measures. We anticipate that many of the measure could be further clarified and the State may wish to add or eliminate measures once the tool is more concrete.

- **Participant Support Infrastructure:** CFC requires the State to be able to provide various supports to Participants for selecting and managing services. In this phase, SDS (with Council

input) will select the specific tools to be developed and identify who will be responsible for developing and updating tools. We envision that the actual development of the tools will occur in the infrastructure development phase.

- **Worker Training Requirements and Infrastructure:** Under this task, SDS would work with Council members to finalize the list of worker qualifications and training requirements identified in this document. This effort will involve “getting into the weeds” to identify the specific components of the training curricula and competency requirements. It is important to note that the actual development of the training materials would occur during the infrastructure development phase. This phase would also address plans for obtaining Medicaid administrative FFP to fund these activities and other more detailed policy issues, such as the ability to opt out of State-sponsored training and grandfathering existing staff. This latter decision will be particularly important because of the change in requirements for existing CDPCA workers.

As described earlier in this report, SDS envisions building this capacity through the TTC. This phase also includes developing a plan for delivering training in remote areas and non-English speaking populations. This would likely be an enhancement to the work started by the TTC.

- **Continuous Quality Improvement Infrastructure:** SDS will need to integrate the various performance indicators for the ACC that were described in Chapter V and will be revisited as the processes, procedures, and tools are fleshed out. SDS should also make efforts to integrate these measures with the existing measures applied to the Waivers to have a single set of measures that applies across all funding streams included in the ACC effort.

These performance indicators should be translated into management reports that are targeted to the key actors who potentially impact the quality of the program. Management reports would be generated and used to inform managers and staff about performance on the quality indicators. The State would also want to develop protocols for how the management reports should be used. For example, the State may want to establish processes for how the reports will be used at each level of the report.

This task area would also include planning for any special issues related to bringing up the infrastructure to support quality management, such as 1) need for a strategy for phasing in the use of the measures, 2) enhancements to the critical incident reporting, and 3) development of procedures for ensuring service continuity when Participants change service models.

It is important to note that the remaining tasks in the implementation plan will be impacted by the decisions made during this phase. Therefore, it was not possible to lay out the tasks in as great of detail for the infrastructure development and implementation phases.

As part of the culmination of this phase, we recommend that the State revise and provide more detail to the rest of the tasks included in this work plan to reflect the decisions that were made.

Task 4: Approvals and Rules

Once the specifics of how the ACC will operate have been developed and stakeholder input incorporated, SDS will be in a much stronger position to receive the necessary approvals to proceed. Thus, we have included sequential tasks for receiving approvals from the following:

- Executive branch
- Legislative approvals, including passage of any statutory authority required by the State
- CMS approval to amend the Medicaid State Plan and Waivers
- Promulgation of regulations necessary for SDS to be able to administer the program and to establish standards for the provision of service

During the process of obtaining approvals and promulgating rules, it may be necessary for SDS to modify policies, procedures or tools developed during Task 3. The State Plan Amendment submitted to CMS will reflect the direction given by both the executive and legislative branches of the State. However, CMS may still require the State to modify plans. In this case, the State would need to determine what steps might be required in order to make the requested changes. For example, a change required by CMS might be inconsistent with statutory authorities given to the Department. In those cases, SDS would need to determine what flexibility it had to proceed and what areas might need to go back to legislators to be modified.

The timeframes for this section of the plan are sometimes difficult to predict. CMS uses timelines for responses to States concerning amendments, but “the clock” can stop and restart based on changes CMS wants to see in the proposed plan. Because few states have submitted amendments concerning CFC, it is difficult to predict how quickly (or slowly) this step of the approval process will proceed. CMS is likely to take longer to address CFC, because it is a new service and decisions may be setting precedents for future requests by other states.

Task 5: Operations Infrastructure Development

A smooth transition to ACC depends on developing the operations infrastructure required to carry out all of the new policies, procedures and operations, to include:

- Automate new protocols and tools.
- Ensure that new protocols and tools used for intake, triage, assessment and support planning are efficient and clear to workers using them. This may include piloting tools to ensure clarity of the tool and training materials and to garner estimates about the amount of time the protocols are taking to complete.
- Adjust staff capacity within SDS to reflect the changes required to implement ACC efficiently and effectively. For example, SDS staff will need to be available to develop Support Plans for individuals without access to any private-independent Support Plan Coordinator.
- Establish and implement new private sector resource roles and provide necessary infrastructure support for each. Examples of new private sector resource roles include the ADRC role in Intake

and Triage, independent Support Plan Coordinators, and changes to current Waiver Coordinator roles for Participants receiving both CFC and HCBS Waiver.

- Implement the new quality infrastructure. For example, new data collection and data aggregation will be required to generate management reports used in the continuous quality improvement process.
- Establish and implement the new training infrastructure. The State will work with the TTC to establish new curriculum and modes of training for staff providing assistance to ACC Participants.

As we noted earlier, once Task 3 is completed and approvals are received, the State will be able to formulate more detailed plans in these areas.

Task 6: Implement ACC

Once all of the component parts are ready, the State will need to develop and implement a plan for transitioning to ACC. This effort should start with a good plan for communicating with Participants, providers and other stakeholders regarding what will happen. Some of the important topics to address include communicating about what the new program entails, benefits of the changes, the timeline for the changes, who is available to help or answer questions/concerns, what actions need to be taken, where additional information can be obtained and how to report problems. The State should consider various modes of communicating (written information, presentations, forums, etc.) and partners (e.g., advocacy organizations, ADRC, provider groups, etc.) so that there is a broad reach to interested stakeholders.

Another implementation task includes enrollment of providers under new standards established for ACC programs. The State will need to implement a plan to transition existing PCA/CDPCA providers over to the new programs and to enroll new service providers for ACC within an established timeframe. This should include a plan for providing technical assistance and training to providers about the new program and standards.

Finally, individual Participants will need to transition over to the new ACC program. The new programs will offer a variety of options not currently available under PCA/CDPCA. It would be unfeasible to transition all Participants at once and also provide the counseling/information necessary to allow individuals to make an informed choice about their services. In the proposed implementation plan we recommend that the State allow for a smooth transition by using the reassessment process to trigger individual transitions of current Participants. Thus, existing Participants would transition over at the point a reassessment occurs or within the first 6 months (whichever is sooner), using the new protocols and tools.

Appendix A: Questions and Answers from CMS on the Proposed Community First Choice State Plan Option Rules

With CMS' Responses Based on the 1/24/12 & 2/1/12 Conference Calls

Please note all answers are based on the policy proposed in the CFC NPRM published 2/26/11. Some of the answers are no longer relevant because of the publication of the final rules on May 7, 2012.

441.510 – Eligibility

Financial Eligibility

1. What provisions, if any, can be made for the Medicaid Buy-in for working disabled (e.g., BBA or Ticket to Work) when an individual needs personal attendant services but does not meet the institutional level of care and their income is above 150% of FPL?
 - a. CMS response: There are no current allowances, but 1902(r)(2) could potentially be used to address this population
2. For states operating S-CHIP as a Medicaid expansion, can individuals above 150% FPL be eligible for CFC if they meet the institutional level of care?

CMS response: Yes, if these individuals are eligible for medical assistance under the State Plan.

Functional Eligibility

3. Can functional eligibility be set below the institutional level (e.g., using a state's current eligibility criteria for State Plan PCA)?
4. CMS response: Per the NPRM, an institutional level of care is not required for individuals with incomes above 150% FPL. We expect the state to establish medical necessity criteria for individuals with incomes below 150% FPL. This criteria could be set below the institutional level.
5. When applying an institutional level of care (LOC), either as the basis of eligibility or to allow income above 150% of FPL, can a state pick which LOC it applies (the draft regulations identified NF, ICF-MR and IMD) or must it apply all of the LOC criteria.
 - a. CMS response: Must use all LOC criteria. Must use the LOC criteria appropriate for the individual being evaluated.
6. If the latter, if a state does not have any IMD (and hence does not have an IMD criteria), must it develop a criteria or can it exclude this category.
7. CMS response: As indicated above, the State uses the LOC criteria appropriate for the individual being evaluated. While Alaska does not have any IMD's, under the EPSDT mandate, for example, Alaska is required to provide medically necessary psychiatric services for individuals under 21. To meet this mandate, the State has created criteria to determine if such services are medically necessary.
8. May the state allow for continued CFC eligibility in situations where individual health status improvements (resulting in improved function and the individual no longer meeting the CFC eligibility criteria) are directly tied to continued provision of CFC services?

- a. **CMS response:** If a state wanted to propose this, CMS would take it under consideration.

441.520 – Required Services

- 9. To what extent can a state set limitations on the use of other services for individuals selecting CFC to prevent non-duplication of services? (e.g., If maintaining the State Plan PCA, can the state limit access to both the State Plan PCA and CFC?)
 - a. **CMS response:** CMS expects states to have procedures to prevent duplication of services, but want to make sure people have access to medically necessary services. State could set limits as long as needs are met.
- 10. Can CMS provide clarification regarding how it envisions that states will meet the requirement to offer rehabilitation and habilitation services under CFC? How does CMS envision these services differing from rehabilitation or habilitation under the Medicaid Rehabilitation option or a 1915(c) waiver? Is it possible to offer these services as independent services under CFC, such as offering separate rate structures, provider qualifications, etc., rather than trying to fold rehabilitation and habilitation services within an agency-based PCA function or within an individualized budget?
- 11. **CMS response:** We believe you are making reference to the requirement at 441.520, that the State provide “Acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADL’s, IADLs, and health related tasks.” Medicaid regulations at 42 CFR 440.130(d) define rehabilitative services as “any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level”. Services provided under the CFC State plan option do not have to meet the same definition.

Habilitation services are defined in the 1915(c) home and community based (HCBS) waiver application as “services defined to assist participants in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings”. While some of the terms here may be similar to the CFC service requirements at 441.520, we caution the State to not use them interchangeably. We want to point out that the services required under 441.520(a)(2) must be directly related to the provision of home and community-based attendant services and supports.

This is a required service and must be available to all individuals who have an assessed need for it. It is up to the State to determine who will provide these services. It could be offered by providers of attendant services, but could be offered by different provider type and rate type. The state will need to describe who will provide these services in the State Plan.

- 12. Similarly, can a state make arrangements to procure certain back-up systems such as emergency response systems as independent services? For example, many states currently offer emergency response systems under 1915(c) waivers and it may be more efficient to procure

these under the existing arrangements rather than trying to pass the funds through a PCA/HH agency or folding it within a self-directed budget.

a. **CMS response: A state may do that.**

13. Optional services:

a. Can a state set up operations for authorizing and paying for transition costs in a manner similar to what it uses for 1915(c) waivers or must these costs be folded into a rate paid to an agency or a self-directed budget?

i. **CMS response: A state should submit its plan for doing this and CMS will review it. CMS gave an example of states in which they have set this up as a specific provider type. It is important to note that if Alaska were to choose to go this way, it would have to open this up to any willing provider.**

b. Can the ability to purchase items or services that substitute for human assistance be used under an agency model either by having the agency serve as a pass through for those funds or by having another entity review and pay for these items?

i. **CMS response: This could be offered under either the agency or agency with choice model. This discussion for the previous question is also relevant here.**

441.525 – Excluded Services

14. The draft regulations states the following are excluded, “(c) Assistive devices and assistive technology services other than those defined in §441.520(a)(5) of this subpart or those that are based on a specific need identified in the service plan when used in conjunction with other home and community-based attendant services.” We are unclear about how broadly or narrowly to interpret this requirement. Can CMS identify the types of assistive devices and technology that could and could not be paid for?

a. **CMS response: CMS struggled with developing regulatory language that would comply with both the exclusions for assistive devices and services required by the legislation and the ability to pay for items or services that substitute for human services. The resulting language is meant to be relatively broad and provide states with flexibility. The key is to make sure items are related to plan and substitute for human assistance.**

441.530 – Service Setting

15. Can the state apply additional restrictions to allowable settings beyond what are included in the regulations, such as excluding settings with more than a certain number of individuals living together?

• **CMS responded yes on the phone. However, upon further consideration, CMS believes it is necessary to have a conversation with the state to understand the purpose of such a limitation. We expect the setting to support an individual’s desire to participate fully in the their community and provide the individual with as much control over how and when services are provided.**

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• **441.535 – Assessment of Need**

16. The draft regulations require a state to conduct a reassessment whenever the individual requests an assessment. While we support CMS' intention of increasing the person-centered nature of the program, we are concerned that individuals may cause undue burden on the state by repeatedly requesting assessments as a tactic to obtain a higher budget. Theoretically, under this provision, an individual could request to be assessed weekly or on a daily basis). To address this, may a state establish reasonable criteria or limitations on how often an individual or the individual's representative request a reassessment such as no more often than once a month or four times a year?
17. **CMS response: We do not believe establishing hard limits on the number of times an individual may request a reassessment complies with the regulatory requirement that an assessment of need must be conducted at the request of the individual. The State should consider the type of screening questions to ask when such a request is made. If an individual repeatedly requests assessments, without a change in medical status, living situation, or any other event that could affect an individual's need for CFC services we expect that State to use clinical judgment to make a determination of the reassessment is necessary.**
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18. If an individual requests a reassessment, can the state conduct a desk review of a reassessment request to determine if a full reassessment is necessary (e.g., there must be some evidence that a change in the individual's needs has occurred) or must a reassessment be done in all requests?

441.540 – Person-centered service plan

Criteria:

19. Section (b)(6) requires that the person-centered plan, "Be signed by all individuals and providers responsible for its implementation."
 - a. When selecting an agency model, does this mean that every staff member providing support must sign or is a signature from a representative of the agency sufficient?
 - i. **CMS response: Having a representative is sufficient.**
 - b. Under the self-directed option, does this requirement mean that the plan must be updated and signed every time that an individual adds a new person who will provide supports? If signatures are required every time, this requirement could become burdensome.
 - i. **CMS response: We do expect signatures are obtained, however, we do not want this requirement to delay an individual's receipt of services. There are operational procedures a State can establish to allow for flexibility so that meeting this requirement is not overly burdensome.**
20. Section (b)(7) requires that the plan, "Be understandable to the individual receiving services and the individuals important in supporting him or her." Given that many potential participants may have significant intellectual or cognitive disabilities, it may not be possible to craft a plan that they understand. In these cases, is it permissible to ensure that the plan understandable by the individual's representative?

- a. **CMS response: States should interpret this requirement as applying to the individual and/or representative.**
21. Section (b)(10) requires that the plan be distributed to everyone involved in the plan. However, in some cases a participant and/or representative may not want the entire plan shared with everyone. Can a state respect a participant's wishes to limit the distribution of his/her support plan?
- a. **CMS response: Yes.**
22. Section (c)(3) requires that the plan, "Ensure the individual's needs are assessed and the services and supports meet the individual's needs." If the individual's supports needs cannot be met through the support plan budget, can/must the individual be excluded from participating in the CFC option?
- a. **CMS response: States could allow individuals who choose to participate for whom assigned supports may not be sufficient to participate in the program if the state addresses this as part of the risk management agreement. Essentially, the individual would be recognizing and assuming responsibility to take on that risk. CMS staff will have further discussion regarding whether a state can prevent a person from enrolling in CFC if the state determines that there is too much risk or if the individual does not agree to assume responsibility for the risk.**
23. Section (c)(4) establishes conflict of interest standards for the assessment and support plan development that can be interpreted as excluding family members, guardians, and other key individuals from the support planning development process. Can CMS clarify the intention of this requirement given that the regulations also require that the process includes people chosen by the individual (in 441.540 (a)(1)) and in many cases the individual will want family included in the process.
- a. **CMS Response: Individuals should be able to include people that they choose to include in the development of a support plan. The language in the draft regulation is specific to the person who is conducting the assessment and/or facilitating the development of the support plan (e.g., an independent support broker).**

441.545 – Service Models

24. Under agency model, the regulation refers to a model in which services are delivered by an entity under a contract. We would like clarification about the intent of the term "contract." Is this a reference to a provider agreement with the State Medicaid agency or does this refer to another form of contract? (This term also appears in the definition section under 441.505.)
- a. **CMS Response: The reference is to a provider agreement.**
25. If a state selects the agency model, does the term "provider" in the requirement that "individuals maintain the ability to hire and fire providers of their choice" apply to the provider agency or to individual staff members as a provider agency as well?
- a. **CMS Response: It applies to both the provider agency and the individual staff members within the provider agency.**
26. The preamble suggests that CMS consider an "Agency with Choice Model" to be a form of *Agency Model*. Is this correct? If so, would an agency with choice be exempt from the

requirements placed on self-directed models including providing participants with the right to set wages and other budget authority?

- a. **CMS Response:** The requirement to set wages and other budget methodology is specific to the requirements for the self-directed model with service budget (§441.550 of the NPRM). However, CMS hopes that states will provide as much flexibility as possible and encourages states to allow individuals some flexibility in setting wages, however, these are not requirements. Agency with Choice arrangements should be willing to let consumers assist in determining wages for personal attendants.
27. Can a state offer more than one version of a particular type of service model? For example, if agency with choice is considered a type of agency model, could a state offer both a traditional agency model and an agency with choice model?
- a. **CMS Response:** Yes, however, CMS expects that individuals would have a choice of which model to receive services under.

Fiscal Management

28. Can a service provider agency (e.g., a PCA/HH agency) be allowed to perform FMS functions?
- a. **CMS Response:** As long as they meet the provider qualifications to provide the services.
29. Can the FMS function be paid out of a participant's service budget OR must the FMS be an administrative cost? If FMS can be paid as a service, can the state establish a contract that limits this function to one or two providers without a 1915(b) or other waiver?
- a. **CMS Response:** If FMS is paid as a service, then any willing and qualified entity must be allowed to provide the service. A 1915(b) waiver is needed if the state wants to limit free choice of provider.

441.550 – Service Plan Requirements for self-directed model with service budget

30. Are the service plan requirements that pertain to the individual's authority to perform specified tasks such as recruit and hire workers, fire workers, supervise workers, train workers, evaluate workers, etc. applicable only to a self-directed model and not the agency model?
- a. **CMS Response:** Although the CFC regulations parse out the self-directed model, one of the requirements that apply regardless of the model is to allow the individual to have the maximum control over how they receive the model. CMS would expect that individuals would not be auto assigned an attendant, but given a choice of staff that they could interview. CMS also expects that individuals would be allowed to be involved in the supervising or training of staff, but understands that the extent to which this would occur would depend upon the service delivery model.
31. Although under the self-directed model, the participant has authority to perform the functions listed in 441.550; does the state have any ability to set minimum requirements in each of these areas?
- a. **CMS Response:** CMS will have more clarification about this in the final regulation.

441.560 – Service Budget Requirements

32. Do the requirements in 441.560 (b) apply only to the self-directed model or also to the agency and other models?
- a. **CMS Response: This applies only to self-directed model with service budget.**
33. The regulation discusses having, "Procedures that will provide safeguards to individuals when the budgeted service amount is insufficient to meet the individual's needs." Can these safeguards include not allowing individuals to enroll in CFC when the budget may not be sufficient?
- a. **CMS Response: A state would need to have clinical support to justify whatever limits it places on the allocation of hours/budgets under CFC. Before excluding anyone from CFC, CMS expects that the state will look at other services that can be provided and try to develop a risk agreement with the individual. If these processes are not successful in developing a plan with a degree of risk that is acceptable to both the state and/or the individual, then the state could justify not including someone in CFC.**
34. In regulation, the state must notify individuals of limits that apply. Is it reasonable to infer that states may place caps on particular types of services?
- a. **CMS Response: Yes. CMS reminds states that service must be sufficient in amount, duration and scope to reasonably achieve its purpose.**
35. The regulation states that "(e) The budget may not restrict access to other medically necessary care and services furnished under the State plan and approved by the State but which are not included in the budget." Given this provision, can a state restrict access to services that may be duplicative of the attendant care offered under CFC (e.g., state plan PCA)?
- a. **CMS Response: States can do this. See the answer to Question 7.**

441.565 – Provider Qualifications

36. Can the state mandate that individuals or provider agencies have the responsibility to train workers, such that the state will NOT be providing the training under either the agency or self-directed models?
- a. **CMS Response: There is no requirement for States to provide training to attendant care workers. Section 441.565 states that the individual retains the right to train workers in the specific areas of attendant care needed by the individual. Under 441.520 – States are required to make available voluntary training to participants on how to select, manage and dismiss attendants. The only State training requirement is found at Section 441.520(a)(4). State could set minimum training requirements under the agency with choice model. Requirements listed in section 441.565(a) would apply.**

441.580 – Data Collection

CMS plans to issue guidance on this that will provide greater detail than provided in the regulations. Their goal is to align CFC with other HCBS authorities. This guidance will come out some time after the final regulation.

37. Does CMS have defined categories for "type of disability," "education level," and "employment status" that is to be reported by the state? This will be helpful in developing assessment tools.

- a. CMS Response: CMS is considering definitions that are similar to those used for other HCBS authorities. This will be addressed in the supplemental guidance.
- 38. Can CMS provide greater information on the type of data and what data must be provided for CFC and other HCBS (non-CFC) services? Does this go beyond what must be included in a 1915(c) waiver application of the 372 report?
 - a. CMS Response: This will be addressed in the supplemental guidance CMS does not envision that there will be need for additional data collection on non-CFC programs.
- 39. What does CMS require on the data for cost of providing CFC and other HCBS? Does this include more information that is provided on the CMS Form 372 or Form 64?
 - a. CMS Response: The CMS form 64 has been modified to add CFC services.
- 40. Section (g) requires the collection of, "Data regarding how the State provides individuals with disabilities who otherwise qualify for institutional care under the State plan or under a waiver the choice to receive home and community-based services in lieu of institutional care." Should a state infer that a requirement for participating in the program is that it must have a mechanism for providing this choice to all individuals seeking LTSS, such as having a Full-Functioning Aging and Disability Resource Center?
 - a. CMS Response: A form similar to what is used in 1915(c) programs would satisfy this requirement.

441.585 – Quality Assurance

- 41. Would it be advisable for a state to use a format similar to the one included in the 1915(c) waiver template version 3.5 as a basis for the CFC Option?
 - a. CMS Response: Yes, the HCBS quality Framework is a good guide for the CFC state plan option. CMS also suggests looking at the 1915(j) template.
- 42. Section (a)(2) states, "These measures must be made available to CMS upon request and must include a process for the mandatory reporting, investigation, and resolution of allegations of neglect, abuse, or exploitation in connection with the provision of community based attendant services and supports, as well as quality indicators approved or prescribed by the Secretary."
 - a. Would an incident management system such as those used for 1915(c) waivers satisfy the former requirement?
 - i. CMS Response: As long as it provides the required information, notably the ability to reporting on the status of investigations and resolutions.
- 43. Is CMS working to develop a set of quality measures for the latter requirement? If so, can CMS share information on what it may require?
 - a. CMS Response: CMS plans to provide guidance in the near future. It is their goal to align the requirements across all HCBS authorities.
- 44. One of the required performance measures is "Choice of institution or community." Are states required to collect this only for individuals applying for CFC or for all individuals seeking LTSS?

CMS Response: CFC only.

- Section (a)(4), states, “Choice and control. The quality assurance system will employ methods that maximize consumer independence and control and will provide information about the provisions of quality improvement and assurance to each individual receiving such services and supports.” Does this mean that a state must provide a description of the entire quality assurance system to each individual or can a document that describes the components of the quality assurance system that are relevant to program participants be developed and distributed?

CMS Response: CMS believes the entire system is relevant to the individuals, therefore, a document providing a plain English read of the quality assurance system should be developed and distributed. This information may be requested by CMS or reviewed during an onsite review.

Appendix B: Summary of Input Received at the Community Forums

Purpose of Community Forums

Over the week of May 13-May 18, 2012, HCBS Strategies and the State facilitated Community Forums in three locations across Alaska. The State advertised these forums through its community network and associations. The purpose of these community forums was to obtain stakeholder feedback and public comment about the State's vision and design for CFC and ACC. Two sessions occurred at each location, one focused on the provider community and one on the Participant community – all sessions were open to the public.

The provider community forums were held in:

- Juneau – Monday, May 14, 2012
- Anchorage – Wednesday, May 16, 2012
- Fairbanks – Friday, May 18, 2012

The Participant community forums were held in:

- Juneau – Sunday, May 13, 2012
- Anchorage – Wednesday, May 16, 2012
- Fairbanks – Thursday, May 17, 2012

Each session lasted approximately 2 hours. The sessions in Anchorage were also made available via teleconference.

The presentation slides are available at <http://akcfc.blogspot.com>

Summary of Input from Community Forums

The format for each meeting included a presentation of the proposed design of CFC and ACC. These presentations walked through an overview of Alaska's current LTSS programs, briefly discussed opportunities and challenges to those programs, and shared the vision and goals of the State. The presentation then goes through the various components and design considerations for CFC and ACC. The core components were the eligibility criteria, operational model to provide access and supports, and the quality and training of workers. The audience was invited to participate and provide comments at any time during the presentation and allowed the opportunity for an open dialogue and discussion. HCBS Strategies and the State provided clarification or acknowledged the comments that were brought up by the attendees. The summary of the community forums are categorized around the topic areas of discussion during the presentations.

PCA participant attendees expressed the importance of the supports received under PCA, but were positive by acknowledging the State's vision to make improvements and offered willingness to participate in the design process of CFC and ACC. Participant attendees expressed their desire to preserve the invaluable services they receive. Participant attendees were initially concerned that the

proposed changes would decrease services. Clarification was provided that there is no intention to reduce services – only to improve the consistency, quality, and sustainability of the services with the Participants in mind.

Providers had a variety of questions and concerns about the proposed design of CFC and ACC. The majority of feedback on the design of CFC and ACC was from the provider community and is describe in this summary. While many providers agreed with the intention to support and improve the quality of long-term services and supports through CFC, there were concerns on the proposed changes that would occur through the ACC design. General anxieties were raised about the State's current capacity and its ability to meet the CFC requirements. Some providers requested that the State consider changes to the current PCA infrastructure before moving toward a broader systems change. Some reservations were the based on the uncertainty of when these proposed changes would begin implementation.

One provider expressed strong concerns and limited support for the proposed implementation of CFC. The provider emphasized that the State and HCBS Strategies had not provided evidence or indications that the current PCA program needed to be changed. The provider also reiterated concerns around the State's capacity for this systems change and expressed that there are potentially limited cost benefits of this change.

The State and HCBS Strategies explained that the proposed design of CFC and ACC is a broad and long-term vision for Alaska. The State's intention is to strengthen and improve the quality and efficiency to the supports provided to the State's program Participants. The proposed design presented is the first step of a gradual process that will require continued discussion between the State, the Participants and their families, and the providers. The State is at the design and evaluation phase of this process. Any implementation efforts will require building the capacity at the both State and provider levels. As part of this on-going effort, the State will need to evaluate the planning of any such implementation as well as any funding and sustainability design decisions.

Conflict Free Provision

CFC include provisions for "conflict-free" access to services where the party that provides Participants information and access to services must be independent of the entity that provide services to the Participant. The State's proposed assurances of delineating activities to specific staff in CFC and were noted with some concerns from providers. Providers noted that in many occasions, workers are tasked with many roles and it would be difficult to have separate roles to meet the conflict-free provision.

Additionally, there were comments from the provider community that they already offer PCA Participants with options to maximize Participant choice. Some providers identified themselves as non-profit entities and that Participant choice and objective information is built into their core mission.

Providers expressed opinions that the proposed requirements for an independent "conflict-free" party would delay the time that a Participant would wait to receive services. Providers requested that the State consider its interpretation of the "conflict-free" requirement and allow exemptions or flexibility in the policy. For example, the State should consider allowing non-professional service providers such as transportation and meal delivery to be exempt from the "conflict-free" requirement or develop a flexible policy for rural areas where a provider can serve multiple roles.

The State recognized that many providers do currently offer choice and support options to Participants in an objective manner, but setting a statewide “conflict-free” provision will assure all Participants receive objective counseling and access to a consistent set of information in obtaining supports.

Person Centered Principles

Related to the “conflict-free” provision is the guidance to develop processes that are person-centered. Under CFC, the State must establish guidelines for incorporating person-centered principles when providing access to supports. This incorporates not just accessing what a Participant functionally needs, but developing a process to incorporate the goals and preferences of the Participant. These goals and preferences may not necessarily be a direct functional need, but an outcome of a holistic plan.

For example, a Participant attendee expressed his desire to be connected to his community even though he had physical challenges to getting outside. He was able to overcome this by getting assistance to setup a web-cam and Skype. While the support he received does not necessarily address a functional need, it allowed him to connect to his family and friends – helping him achieve a personal goal.

The State acknowledged that many providers do offer person-centered supports, but the State wants to establish standards for Participant to access supports through person-centered processes as a core vision in the design of ACC.

Accessing ACC with ACA Navigators

There was discussion on the design of how individuals would access the system by building capacity for the State and the ADRC to become the entry point for consumers to access supports and services. Currently providers conduct much of the information and outreach effort. However, while providers have good intentions to provide Participants objective information, this potentially creates a conflict of interest. This led to discussion on how to build up capacity and utilize the existing provider networks to assist with Participant access to supports.

There were mentions of utilizing Navigator entities as potential resources – as described and supported under the Affordable Care Act (ACA). Navigators serve as guide to Participants in accessing long-term supports and services. This led to comments about potentially establishing providers as Navigator entities that meet “conflict-free” assurances. This could be a potential access point as providers are already trusted and known resources in the community and could potentially support the State in providing consumers information in accessing supports in Alaska.

Coordination of Services & Care Coordination

In the proposed operational design, the ACC is intended to coordinate access between CFC and waiver services. The State will explore ways to improve service coordination and reduce duplication of effort between waiver programs and CFC services. Examples include preventing duplication of services and streamlining eligibility determination and assessments.

After the intake screening and assessment, there should be only one plan that encompasses all Medicaid services – being be most efficient for the State, the providers, and the Participant. This improved coordination of services would also allow better resource allocation from respective funding sources.

As part of the coordination of services, clarifications were made on the role of care coordinators. Providers wanted to know how this provision would change the role of care coordinators. While the State wants to maintain much of the role of care coordinators, the role of an agency-based care coordinator would need to meet CFC “conflict-free” requirements. While independent waiver care coordinators would continue to provide support planning and monitoring, care coordinators that are tied to the provider agency will have a lesser role in the development of a Participant’s support plan.

Option to Purchase of Goods and Services that Replace Human Assistance

CFC allows the State to choose the option of offering Participants to purchase goods and services that replace human assistance. The State proposed including this option in Alaska. There was discussion of the benefit and questions if the State would be defining the flexibility of the option. Providers also asked the State to address how goods and services would be purchased – e.g., if the provider would become the purchaser. Providers also asked if there would be limits or caps placed on the amount of eligible services.

Clarifications were provided on the flexibility of the benefit and that the State will provide exemptions but not attempt to provide an inclusive list. The flexible benefit can be especially helpful for tribal and rural populations that may not have electricity, modern appliances, or running water – needs that might be taken for granted in urban or developed areas. An example is hiring someone to chop firewood for the winter months that would potentially be justifiable for a Participant that requires firewood for heating to remain at home or in the community. The ability to purchase goods and services can be used to pay for workers, services, and technology that would increase the independence of the Participant.

Cultural and Geographical Considerations

With the proposed direction of having the State take a more direct role with Participants accessing long-term supports and services in Alaska, providers offered guidance to the State about cultural and geographical consideration in the design of ACC.

The providers at the community forums offered examples of many useful experiences and guidance to the State on cultural and geographical considerations. The providers have worked to build relationships within many communities in Alaska and expressed that some of the proposed design should consider the accessibility to a point person/contact and trust that needs to be facilitated in many communities. Some populations do not generally reach out to public entities to obtain help. Providers have played an important role in building credibility within those communities to provide information and access. There are tribal areas where English is not the primary language spoken, the community has culturally unique practices, and have there is limited access to metropolitan services such as running water or telephone service.

The State acknowledged the feedback and welcomed the providers to share those experiences as the State continues to design the capacity and infrastructure for ACC in Alaska. The State realizes that there are many populations that will continue to need these providers as an integral part of the State’s capacity to provide supports in these unique and local areas.

Worker Training Requirements

There was a productive discussion with providers around proposed worker training requirements. The State is proposing to establish a minimum standard for workers who provide attendant care services under ACC.

Many providers commented that they already offer and/or require skills training for their workers. Providers had various comments ranging from concerns about the amount of training required and potential delays that may result in getting services to the Participant, to concerns about who would pay for training.

Some providers commented that some of the proposed training requirements are covered under other mandates or the provider already requires certain training. Additionally, some training is required part of the agency's liability insurance. Providers also offered suggestions on additional training that the State should consider. These additional trainings included lifting techniques and following consumer direction. Some providers also have their own online training programs.

Providers were concerned that the amount of training required would potentially delay a Participant to hire a qualified worker. The State clarified that some training requirements can occur after the start of services and other requirements are tailored to the needs of the Participant or as requested by the Participant. The State desires to get qualified workers to the Participant as expeditiously as possible, and recognizes the potential for administrative delay.

Some providers had questions on the cost of the training. Providers were concerned that training costs could potentially shift to the agencies. Additionally, there are costs that are tied with turnover of workers and time charged for training. The State acknowledged that it will work with the providers to develop a training program that is sustainable.

There were concerns on the infrastructure required to train and manage the training of the workers. The State clarified that it is exploring the infrastructure through the cooperation with the Training Trust Cooperative at University of Alaska. The Training Trust Cooperative has a learning management system that offers various training modules that can be adapted as well as track the completion of the training.

The State will be able to leverage much of this feedback and information in the design of a training program for ACC. The ability to work with providers to establish a minimum set of training requirements and a statewide training infrastructure will improve the consistency of services provided for all ACC Participants.

Appendix C: Preliminary Version of the Intake Protocol

This is a rough draft that has not been extensively reviewed by the State, nor has input been received from stakeholders. Thus, it should be viewed as a starting point or a potential example rather than a completed tool.

[If the Participant is making an LTSS request, record any specific service that the Participant is requesting. Do not prompt services to the Participant; record only if a specific service is requested. These listed services are offered under ACC.]

B4. Person is requesting specific services:

- No specific service requested
- Adult Day Services
- Care Coordination
- Day Habilitation
- Residential Habilitation
- Respite
- Supported Employment
- Chore
- Other (specify) _____
- Environmental Modifications
- Intensive Active Treatment
- Meals
- Residential Supported Living
- Specialized Medical Equipment & Supplies
- Specialized Private Duty Nursing
- Transportation
- Personal Care

C. CALLER INFORMATION

C1. May I get your name please? Anonymous

[Verify the spelling of the name, first and last name, of the person who you are talking with.]

First name: _____

Last name: _____

Middle name: _____

[In Section B: Reason for Contact (item B1), if conducting the intake with the Participant, select Self-referral. Otherwise ask the individual and select the appropriate relationship.]

C2. What is your relationship to the Participant?

- m Self-referral
- m Spouse
- m Partner/Significant Other
- m Child or Child-in-law
- m Parent/Guardian
- m Other relative
- m Friend
- m Neighbor
- m Other informal helper
- m Service/Provider Agency/Hospital/Clinic**

[If Service/Provider Agency/Hospital/Clinic selected in C2, then please specify the appropriate agency item in below.]

C2. What is the name of the organization you are representing?

Agency name: _____

[Get information about Participant requesting services (i.e., first name, last name, dob, age, and gender.) If this is a Self-Referral (C2), this question will be skipped.]

C3. First I would like to get some basic information about the Participant. May I get the Participant's:

First name: _____

Last name: _____

Middle name: _____

C4. Birth date:

/ /

C5. Age: [Age from DOB]

C6. Gender:

m M m F

D. DEMOGRAPHIC INFORMATION

I would like to ask for some general demographic information on **the Participant**.

D1. What is the Participant's marital status?

- m Never Married
- m Married
- m Civil Union
- m Partner/Significant other
- m Widowed
- m Separated
- m Divorced

D2. What is the Participant's race? (select all that apply)

- White
- American Indian/Native Alaskan (tribe): _____
- Black/African American
- Asian Indian
- Japanese
- Native Hawaiian
- Chinese
- Korean
- Guamanian/Chamorro
- Filipino
- Vietnamese
- Samoan
- Other Asian/Other Pacific Islander (specify): _____
- Other (specify): _____
- Unknown

D3. Is the Participant of Hispanic, Latino, or Spanish origin?
 m No, not of Hispanic, Latino, or Spanish origin
 m Yes, Mexican, Mexican Am, Chicano
 m Yes, Puerto Rican
 m Yes, Cuban
 m Yes, another Hispanic, Latino, or Spanish origin (specify): _____

D4. What is the Participant's spoken language(s)?
 English Spanish ASL Other (specify): _____

[If English is not the primary language selected in response D4 then complete D5, otherwise skip D5.]

D5. Would the Participant like to have an interpreter if available? m Yes m No

D6. Is the Participant a U.S. Citizen or legal resident of the US? m Yes m No

D7. Is the Participant an Alaskan Resident? m Yes m No

D8. Is the Participant a U.S. Veteran? m Yes m No

E. ADLS/IADLS SCREEN

I would now like to get a sense of the Participant's ability to perform daily activities such as mobility, transportation, and general ability to care for himself/herself.

E1. Can the Participant take care of his/her daily personal care needs on his/her own? These include personal care tasks such as personal hygiene and grooming, dressing, bathing, dressing, eating, toileting, getting around. Can you describe the tasks that the Participant needs or have received assistance on?

[Indicate ADLs where the Participant required assistance in the form of hands on assistance or supervision & cueing. Prompt the Participant if the ADL is not mentioned.]

- ADLs that the Participant has described as needing assistance:**
- Bed Mobility
 - Transfers
 - Locomotion
 - Dressing
 - Eating
 - Toileting
 - Personal Care/Grooming
 - Bathing

E2. Is the Participant able to do day to day activities such as doing housework, shop, pay the Participant's bills, fix the Participant's own meals, or managing the Participant's medications?

[Indicate IADLs where the Participant required assistance in the form of hands of assistance or supervision & cueing. Prompt the Participant if the IADL is not mentioned.]

- IADLs that the Participant has described as needing assistance:**
- Meal Preparation
 - Using the telephone
 - Light house work (e.g., dishes, dusting (on daily basis), making own bed)
 - Managing finances
 - Routine Housework (e.g., vacuuming, cleaning floors, trash removal, cleaning bathroom)
 - Grocery Shopping
 - Laundry
 - Transportation

[If any ADLs are identified in E1, the Participant may be eligible for services through ACC and targeted for an ACC in-home assessment.]
E3. The **Participant** may be able to receive some assistance based on his/her needs. I will need to ask you some additional questions to best determine how to assist the **Participant**. This may include scheduling an in-home assessment. Do you agree to continue with this intake?

(a) **Participant agrees to continue with intake:** m Yes m No

[If Yes, skip to Section F. Contact Information of Person Needing Services]

[If No, complete item (b), ask why the Participant is not able to continue.]

(b) **Reason individual is unable to continue with intake:** _____

· [Skip to Section H. Alaska Community Choices Outcomes, schedule a follow-up intake call if the Participant unable to complete the intake at this time.]

[If no ADLs are identified in E1, but IADLs are identified in E2, the Participant may be eligible for services through state Grant Programs.]

E4. I can refer you to resources that may meet the needs described for the **Participant**. Would you like me to refer you to see if you might be eligible for those supports?

m YES m NO

[If Yes, make referral to Grant Programs and skip to Section H. Alaska Community Choices Outcomes]

[If No, provide General Information and Assistance as appropriate and skip to Section H. Alaska Community Choices Outcomes]

[If no ADLs/IADLs identified in E1 or E2, provide General Information and Assistance as appropriate and skip to Section H. Outcomes]

F. CONTACT INFORMATION OF PERSON NEEDING SERVICES

I would like to continue this intake and get some of the **Participant's** contact information.

F1. What is the **Participant's** type of residence? The **Participant** is currently residing in a:

[Select one]

- | | |
|--|--|
| <ul style="list-style-type: none"> m Private home / apartment / rented room m Adult Residential Care Home m Assisted Living m Mental health residence—e.g., psychiatric group home (care and/or foster homes) m Group home for persons with physical disability (care and/or foster homes) m Setting for persons with intellectual disability (care and/or foster homes) m Psychiatric hospital or unit m Long-term care facility (nursing home) m Hospice facility / palliative care unit m Correctional facility m Unclear, need to clarify (provide description from available information): _____ | <ul style="list-style-type: none"> m Board and care m Community Care Family Foster Home m Homeless (with or without shelter) m Rehabilitation hospital / unit m Acute care hospital m Other (specify): _____ |
|--|--|

[If a facility is selected the current residence in C1, then complete F2-F7 for the facility information, otherwise skip to F8.]

What is the address of the facility the **Participant** residing at?

F2. Facility street address: <input type="checkbox"/> N/A	F3. City: <input type="checkbox"/> N/A	F6. Main Phone: () <input type="checkbox"/> N/A
--	---	--

		F7. Alternative: ()
--	--	--------------------------------

F4. State:	F5. ZIP Code: <input type="checkbox"/> N/A	
-------------------	---	--

What is the **Participant's** home address?

F8. Home street address: <input type="checkbox"/> N/A	F9. City: <input type="checkbox"/> N/A	F12. Home Phone: () <input type="checkbox"/> N/A
--	---	---

		F13. Work/Cell: ()
--	--	-------------------------------

F10. State:	F11. ZIP Code: <input type="checkbox"/> N/A	
--------------------	--	--

F14. Is the home or facility address the Participant's mailing address? <input type="checkbox"/> Home <input type="checkbox"/> Facility <input type="checkbox"/> Other [If the mailing address is not the Home or Facility, select Other. If the mailing address is the Home/Facility, use the Facility (F2-F7) or Home (F8-F13) address information. If Other, get mailing address information for F15-F21.] [Complete F22 and F23.]			
F15. Mailing address: <input type="checkbox"/> N/A	F16. City: <input type="checkbox"/> N/A	F19. Home: () <input type="checkbox"/> N/A	F20. Work/Cell: ()
F17. State:	F18. ZIP Code: <input type="checkbox"/> N/A	F21. Email: <input type="checkbox"/> N/A	
F22. How would the Participant prefer to be contacted? <input type="checkbox"/> By mail <input type="checkbox"/> In-person <input type="checkbox"/> Phone (specify): _____ <input type="checkbox"/> Email			
F23. Does the Participant have access to a computer with online access (internet, email)? <input type="checkbox"/> YES <input type="checkbox"/> NO			

E. IDENTIFYING DECISION MAKERS

I would now like to ask a few questions about how the **Participant** make(s) everyday decisions.

E1. Is the **Participant able to make independent decisions about his/her health care, money or other issues?**
 Yes No Chose not to answer

 [If Yes, omit the rest of Section E. and skip to Section F. Medicaid Enrollment]

E2. Does someone have the legal authority to make decisions or sign papers for the **Participant?**
 Yes No Unsure

 [If No or Unsure, complete E3. If Yes, skip to E4.]

E3. Is there someone the **Participant would like to have assist or support them in making decisions?**
 Yes No Unsure

 [If No/Unsure, consult with supervisor to follow-up with Participant to get appropriate assistance.]

E4. We want people to be in charge of planning their own services. To what extent is the **Participant able to participate?**
 Actively Limited Not able to meaningfully participate

 [If the person is unable to actively participate, provide justification/clarification.]

E5. How could we maximize the **Participant's participation?**

[Complete for information for the substitute decision maker, E6-E18.]
 If there is someone who helps the **Participant** make decisions, what is the name, the type of authority, the **Participant's** relationship with, and contact information of the person?

E6. First name:	E8. Middle name:
E7. Last name:	

E9. Please indicate the type of decision-making authority:
 [check all that apply]

<input type="checkbox"/> Informal decision-making support (no legal authority)	<input type="checkbox"/> Responsible Party (for receiving services)
<input type="checkbox"/> Public guardian	<input type="checkbox"/> Unpaid private guardian
<input type="checkbox"/> Paid private guardian	<input type="checkbox"/> Private conservator for finances and property only
<input type="checkbox"/> Trustee for supplemental or special needs	<input type="checkbox"/> General Power of Attorney
<input type="checkbox"/> Durable Power of Attorney/Financial	<input type="checkbox"/> Health Directive Agent
<input type="checkbox"/> Representative/Protective Payee	<input type="checkbox"/> Tribal guardianship
<input type="checkbox"/> Other (specify) : _____	
<input type="checkbox"/> Unsure (describe) : _____	

E10. Relationship to the Participant: _____

E11. Street address: <input type="checkbox"/> N/A	E12. City: <input type="checkbox"/> N/A	E15. Main Phone: () <input type="checkbox"/> N/A
		E16. Work/Cell: ()
E13. State:	E14. ZIP Code: <input type="checkbox"/> N/A	E17. Email: <input type="checkbox"/> N/A

E18. How would he/she prefer to be contacted?
 By mail In-person Phone Email

Who can we contact if we cannot reach individual that you have identified to assist with decisions?
 [If information is available, complete information for alternative contact, E19-E31.]

E19. Last name: _____

E20. First name: _____ **E21. Middle name:** _____

E22. Please indicate the type of decision-making authority:
 [check all that apply]

<input type="checkbox"/> Informal decision-making support (no legal authority)	<input type="checkbox"/> Responsible Party (for receiving services)
<input type="checkbox"/> Public guardian	<input type="checkbox"/> Unpaid private guardian
<input type="checkbox"/> Paid private guardian	<input type="checkbox"/> Private conservator for finances and property only
<input type="checkbox"/> Trustee for supplemental or special needs	<input type="checkbox"/> General Power of Attorney
<input type="checkbox"/> Durable Power of Attorney/Financial	<input type="checkbox"/> Health Directive Agent
<input type="checkbox"/> Representative/Protective Payee	<input type="checkbox"/> Tribal guardianship
<input type="checkbox"/> Other (specify) : _____	
<input type="checkbox"/> Unsure (describe) : _____	

E23. Relationship to the Participant: _____

E24. Street address: <input type="checkbox"/> N/A	E25. City: <input type="checkbox"/> N/A	E28. Main Phone: () <input type="checkbox"/> N/A
		E29. Work/Cell: ()
E26. State:	E27. ZIP Code: <input type="checkbox"/> N/A	E30. Email: <input type="checkbox"/> N/A

E31. How would he/she prefer to be contacted?
 By mail In-person Phone Email

F. MEDICAID ENROLLMENT

Get information about if the Participant is enrolled in Medicaid.

F1. Is the Participant enrolled in Medicaid?

The Participant is enrolled in Medicaid: m Yes m No m Unsure

[If the Participant is not enrolled or UNSURE in Medicaid enrollment (F1), then complete F3. Otherwise the Participant is enrolled in Medicaid; skip to Section G. Assessment Logistics to schedule an ACC in-home assessment.]

G2. What does the Participant want to happen as a result of a plan for long-term care supports?

[Schedule an ACC in-home assessment and discuss what the Participant may need to have available. (This may include medication lists, someone to assist during the assessment process, other documents, etc.)]
G3. Additional Information for an Alaska Community Choices In-home Assessment: e.g., how to reach person/directions to person's residence/beware of dog

[Please record the date of scheduled for the ACC in-home assessment that was made.]
G4. Scheduled Alaska Community Choices In-home Assessment Date/Time: _____(month/day/year)
 _____(approximate time)

[ALASKA COMMUNITY CHOICES INITIAL INTAKE IS COMPLETE, END OF INTAKE]

H. ALASKA COMMUNITY CHOICES OUTCOMES

[Please record the outcome of the Alaska Community Choices initial intake if General Information and Assistance was provided and no ACC in-home assessment was scheduled. If a referral was also made, include the agency information.]

[Check all that apply]
H1. ACC Referrals/Action Taken: General Information and Assistance only
 General Information and Assistance, made referral
 Intake Follow-up Required (e.g., Participant needs assistance from representative)

H2. Agency Accepting the Referral:		H3. Agency Staff Contact: <input type="checkbox"/> N/A	
H4. Agency street address: <input type="checkbox"/> N/A	H5. City: <input type="checkbox"/> N/A	H8. Main: () <input type="checkbox"/> N/A	H9. Fax: () <input type="checkbox"/> N/A
H6. State:	H7. ZIP Code: <input type="checkbox"/> N/A	H10. Email: <input type="checkbox"/> N/A	

[Please record the date that the referral was made.]
H11. ACC Referral Date Made: _____(month/day/year)

[If selected, will include additional agency information fields H2-H11 (additional fields fill).]
H12. Additional Referral

H13. Additional Follow-up Needed, describe:

H14. Summary of Information and Referral Provided:

Appendix D: Preliminary Version of the Assessment Protocol

This is a rough draft that has not been extensively reviewed by the State, nor has input been received from stakeholders. Thus, it should be viewed as a starting point or a potential example rather than a completed tool.

DRAFT ALASKA COMMUNITY CHOICES – IN-HOME ASSESSMENT

A. ADMINISTRATIVE INFORMATION & ASSESSMENT LOGISTICS			
<p>[Make introductions with Participant and/or representative if also present about the scheduled ACC in-home assessment from the recommendation/request that was made based on the intake information. Information from the ACC intake can feed forward into the ACC in-home assessment.]</p>			
<p>[Information from intake.] A1. Information for ACC In-home Assessment: e.g., how to reach person/directions to person's residence/beware of dog:</p> <p>_____</p>			
<p>[Information from intake.] A2. Scheduled ACC In-home Assessment Date/Time: _____/_____/_____(month/day/year) _____ (approximate time)</p>			
<p>A3. Date/Time of ACC In-home Assessment Conducted: _____/_____/_____(month/day/year) _____ (time)</p>			
<p>A4. Notes prior to ACC in-home assessment:</p> <p>_____</p>			
<p>A5. Name of Participant [From initial intake.]</p> <p>Last name: _____ Middle name: _____</p> <p>First name: _____ Jr/Sr/III: _____</p>			
<p>A6. Participant Contact Information and Demographic Data [The demographic information should be automated to populate from the initial intake. The assessor should verify for completeness. Items not collected from the intake should be asked.]</p> <table style="width:100%; border: none;"> <tr> <td style="width:50%; vertical-align: top; border: none;"> <p><u>Participant Contact Information</u> [Verify or gather as noted]</p> <p>Street Address: City: State: Zip Code: Home Phone: Work Phone: Cell Phone: Date of Birth: Current Age: Medicaid #: [Gather from Participant] Medicare #: [Gather from Participant] Veteran #: [Gather from Participant] Other Insurance: [Gather from Participant]</p> <p><u>Present Location</u> <input type="checkbox"/> Same As Above Facility: Street Address: City: State: Zip Code: Phone:</p> </td> <td style="width:50%; vertical-align: top; border: none;"> <p><u>Demographic Data</u> [Verify or gather as noted]</p> <p>Race: Primary Language: Gender: Marital Status: Education: [Gather from Participant] Living Arrangements: [Gather from Participant] Total In Home: [Gather from Participant]</p> <p>If client does not live alone, indicate number of persons under each category: [Gather from Participant] Participant's Spouse: Participant's Parent(s): Participant's Siblings: Children (under age 18, regardless of parentage): Adult Children: Other Relatives: Others (ex: friends, roommates):</p> </td> </tr> </table>		<p><u>Participant Contact Information</u> [Verify or gather as noted]</p> <p>Street Address: City: State: Zip Code: Home Phone: Work Phone: Cell Phone: Date of Birth: Current Age: Medicaid #: [Gather from Participant] Medicare #: [Gather from Participant] Veteran #: [Gather from Participant] Other Insurance: [Gather from Participant]</p> <p><u>Present Location</u> <input type="checkbox"/> Same As Above Facility: Street Address: City: State: Zip Code: Phone:</p>	<p><u>Demographic Data</u> [Verify or gather as noted]</p> <p>Race: Primary Language: Gender: Marital Status: Education: [Gather from Participant] Living Arrangements: [Gather from Participant] Total In Home: [Gather from Participant]</p> <p>If client does not live alone, indicate number of persons under each category: [Gather from Participant] Participant's Spouse: Participant's Parent(s): Participant's Siblings: Children (under age 18, regardless of parentage): Adult Children: Other Relatives: Others (ex: friends, roommates):</p>
<p><u>Participant Contact Information</u> [Verify or gather as noted]</p> <p>Street Address: City: State: Zip Code: Home Phone: Work Phone: Cell Phone: Date of Birth: Current Age: Medicaid #: [Gather from Participant] Medicare #: [Gather from Participant] Veteran #: [Gather from Participant] Other Insurance: [Gather from Participant]</p> <p><u>Present Location</u> <input type="checkbox"/> Same As Above Facility: Street Address: City: State: Zip Code: Phone:</p>	<p><u>Demographic Data</u> [Verify or gather as noted]</p> <p>Race: Primary Language: Gender: Marital Status: Education: [Gather from Participant] Living Arrangements: [Gather from Participant] Total In Home: [Gather from Participant]</p> <p>If client does not live alone, indicate number of persons under each category: [Gather from Participant] Participant's Spouse: Participant's Parent(s): Participant's Siblings: Children (under age 18, regardless of parentage): Adult Children: Other Relatives: Others (ex: friends, roommates):</p>		
<p>A7. Participant Identification Number</p> <p>Identification Number: _____ [if applicable, e.g., a universal identifier not tied to SSN]</p>			

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A8. Medicaid Status			
m Medicaid Enrolled	m Medicaid Pending (Submitted)	m Completing Medicaid Application	m Unknown
A9. Reason for Assessment			
m 1. First assessment m 3. Return assessment m 5. Discharge assessment, covers last 3 days of service m 7. Other—e.g., research		m 2. Routine reassessment m 4. Significant change in status reassessment m 6. Discharge tracking only	
A10. Assessor Information			
First name: _____		Last name: _____	
Phone: _____		Email: _____	
A11. Representative Assisting During Assessment		[complete if applicable]	
Last name: _____		First name: _____	
Relationship to Participant: _____		Does the representative have Decision Maker Status: m Yes m No	
[Complete these items only if the representative has Decision Maker Status]			
Copy of the legal paperwork has been obtained/verified: m Yes m No [If No, obtain a copy from the Participant or contact the appropriate authorities to obtain a copy]		Copy of legal paperwork in the person's file/record: m Yes m No [If No, ensure copy is placed in person's file/record]	

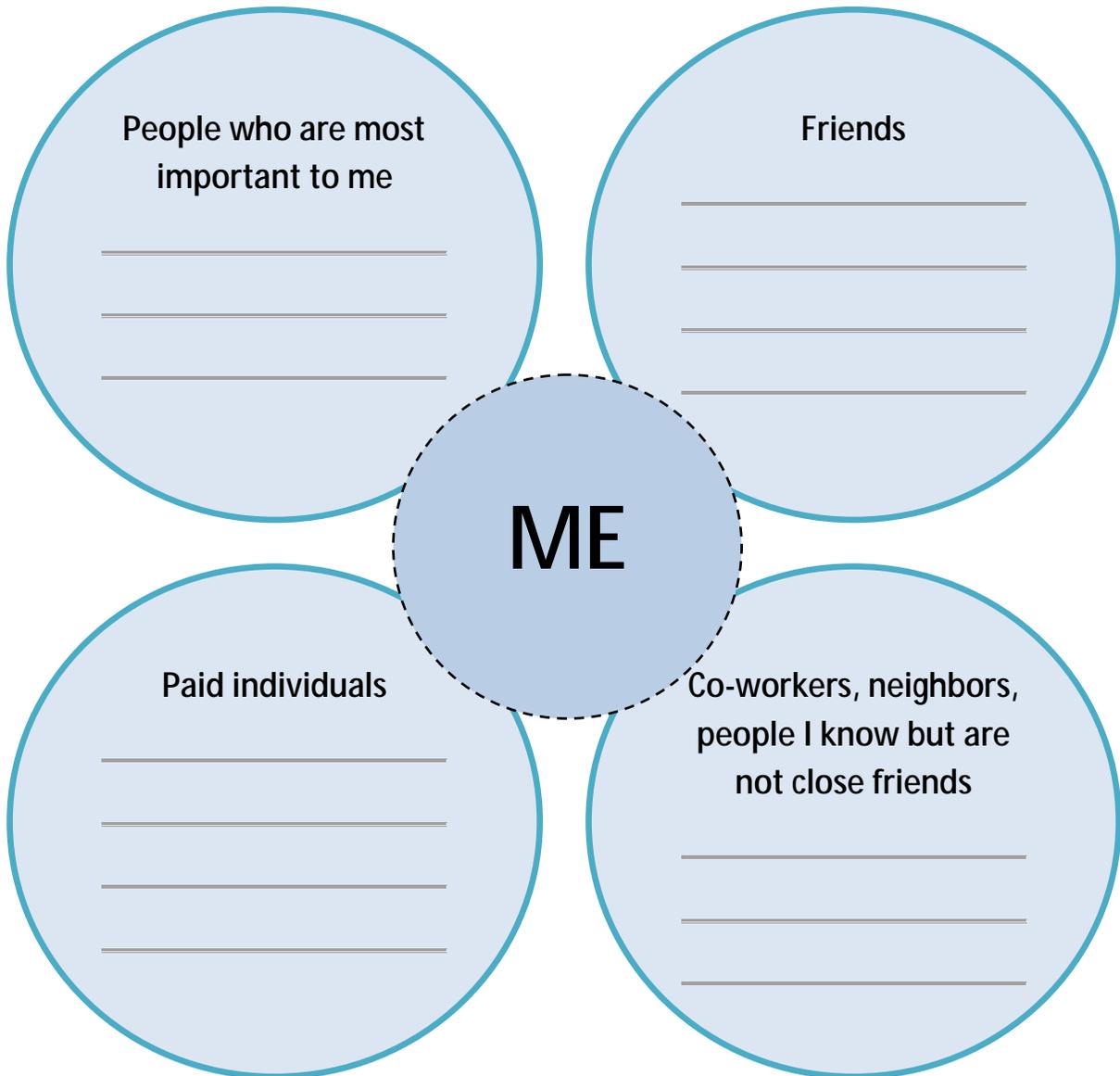
Protocol Format Legend:

Prompts for intake staff to ask the Participant/Participant's representative.
Item for intake staff to complete, not a prompted question to ask.
[Guidance and instructions for the intake staff.]

B. BRIEF PERSON-CENTERED INTERVIEW

In this part of the **Alaska Community Choices** in-home assessment, I will be asking you a series of questions so we can understand your personal preferences, your supports and resources, your health history and your ability to perform day to day activities.

Everyone counts on a variety of supports from other people to get through the day. The people you count on become especially important when there are major changes in your life. Imagine yourself in the center of the circles below. Fill in the names of people that you can count on and who are part of your support system. One person may be in more than one circle.



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Personal Interview

The Person Centered interview gathers information about the preferences, strengths, concerns, needs, and informal resources. The assessor will ask the Participant for information and record responses. These responses will assist in developing the Personal Support Plan.

This section contains open ended questions about the Participant’s perspective on what is happening in his/her life.

I’d like to ask you some questions about the things going on in your life. For example, I will ask you about what is going well for you at this time. These questions will help me to understand more about what works or does not work, and areas that we need to pay close attention to as we develop your plan.

If you were planning a “Good Day”, it would look like:

A “bad day” might be...

Please describe any ongoing responsibilities that you have to take care of.

What are your strengths and accomplishments?

What are your needs and concerns?

Who are the people who might help you?

(List them below and how they may help. The assessor may refer back to the Personal Relationship Chart to help identify individuals. This item will also feed into the catalog of supports.)

Name	Relationship	How Person Might Help

What additional resources or training might help address your needs or the needs of people who assist you?

This next section is a facilitated conversation to gather information from the person about 1) life now and 2) life as he/she wants it within various life domains. The worker may need to use prompts to elicit information. Prompts should include questions to help the person talk about what works well and what kinds of concerns he/she might have. If some of these areas have been already mentioned, then the worker may simply use the opportunity to verify or add to the assessors understanding.

I am going to ask you about several areas of your life. The purpose of this exercise is to learn about the things you do now, what is going well or not going well, and then what you’d like to see in the future. For example, I will ask you about what you do for fun or to relax. This can include hobbies, outings with friends, reading, music or anything you enjoy doing. If you have difficulty getting to do things you enjoy or help you relax, please tell me about that. After we talk about what happens now, we can talk about what you’d like to see happen in the future.

MY LIFE NOW	WHAT I WANT
Home/ Family	Home/ Family
Recreation/Fun/Relaxation	Recreation/Fun/Relaxation
Community Involvement/Social/Religious/Cultural	Community Involvement/Social/Religious/Cultural
Work/Volunteer Activities/Learning	Work/Volunteer Activities/Learning

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C. PARTICIPANT QUALITY OF LIFE SURVEY

[This section is a survey of quality of life measures using the Participant Outcomes and Status Measures (POSM). The survey contains eight domains including Availability of Paid Care/Supports, Relationship with Support Workers, Activities and Community Integration, Personal Relationships, Dignity and Respect, Autonomy, Privacy, and Security. Each domain contains a set of statements that the program participants rates on a scale from (1) strongly disagree to (5) strongly agree. Some statements may be coded as Not Applicable (N/A) because the survey is administered prior to services being initiated.]

Part of planning for your needs is to find out more about your opinions about areas that affect your quality of life. I am going to read a statement. I will ask you to tell me whether you strongly disagree, disagree, are neutral, agree, or strongly agree. (The worker may want to provide the individual with a list of these responses.)

Participant Outcomes and Status Measures (POSM) Quality of Life Survey

INSTRUCTIONS: Please fill in only ONE circle for each question below.

Section A: Availability of Paid Care/Supports	n/a	Strongly Disagree	Not Sure	Strongly Agree
<i>(Select n/a if not receiving services)</i>				
A1. My services are what I think I need.				
A2. My services are delivered when I want them.				
A3. My services are helping me live my life the way I want.				
Section B: Relationship with Support Workers	n/a	Strongly Disagree	Not Sure	Strongly Agree
<i>(Select n/a if not using support workers)</i>				
B1. Workers respect what I like and dislike.				
B2. I can pick the workers who come into my home.				
B3. I control and direct their work.				
B4. I can dismiss a worker when I want.				
Section C: Activities and Community Integration		Strongly Disagree	Not Sure	Strongly Agree
C1. I can do activities that are important to me.				
C2. I play an important role in people's lives.				
C3. People know the story of my life.				
C4. I belong to a group that values me.				
C5. I take part in activities in the community when I want to.				
Section D: Personal Relationships		Strongly Disagree	Not Sure	Strongly Agree
D1. I have people I can count on.				
D2. I have people who want to do things with me.				

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D3. People outside my home ask for my help or advice.						
D4. I have opportunities for affection or romance.						
Section E: Dignity/Respect	n/a	Strongly Disagree	Not Sure	Strongly Agree		
E1. I am treated with respect by: <i>(Select n/a if not applicable)</i>						
a. ... by my support workers						
b. ... my family/friends						
Section F: Autonomy	n/a	Strongly Disagree	Not Sure	Strongly Agree		
F1. I live where I want.						
F2. I decide how I spend my free time.						
F3. I pick when to go to bed and get up.						
F4. I control who comes into my home.						
F5. If money is left after paying all my bills, I control how I spend it. <i>(Select n/a if no money left after bills)</i>						
F6. I can go where I want on the "spur of the moment".						
F7. If I want a pet, I can have the type of pet I want. <i>(Select n/a if you don't want a pet)</i>						
F8. I have the strength to face difficulties.						
Section G: Privacy		Strongly Disagree	Not Sure	Strongly Agree		
G1. I can be alone when I want.						
G2. People ask before using my things.						
G3. I can have a private conversation if I want.						
G4. Information about me is kept private.						
Section H: Security		Strongly Disagree	Not Sure	Strongly Agree		
H1. I feel safe when I am alone.						
H2. I feel safe around my support workers.						
H3. If I need help right away, I can get it.						

D. IDENTIFICATION OF PERSON-CENTERED GOALS

[Summarize Person-Centered Goals based on the Participant's responses in Section B. **Brief Person-Centered Interview** and identified quality of life domains that are important to the Participant in Section C. **Participant Quality of Life Survey**. The Participant Goals will drive the development of the Support Plan; these goals are not limited to the number of lines provided below.]

Participant Goal A.

Participant Goal B.

Participant Goal C.

Participant Goal D.

E. CONSUMER ASSESSMENT TOOL (CAT)

SECTION A: Professional Nursing Services

Use the following codes for section A. 1-A.10 (every block should be coded with a response). Personnel will need care that is or otherwise would be performed by or under the supervision of a registered professional nurse.

- 0. Condition/treatment not present in the last 7 days
- 1. 1-2 days a week
- 2. 3-4 days a week
- 3. 5-6 days a week
- 4. 7 days a week
- 5. Once a month
- 6. At least once every 8 hours/7 days a week (used for Extended PDN only)
- 7. Twice a month

1. Injections/IV Feeding *Injections/IV feeding for an unstable condition (excluding daily insulin for a person whose diabetes is under control):*

- a. Intraarterial injection 0
- b. Intramuscular injection 0
- 0. Subcutaneous injection 0
- d. Intravenous injection 0
- e. Intravenous feeding (Parenteral or IV feeding.) 0

2. Feeding Tube *Feeding tube for a new/recent (within 30 days) or an unstable condition:*

- Insertion date:
- a. Nasogastric tube 0
 - b. Gastrostomy tube 0
 - c. Jejunostomy tube 0

3. Suctioning/Trach Care

- a. Nasopharyngeal suctioning 0
 - b. Tracheostomy care for a new/recent (within 30 days) or an unstable condition 0
- Start date:

4. Treatment/Dressings *Treatment and/or application of dressings for one of the following conditions for which the physician has prescribed irrigation, application of medications, or sterile dressings and which requires the skill of an RN:*

- a. Stage 3 or 4 decubitus ulcers 0
- b. Open surgical site 0
- c. 2nd or 3rd degree burns 0
- d. Stasis ulcer 0
- e. Open lesions other than stasis/pressure ulcers or cuts (including but not limited to fistulas, tube sites and tumor erosions) 0
- f. Other/Explain:

SECTION B: Special Treatments and Therapies

1. Treatments-Chronic Conditions

Code for number of days care would be performed by or under the supervision of a registered nurse.

- 0. Not required
- 1. 1-2 days/week
- 2. 3 or more day/week
- 3. Once a month
- 7. Twice a month

5. Oxygen

Administration of oxygen on a regular and continuing basis when recipient's condition warrants professional observation for a new/recent (within 30 days) condition.
Start date: 0

6. Assessment/Management

Professional nursing assessment, observation and management required for unstable medical conditions. Observation must be needed at least once every 8 hours. Specify condition and code for applicant's need
Please specify: 0

7. Catheter

Insertion and maintenance of a urethral or suprapubic catheter as an adjunct to a disease or a medical condition 0

8. Comatose

Professional care is needed to manage a comatose condition. 0

9. Ventilator/Respirator

Care is needed to manage ventilator/respirator equipment. 0

10. Uncontrolled Seizure Disorder

Direct assistance from others is needed for safe management of an uncontrolled seizure disorder. 0

11. Therapy-Therapies provided by a qualified therapist. (Indicate the number of days per week for each therapy required. Enter 0 if none.)

- | | |
|----------------------------|---------------|
| | Days per Week |
| a. Physical therapy | ___ 0 ___ |
| b. Speech/language therapy | ___ 0 ___ |
| c. Occupational therapy | ___ 0 ___ |
| d. Respiratory therapy | ___ 0 ___ |
- Total # of days of therapy per week

12. Therapy- Is therapy required a least once a month for any of the following: physical, speech/language, occupational or respiratory therapy?

0 – No 1 – Yes 0

13. Assessment/Management

Professional nursing assessment, observation and management of a medical conditions once a month. Specify condition and code for applicant's need.
Please specify:

0 – No 1 – Yes 0

2. Treatments/Procedures

Code for number of days professional nursing is required.

- a. Chemotherapy 0
- b. Radiation Therapy 0
- g. Hemodialysis 0
- h. Peritoneal Dialysis 0

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<p>Professional nursing care and monitoring for administration of treatments, procedures, or dressing changes which involve prescription medications, for post-operative or chronic conditions according to physician orders.</p> <ul style="list-style-type: none"> a. Medications via tube <input type="radio"/> b. Tracheostomy care-chronic stable <input type="radio"/> c. Urinary catheter change <input type="radio"/> d. Urinary catheter irrigation <input type="radio"/> e. Veni puncture by RN <input type="radio"/> 	<ul style="list-style-type: none"> f. Monthly injections <input type="radio"/> g. Barrier dressings for Stage 1 or 2 ulcers <input type="radio"/> h. Chest PT by RN <input type="radio"/> i. O2 therapy by RN for chronic unstable condition <input type="radio"/> j. Other, specify: <input type="radio"/> k. Teach/Train <input type="radio"/>
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<p>SECTION C: Cognition</p> <p>1. Memory (Recall of what was learned or known)</p> <p>0 – Memory OK 1 – Memory problems</p> <ul style="list-style-type: none"> a. Short-term memory – seems/appears to recall after 5 minutes <input type="radio"/> b. Long –term memory – seems/appears to call long past <input type="radio"/> 	<p>2. Memory/Recall Ability (Check all that person normally able to recall during last 7 days; 24 – 48 hrs, if in hospital)</p> <ul style="list-style-type: none"> a. Current season <input type="checkbox"/> b. Location of own room <input type="checkbox"/> c. Names/faces <input type="checkbox"/> d. Where he/she is <input type="checkbox"/> e. None of the above were recalled <input type="checkbox"/>
<p>3. Cognitive Skills for Daily Decision-Making - Made decisions regarding tasks of daily life.</p> <ul style="list-style-type: none"> 0. Independent – decisions consistent/reasonable 1. Modified independence – some difficulty in new situations only 2. Moderately impaired – decisions poor, cues/ supervision required 3. Severely impaired – never/rarely made decisions <input type="radio"/> 	<p>4A. Is professional nursing assessment, observation and management required at least 3 days/week to manage all the above cognitive patterns? 0 – No 1 – Yes <input type="radio"/></p> <p>If 4A = 1 (Yes), proceed to 5. If 4A = 0 (No) and person meets the cognitive impairment threshold, then go to Section C.4B of the Supplemental Screening Tool.</p> <p>5. Is professional nursing assessment, observation and management required once a month to manage all the above cognitive patterns? 0 – No 1 – Yes <input type="radio"/></p>

<p>SECTION D: Problem Behavior</p> <p>1. Column A Codes: Code for the frequency of behavior in last 7 days</p> <ul style="list-style-type: none"> 0. Behavior not exhibited in last 7 days 1. Behavior of this type occurred 1 to 3 days in last 7 days 2. Behavior of this type occurred 4 to 6 days, but less than daily 3. Behavior of this type occurred daily <p>Column B Codes: Alterability of behavior symptoms</p> <ul style="list-style-type: none"> 0. Not present or easily altered 1. Behavior not easily altered a. Wandering (moved with no rational purpose, seemingly oblivious to needs or safety) A0 B0 b. Verbally Abusive (others threatened, screamed at, cursed at) A0 B0 c. Physically Abusive (others were hit, shoved, scratched, sexually abused) A0 B0 	<ul style="list-style-type: none"> d. Socially Inappropriate/Disruptive Behavior (made disruptive sounds, noisy, screams, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings) A0 B0 e. Resists Care (resisted taking medications/injections, ADL assistance or eating) A0 B0 <p>2a. Is professional nursing assessment, observation and management required at least 3 days/week to manage the behavior problems – items a-d? 0 – No 1 – Yes <input type="radio"/></p> <p>If 2a = 1 (Yes) proceed to 3. If 2A = 0 (No) and person meets the behavioral impairment threshold, then go to page 3A and complete Section D.2B of the Supplemental Screening Tool.</p> <p>3. Is professional nursing assessment, observation and management required once a month to manage the above behavior problems? 0 – No 1 – Yes <input type="radio"/></p>
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SECTION C4B: COGNITION

(Enter the code that most accurately describes the person's cognition for the last 7 days)

1. Memory For Events: 0

- 0. Can recall details and sequences of recent experiences and remember names of meaningful acquaintances.
- 1. Cannot recall details or sequences of recent events or remember names of meaningful acquaintances.
- 2. Cannot recall entire events (e.g. recent outings, visits of relatives or friends) or names of close friends or relatives without prompting.
- 3. Cannot recall entire events or name of spouse or other living partner even with prompting.

2. Memory And Use Of Information: 0

- 0. Does not have difficulty remembering and using information. Does not require directions or reminding from others.
- 1. Has minimal difficulty remembering and using information. Requires direction and reminding from others one to three times per day. Can follow simple written instructions.
- 3. Has difficulty remembering and using information. Requires direction reminding from others four or more times per day. Cannot follow written instructions.
- 4. Cannot remember or use information. Requires continual verbal reminding.

3. Global Confusion: 0

- 0. Appropriately responsive to environment.
- 1. Nocturnal confusion on awakening.
- 2. Periodic confusion during daytime.
- 3. Nearly always confused.

4. Spatial Orientation: 0

- 0. Oriented, able to find and keep his/her bearings.
- 1. Spatial confusion when driving or riding in local community.
- 2. Gets lost when walking neighborhood.
- 3. Gets lost in own home or present environment.

5. Verbal Communication: 0

- 0. Speaks normally.
- 1. Minor difficulty with speech or word-finding difficulties.
- 2. Able to carry out only simple conversations.
- 4. Unable to speak coherently or make needs known.

C.4B Total Cognitive Score

SECTION D.2B: BEHAVIOR

(Enter the code that most accurately describes the person's behavior for the last 7 days.)

1. Sleep Patterns: 0

- 0. Unchanged from "normal" for the consumer.
- 1. Sleeps noticeably more or less than "normal."
- 3. Restless, nightmares, disturbed sleep, increased awakenings.
- 4. Up wandering for all or most of the night, inability to sleep.

2. Wandering: 0

- 0. Does not wander.
- 1. Does not wander. Is chair bound or bed bound.
- 2. Wanders within the facility or residence and may wander outside, but does not jeopardize health and safety.
- 3. Wanders within the facility or residence. May wander outside, health and safety may be jeopardized. Does not have history of getting lost and is not combative about returning.
- 4. Wanders outside and leaves grounds. Has consistent history of leaving grounds, getting lost or being combative about returning. Requires a treatment plan that may include the use of psychotropic drugs for management and safety.

3. Behavioral Demands On Others: 0

- 0. Attitudes, habits and emotional states do not limit the individual's type of living arrangement and companions.
- 1. Attitudes, habits and emotional states limit the individual's type of living arrangement and companions.
- 3. Attitudes, disturbances and emotional states create consistent difficulties that are modifiable to manageable levels. The consumer's behavior can be changed to reach the desired outcome through respite, in-home services, or exiting facility staffing.
- 4. Attitudes, disturbances and emotional states create consistent difficulties that are not modifiable to manageable levels. The consumer's behavior cannot be changed to reach the desired outcome through respite, in-home services, or existing facility staffing even given training for the caregiver.

4. Danger To Self And Others: 0

- 0. Is not disruptive or aggressive, and is not dangerous.
- 1. Is not capable of harming self or others because of mobility limitations (is bed bound or chair bound).
- 2. Is sometimes (1 to 3 times in the last 7 days) disruptive or aggressive, either physically or verbally, or is sometimes extremely agitated or anxious, even after proper evaluation and treatment.
- 3. Is frequently (4 or more time during the last 7 days) disruptive or aggressive, or is frequently extremely agitated or anxious; and professional judgment is required to determine when to administer prescribed medication.
- 5. Is dangerous or physically abusive, and even with proper evaluation and treatment may require physician's orders for appropriate intervention.

5. Awareness of Needs/Judgment: 0

- 0. Understands those needs that must be met to maintain self care.
- 1. Sometimes (1 to 3 times in the last 7 days) has difficulty understanding those needs that must be met but will cooperate when given direction or explanation.
- 2. Frequently (4 or more time during the last 7 days) has difficulty understanding those needs that must be met but will cooperate when given direction or explanation.
- 3. Does not understand those needs that must be met for self care and will not cooperate even though given direction or explanation.

D.2B total Behavior Score

Return to Section D3

SECTION E: Physical Functioning/Structural Problems

- 1. ADL Self-Performance** (Code for Performance during last 7 days (24 – 48 hrs if in hospital) – not including setup.)
- 0. Independent – No help or oversight – or – Help/oversight provided only 1 or 2 times during last 7 days.
 - 1. Supervision – Oversight, encouragement or cueing provided 3 + times during last 7 days –OR– Supervision plus nonweight-bearing physical assistance provided only 1 or 2 times during last 7 days.
 - 2. Limited Assistance – Person highly involved in activity; received physical help in guided maneuvering of limbs, or other nonweight-bearing assistance 3+ times – OR – Limited assistance (as just described) plus weight-bearing 1 or 2 times during the last 7 days.
 - 3. Extensive Assistance – While person performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
 - Weight-bearing support
 - Full staff/caregiver performance during part (but not all) of last 7 days.
 - 4. Total Dependence – Full staff/caregiver performance of activity during ENTIRE 7 days.
 - 5. Cueing – Spoken instruction or physical guidance which serves as a signal to do an activity are required 7 days a week. Cueing is typically used when caring for individuals who are cognitively impaired.
 - 8. **ACTIVITY DID NOT OCCUR** during entire 7 days.
-
- 2. ADL Support Provided** - (Code for Most Support Provided Over Each 24 Hour Period during last 7 days (24-48 hours if person is in hospital); code regardless of person's self-performance classification.)
- 0. No setup or physical help from staff
 - 1. Setup help only
 - 2. One-person physical assist
 - 3. Two+ persons physical assist
 - 5. Cueing- Cueing support required 7 days a week
 - 8. Activity did not occur during entire 7 days

Self-Performance

- a. **Bed Mobility** (How person moves to and from lying position, turns side to side, and positions body while in bed) A 0 B 0
- b. **Transfer** (How person moves between surfaces – to/from bed, chair, wheelchair, standing position (Exclude to/from bath/toilet) A 0 B 0
- c. **Locomotion** (How person moves between locations in his/her room and other areas on same floor. If in wheelchair, self-sufficiency once in chair) A 0 B 0
- d. **Dressing** (How person puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis) A 0 B 0
- e. **Eating** (How person eats and drinks regardless of skill) A 0 B 0
- f. **Toilet Use** (How persons uses the toilet room (or commode, bedpan, urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes) A 0 B 0
- g. **Personal Hygiene** (How person maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (Exclude baths and showers) A 0 B 0

3. Walking

- a. How person walks for exercise only A 0 B 0
- b. How person walks around own room A 0 B 0
- c. How person walks within home A 0 B 0
- d. How person walks outside A 0 B 0

4. Bathing (How person takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (Exclude washing of back and hair). (Code for most dependent in self performance and support. Bathing Self-Performance codes appear below.)

- 0. Independent – No help provided A 0 B 0
- 1. Supervision – Oversight help only A 0 B 0
- 2. Physical help limited to transfer only A 0 B 0
- 3. Physical help in part of bathing activity A 0 B 0
- 4. Total dependence A 0 B 0
- 5. Cueing – Cueing support required 7 days a week A 0 B 0
- 8. Activity did not occur during entire 7 days. A 0 B 0

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SECTION H: Diagnoses

1. Diagnoses: Check only those diagnoses that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nurse monitoring, or risk of death. (Do not list inactive diagnoses.) **If none apply, check "xx. None of the Above."**

2.

<p>ENDOCRINE/METABOLIC/ NUTRITIONAL</p> <p><input type="checkbox"/> a. Diabetes mellitus</p> <p><input type="checkbox"/> b. Hyperthyroidism</p> <p><input type="checkbox"/> c. Hypothyroidism</p> <p>HEART/CIRCULATION</p> <p><input type="checkbox"/> d. Arteriosclerotic heart disease-ASHD</p> <p><input type="checkbox"/> e. Cardiac dysrhythmia</p> <p><input type="checkbox"/> f. Congestive heart failure</p> <p><input type="checkbox"/> g. Deep vein thrombosis</p> <p><input type="checkbox"/> h. Hypertension</p> <p><input type="checkbox"/> i. Hypotension</p> <p><input type="checkbox"/> j. Peripheral vascular disease</p> <p><input type="checkbox"/> k. Other cardiovascular disease</p> <p>MUSCULOSKELETAL</p> <p><input type="checkbox"/> l. Arthritis</p> <p><input type="checkbox"/> m. Hip fracture</p> <p><input type="checkbox"/> n. Missing limb(e.g. amputation)</p> <p><input type="checkbox"/> o. Osteoporosis</p> <p><input type="checkbox"/> p. Pathological bone fracture</p>	<p>NEUROLOGICAL</p> <p><input type="checkbox"/> q. Alzheimer's disease</p> <p><input type="checkbox"/> r. Aphasia</p> <p><input type="checkbox"/> s. Cerebral palsy</p> <p><input type="checkbox"/> t. Cerebrovascular accident (stroke)</p> <p><input type="checkbox"/> u. Dementia other than Alzheimer's</p> <p><input type="checkbox"/> v. Hemiplegia / hemiparesis</p> <p><input type="checkbox"/> w. Multiple sclerosis</p> <p><input type="checkbox"/> x. Paraplegia</p> <p><input type="checkbox"/> y. Parkinson's disease</p> <p><input type="checkbox"/> z. Quadriplegia</p> <p><input type="checkbox"/> aa. Seizure disorder</p> <p><input type="checkbox"/> bb. Transient ischemic attack (TIA)</p> <p><input type="checkbox"/> cc. Traumatic brain injury</p> <p>PSYCHIATRIC/MOOD</p> <p><input type="checkbox"/> dd. Anxiety disorder</p> <p><input type="checkbox"/> ee. Depression</p> <p><input type="checkbox"/> ff. Manic Depression (Bipolar Disease)</p> <p><input type="checkbox"/> gg. Schizophrenia</p>	<p>PULMONARY</p> <p><input type="checkbox"/> hh. Asthma</p> <p><input type="checkbox"/> ii. Emphysema / COPD</p> <p><input type="checkbox"/> ii.a. Bronchitis</p> <p><input type="checkbox"/> ii.b. Pneumonia</p> <p>SENSORY</p> <p><input type="checkbox"/> jj. Cataracts</p> <p><input type="checkbox"/> kk. Diabetic retinopathy</p> <p><input type="checkbox"/> ll. Glaucoma</p> <p><input type="checkbox"/> mm. Macular degeneration</p> <p>OTHER</p> <p><input type="checkbox"/> nn. Allergies (specify)</p> <p><input type="checkbox"/> oo. Anemia</p> <p><input type="checkbox"/> pp. Cancer</p> <p><input type="checkbox"/> qq. Renal failure</p> <p><input type="checkbox"/> rr. Tuberculosis</p> <p><input type="checkbox"/> ss. HIV</p> <p><input type="checkbox"/> tt. Mental retardation(e.g., Down's syndrome, autism, or other condition related to MR or DD)</p> <p><input type="checkbox"/> uu. Substance abuse (alcohol or drug)</p> <p><input type="checkbox"/> vv. Other psychiatric diagnosis, (e.g. paranoia, phobias, personality disorder)</p> <p><input type="checkbox"/> ww. Explicit terminal prognosis</p> <p><input type="checkbox"/> xx. None of the Above</p>
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2. Other Current DX. & ICD-9 Codes

- a.
- b.
- c.

3. 2 or more hospitalizations r/t primary / secondary diagnosis

3a. NF placement in the past 12 months r/t primary / secondary diagnosis

3b. 5 or more ER visits r/t primary / secondary diagnosis

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SECTION I: Communication/ Hearing Patterns

- 1. Hearing (Choose only one)** (With hearing appliance, if used)
 0. Hears adequately-normal talk, TV, phone
 1. Minimal Difficulty when not in quiet setting
 2. Hears in Special Situations only-speaker has to adjust tonal quality and speak distinctly
 3. Highly Impaired absence of useful hearing

0

- 2. Communication Devices/Techniques** (Check all that apply during last 7 days)
 - a. Hearing aid, present and used
 - b. Hearing aid, present and not used regularly
 - c. Other receptive communication techniques used (e.g., lip reading)
 - d. None of the Above

- 3. Making Self Understood** (Expressing information content-however able) **(Choose only one)**
 0. Understood
 1. Usually understood-difficulty finding words or finishing thoughts
 2. Sometimes understood-ability is limited to making concrete requests
 3. Rarely/Never understood

0

- 4. Ability to Understand Others** (Understanding information content-however able) **(Choose only one)**
 0. Understands
 1. Usually understands-may miss some part/intent of message
 2. Sometimes understands-responds adequately to simple, direct communication
 3. Rarely/Never understands

0

SECTION J. Vision Patterns

- 1. Vision** (Ability to see in adequate light & with glasses if used)
 0. Adequate - sees fine detail, including regular print in newspapers/books
 1. Impaired - sees large print, but not regular print in newspapers/books
 2. Moderately impaired - limited vision; not able to see newspaper headlines, but can identify objects.
 3. Highly impaired - object identification in question, but eyes appear to follow objects.
 4. Severely impaired - no vision or sees only light, colors, or shapes; eyes do not appear to follow objects. **0**

- 2. Visual appliances**
 - a. Glasses, contact lenses 0 – No 1 – Yes
 - b. Artificial eye 0 – No 1 – Yes

SECTION K: Nutritional Status

- 1. Weight** (optional if info is not available.)
Record weight in pounds. Base weight on most recent measure in last 30 days; measure weight consistently in accord with standard practice (e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes) WT _____

- 2. Weight Change** (optional if info is not available.)
 0. No weight change
 1. Unintended weight gain* (*5% or more in last 30 days; or _____
 2. Unintended weight loss * 10% or more in last 180 days) _____

- 3. Nutritional Problems or Approaches** (check all that apply)

<ul style="list-style-type: none"> <input type="checkbox"/> a. Chewing or swallowing <input type="checkbox"/> b. Complains about the taste of many foods <input type="checkbox"/> c. Regular or repetitive complaints of hunger <input type="checkbox"/> d. Leaves 25% or more of food uneaten at most meals <input type="checkbox"/> e. Therapeutic diet 	<ul style="list-style-type: none"> <input type="checkbox"/> f. Mechanically altered (or pureed) diet. <input type="checkbox"/> g. Noncompliance with diet <input type="checkbox"/> h. Food Allergies/specify: <input type="checkbox"/> i. Restrictions/specify: <input type="checkbox"/> j. None of the Above
--	--

SECTION L: Continence in Last 14 Days

1. Bladder Continence (Choose only one.)
Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants) with appliances if used (e.g., pads or incontinence program employed) in last 14 days.

- 0. Continent-complete control
- 1. Usually Continent- incontinent episodes once a week or less
- 2. Occasionally incontinent-2 or more times a week but not daily
- 3. Frequently incontinent-tended to be incontinent daily, some control present
- 4. Incontinent-bladder incontinent all (or almost all) of the time

2. Bowel Continence (Choose only one)

- 0. Continent - complete control
- 1. Usually Continent - Bowel incontinent episodes less than weekly
- 2. Occasionally incontinent - bowel incontinent episode once a week
- 3. Frequently incontinent – bowel incontinent episodes 2 to 3 times per week
- 4. Incontinent - Bowel incontinent all (or almost all) of the time

3. Appliances/Programs (Check all that apply)

- a. External (condom) catheter
- b. Indwelling catheter
- c. Pads/brief's
- d. Ostomy present
- e. Scheduled toileting/other program
- f. None of the Above

SECTION M: Balance

1. Accidents (Check all that apply)

- a. Fell in past 30 days
- b. Fell in past 31-180 days
- c. Hip fracture in last 180 days
- d. Other fracture in last 180 days
- e. None of the Above

2. Danger of Fall (Check all that apply)

- a. Has unsteady gait
- b. Has balance problems when standing
- c. Limits activities because person or family fearful of person falling
- d. None of the Above

SECTION N: Oral/Dental Status

1. Oral Status and Disease Prevention (check all that apply)

- a. Has dentures or removable bridge
- b. Some/all natural teeth lost-does not have or does not use dentures(or partial)
- c. Broken, loose, or carious teeth
- d. Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses; ulcers or rashes
- e. None of the Above

SECTION O: Skin Conditions

1. Skin problems (Check all that apply)

- a. Abrasions/ scrapes
- b. Burns
- c. Bruises
- d. Rashes, itchiness body lice, scabies
- e. Open sores or lesions
- f. None of the Above

2. Pressure Ulcers Presence of an ulcer anywhere on the body? This would include an area of persistent skin redness (Stage 1), partial loss of skin layers (Stage 2), deep craters in the skin (Stage 3), and breaks in the skin exposing muscle or bone, (Stage 4) .
0 – No 1 – Yes

3. Foot Problems

- a. Person or someone else inspects feet on a regular basis?
0 – No 1 – Yes
- b. One or more foot problems or infections such as corns, calluses, bunions, hammer toes, overlapping toes, pain, structural problems, gangrene toe, foot fungus, onychomycosis?
0 – No 1 – Yes

SECTION P: Environmental Assessment

1. NF, RCF, Hospital; If person resides in a facility such as a NF, RCF, or hospital, check here and proceed to Section Q

2. Home Environment

(Check any of the following that makes home environment hazardous or uninhabitable. If none apply, check None of Above. If temporarily in institution, base assessment on home visit)

- a. Lighting including adequacy of lighting, exposed wiring
- b. Flooring and carpeting (e.g., holes in floor, electric wires where client walks, scatter rugs)
- c. Bathroom and toiletroom environment (e.g., non-operating toilet, leaking pipes, no rails though needed, slippery bathtub, outside toilet)
- d. Kitchen environment (e.g., dangerous stove, inoperative refrigerator, infestation by rats or bugs)
- e. Heating and cooling (e.g., difficulty entering-leaving home)
- f. Personal safety (e.g., fear of violence, safety problem in going to mailbox or visiting neighbors, heavy traffic in street)
- g. Access to home (e.g., difficulty entering/leaving home)
- h. None of the above

SECTION Q: Mood

1. Indicators of Depression, Anxiety, Sad Mood

Code for behavior in last 30 days irrespective of the assumed cause

- 0. Indicator not exhibited
- 1. Indicator of this type exhibited up to 5 days a week
- 2. Indicator of this type exhibited daily or almost daily (6,7 days a week)

Verbal Expressions of Distress

- a. Person made negative statements-e.g., "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die" **0**
- b. Repetitive questions-e.g., "Where do I go? What do I do?" **0**
- c. Repetitive verbalizations, e.g., calling out for help., ("God help me") **0**
- d. Persistent anger with self or others-e.g., easily annoyed; anger at placement in nursing home; anger at care received. **0**
- e. Self-deprecation-e.g., "I am nothing; I am of no use to anyone." **0**
- f. Expressions of what appear to be unrealistic fears-e.g., fear of being abandoned, left alone, being with others. **0**
- g. Recurrent statements that something terrible is about to happen-e.g., believes he or she is about to die, have a heart attack. **0**
- h. Repetitive health complaints-e.g., persistently seeks medical attention, obsessive concern with body functions. **0**
- i. Repetitive anxious complaints/concerns (non-health related)- e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues. **0**

Sleep-Cycle Issues

- j. Unpleasant mood in morning **0**
- k. Insomnia/change in usual sleep pattern **0**

Loss of Interest

- l. Sad, pained, worried facial expressions-e.g., furrowed brows **0**
- m. Crying, tearfulness **0**
- n. Repetitive physical movements-e.g., pacing, hand-wringing, restlessness, fidgeting, picking. **0**
- o. Withdrawal from activities of interest-e.g., no interest in longstanding activities or being with family/friends. **0**
- p. Reduced social interaction. **0**

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	<p>2. Mood Persistence <i>One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer-up," console or reassure the person over the last 7 days.</i></p> <p>0. No mood indicators 1. Indicators present, easily altered 2. Indications present, not easily altered 0</p> <hr/> <p>3. Mood <i>Person's current mood status compared to person's status 180 days ago.</i></p> <p>0. No change 1. Improved 2. Declined 0</p>
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SECTION R. INSTRUMENTAL ACTIVITIES OF DAILY LIVING		
<p>1. IADL SELF-PERFORMANCE CODES:</p> <p>0. INDEPENDENT: (with/without assistive devices) – No help provided. 1. INDEPENDENT WITH DIFFICULTY: Person performed task, but did so with difficulty or took a great amount of time to do it. 2. ASSISTANCE/DONE WITH HELP: Person involved in activity but help (including supervision, reminders, and /or physical "hands-on" help) was provided. 3. DEPENDENT/DONE BY OTHERS: Full performance of the activity was done by others. The person was not involved at all each time the activity was performed. 8. Activity did not occur.</p> <p>2. IADL SUPPORT CODES:</p> <p>0. No support provided. 1. Supervision/cueing provided. 2. Set-up help only. 3. Physical assistance was provided. 4. Total dependence – the person was not involved at all when the activity was performed. 8. Activity did not occur.</p>		
1. DAILY INSTRUMENTAL ACTIVITIES Code for level of independence based on person's involvement in the activity in the last 7 days	SELF PERFORMANCE	SUPPORT
a. Meal Preparation: Prepared breakfast and light meals.	0	0
b. Main Meal Preparation: Prepared or received main meal times per week.	0	0
c. Telephone: Used telephone as necessary, e.g., able to contact people in an emergency.	0	0
d. Light Housework: Did light housework such as dishes, dusting (on daily basis), making own bed.	0	0
2. OTHER INSTRUMENTAL ACTIVITIES OF DAILY LIVING Code for level of independence based on person's involvement in the activity in the last 14 days	SELF PERFORMANCE	SUPPORT
a. Managing Finances: Managed own finances, including banking, handling checkbook, paying bills.	0	0
b. Routine Housework: Did routine housework such as vacuuming, cleaning floors, trash removal, cleaning bathroom, as needed.	0	0

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SECTION S: Assistive Devices

- 0. Does not need
1. Does not have needed device (refer to physician for DME)
2. Has device in home and is independent with use
3. Has device in home and needs assistance with use

Bath Bench 0
Braces/AFOs 0
Cane 0
Commode 0
Elevated Toilet 0
Gait Belt 0
Grab Bars 0
Hand Held Shower 0
Hospital Bed 0
Lifeline 0
Lift/Hoyer 0
Stair glide 0
Wheelchair 0
Walker 0
Other: 0
Other: 0

SECTION T: Advanced Directives

- 0. No
1. Yes
1. Informed of Advanced Directives
2. Living Will
0. Comfort One

SECTION U: Mailing Address: (If different from CAT client location data)

Address:
City:
State: AK
Zip Code:

SECTION V: Split Service Plan

- 0. No
1. Yes
Split Service Plan

SECTION W: Current Formal and Informal Supports

- 0. No
1. Yes
1. Adult Day Services
2. Assisted Living
3. Care Coordination
Name:
Phone Number:
4. Chore
5. Church
6. Equipment/Supplies
7. Family
8. Friends
9. Foster Care
10. Home Health
11. Hospital/Medical
12. Meals
13. Medications (mediset, prefilled syringes)
14. Personal Care Attendant(s)
Name(s):
Name(s):
15. Back Up Personal Care Assistant(s)
Name(s):
Name(s):
16. Respite
17. Skilled Nursing
18. Transportation

SECTION X: Legal Representative(s)

- 0. No
1. Yes
0. An unpaid care provider involved in the day-to-day care of the recipient
1. Manage and evaluate the recipient's care as it occurs in the recipient's home
2. Complete recipient training
3. Make, understand, and assume responsibility for choices regarding the recipients activities of daily living
4. Designate a Consumer-Directed agency for services
5. Cooperate with the Division or its designee
6. Specify training requirements of the worker
7. Schedule, train, supervise, and terminate the employment of personal care assistant
[Verified information from initial intake or capture]
8. Power of Attorney (Durable, regular or special)
Name(s):
Address:
Phone Number:
Name(s):
Address:
Phone Number:
9. Legal Guardian(s)
Name(s):
Address:
Phone Number:
Name(s):
Address:
Phone Number:

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ALASKA COMMUNITY CHOICES – ELIGIBILITY DETERMINATION

NF LEVEL OF CARE

NF. 1.

- a. Yes No: In section A, Nursing Services, items 1-8, did you code any of the responses with a 4 (i.e., services needed 7 days/wk)?
- b. Yes No: In Section A, items 9 (Ventilator/Respirator) did you code this response with a 2, 3 or 4 (treatment needed at least 3 days/wk)?
- c. Yes No: In Section A, item 10 (Uncontrolled seizure), did you code this response with a 1, 2, 3, or 4 (care needed at least once/wk)?
- d. Yes No: In Section A, item 11 (Therapies), was the total number of days of therapy 5 or more days/wk?
- e. Yes No: In Section E, (Physical Functioning/Structural Problems), were 3 or more shaded ADLs coded with a 3 (extensive assistance) or 4 (dependent) in self performance?

*If the answer to any of these questions is "Yes", then the person will be found medically eligible for NF level of care and will be scored a 3 or presumed to have a score of 3 or more.

NF. 2. Professional Nursing Services:

- a. In Section A, Nursing Services, items 1-8, how many were coded with a 2 or 3 (service needed 3-6 days/week)? 0 – No 1 – Yes
- b. In Section A, item 11 (Therapies), was the total number of days of therapy 3 or 4 days/week? 0 – No 1 – Yes
- c. In Section B, items 1a-1e and 1g-1j (excluding 1f, monthly injection), did you code any of the responses with a 2? 0 – No 1 – Yes
- d. In Section B, items 2a-2d, did you code any of the responses with a 2? 0 – No 1 – Yes

Compute the nursing services score from 2a-2d and enter it here.

Total

NF. 3. Impaired Cognition

- a. Is Section C1a (short-term memory), coded with a "1"? 0 – No 1 – Yes
- b. In section C2 (memory recall) are 1 or 2 boxes checked in C2a-C2d or is C2e. *None of the Above* checked? 0 – No 1 – Yes
- c. Is Section C3 coded with a 2 or 3? 0 – No 1 – Yes
- d. [Is Section C4A coded with a 1] **OR** [in Section E, is at least one shaded ADL coded with a 2, 3, or 4 in self-performance and a 2 or 3 in support **AND** C4B (from page 3A Supplemental Screening Tool) is 13 or more]? 0 – No 1 – Yes

If **all** the answers to the above questions are "yes," then score this section with a "1".

NF. 4. Behavior Problems

- a. In Section D, are one or more of the behaviors from items a-d (wandering, verbally abusive, physically abusive, socially inappropriate behavior) coded with a 2 or 3? 0 – No 1 – Yes
- b. [Is Section D2A coded with a 1] **OR** [in Section E, is at least one shaded ADL coded with a 2, 3 or 4 in self-performance and a 2 or 3 in support **AND** D2B (from page 3A Supplemental Screening Tool) is 14 or more]? 0 – No 1 – Yes

If the answer to both questions is yes, then score this section with a "1".

NF. 5. Compute the total nursing score from questions 2, 3 and 4. If the total nursing score is 1 or more, proceed. Otherwise person appears not to be medically eligible for NF level of care.

Total Nursing

NF. 6. In Section E (Physical Functioning/Structural Problems), how many "shaded" ADL's were coded with a 2, 3 or 4 in self-performance **AND** required a one or more physical assist in support (support coded as 2 or 3)?

Total ADL Needs

NF.7. Total nursing and ADL Needs Score (NF.5 + NF.6)

If the Total Nursing and ADL Needs Score is 3 or more, the person appears to be medically eligible for NF level of care. Otherwise, person appears not to be medically eligible.

[Yes, if Score of 3 or more in NF 7, Else No.]

ACC1. Meets Nursing Facility Level of Care

m Yes m No

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[If No in ACC1, then complete ACC2. If yes, skip to ACC4]

**** Integration with ICAP [Placeholder]****

ICF/MR LOC Criteria – Participant has a severe, chronic disability that meets one (1) of the five (5) following conditions:

- Mental Retardation
- Other Mental Retardation related condition
- Cerebral Palsy
- Epilepsy
- Autism

ACC2. Meets ICF-MR Criteria m Yes m No

If Yes, note documentation that verifies level of care criteria (attach if copy available)

[Option: Listing of standard/required documents to check off.]

[If No in ACC2, then complete ACC3.]

**** Integration with Psych < 21 Criteria [Placeholder]****

- Claims Data Search to Determine if had >30 Inpatient psychiatric days

ACC3. Meets Psychiatric under 21 criteria m Yes m No

If Yes, note documentation that verifies level of care criteria (attach if copy available)

[Option: Listing of standard/required documents to check off.]

ACC4. Income

(a) Is under 300% SSI

m Yes m No

If Yes, note documentation that provides income level (attach if copy available)

[Option: Listing of standard/required documents to check off.]

(b) Is under 150% FPL

m Yes m No

If Yes, note documentation that provides income level (attach if copy available)

[Option: Listing of standard/required documents to check off.]

ACC5. ADLs requiring supervision, cueing, or hand on assistance (1, 2, 3, 4 or 5) from Section E. Physical Functioning/Structural Problems

- Bed Mobility
- Transfers
- Locomotion
- Dressing
- Eating
- Toileting
- Personal Care/Grooming
- Bathing

[If ACC5 has two or more items (ADLs) selected, the Participant appears to be functionally eligible for services provided through Alaska Community Choices. Please proceed to the Section F. Participant Capacity for Self-Direction.]

ACC6. Participant is eligible in ACC if the conditions for the following are meet:

[Check one or can be automated]

m Yes – eligible for CFC

[ACC1 – Yes, ACC4(a) – Yes, & ACC5 – Yes] **OR**

[ACC2 – Yes, ACC4(a) – Yes, & ACC5 – Yes] **OR**

[ACC3 – Yes, ACC4(a) – Yes, & ACC5 – Yes]

[ACC5 – Yes, & ACC4(b) – Yes]

m Yes – eligible for State Plan HCBS

m No

[If No, skip to Section G. Alaska Community Choices – Referral and refer the Participant to State Grant Programs or other available resources. The Participant is not eligible for Alaska Community Choices.]

***** Integration of Waiver Criteria into Consumer Assessment Tool Section [Placeholder]*****

ACC7. Identify the HCBS Waiver the Participant is eligible: [Can be automated from Waiver Criteria]

m Children with Complex Medical Conditions (CCMC)

m Individuals with Mental Retardation/Developmental Disabilities (MRDD)

m Adults with Physical Disabilities (APD)

m Older Alaskans (OA)

F. PARTICIPANT CAPACITY FOR SELF-DIRECTION

Ability to Self-direct Indicators: [Calculated from Section E. Consumer Assessment Tool (CAT)]

- | | |
|--|--------------------|
| 1. Decision Making skills (Section C.3) = 0 or 1 | Yes _____ No _____ |
| 2. Making Self Understood (Section I.3) = 0, 1, or 2 | Yes _____ No _____ |
| 3. Ability to Understand Others (Section I.4) = 0, 1, or 2 | Yes _____ No _____ |
| 4. Managing Finances (Section R.2.a) | |
| a. in Self Performance = 0 or 1 | Yes _____ No _____ |
| b. in Support = 0 or 2 | Yes _____ No _____ |

CC.1 If all the answers to the above questions are “Yes” then score this section with a “1”
 [Participant appears to have cognitive capacity to self-direct their care.]

If CC.1 is not scored with a “1” AND recipient’s legal representative listed in Section X.9 and/or X.10 requests to manage Consumer-Directed Model; continue below:

Ability for Legal Representative Management Indicators:

- CC.2 In Section X, Legal Representative(s), total scores for questions 1-8.
- CC.3 In Section X, Legal Representative(s), total scores for questions 9 & 10.
- CC.4 If CC.2 is scored with an 8 AND CC.3 is scored with a 1 or greater; score this item with a “1”.

[If CC.4 is scored with a “1”, the Participant’s legal representative, used in CC.3 scoring, is likely eligible to manage the recipient’s services under the Consumer-Directed Model]

CD.1 If ACC6 is “Yes”, AND Section C -> D.1a, b, c, e and 2a are all scored with a “0”, AND Section W.15 is scored with “1”, AND CC.1 is scored with a “1”, then score this section with a “1”

CD.2 If ACC6 “Yes”, AND Section C -> W.15 is scored with a “1”, And CC.1 is not scored with a “1”, AND CC.4 is scored with a “1”, then score this section with a “1”

[If CD.1 is scored with a “1”, the Participant appears to be functionally eligible to self-direct under the Consumer-Directed Model.]

If CD.1 is not scored with a “1”, AND CD.2 is scored with a “1”, the Participant’s legal representative as indicated in Section X.9 and/or X.10, appears to be eligible to direct the Participant’s services under the Consumer-Directed Model.]

[The following questions ask the Participant about his/her capacity to self-direct. Evaluate the Participant’s to self-direct using these responses and the scores above in this section.]

Alaska Community Choices has supports that give Participants the opportunity to have more control over the services and supports they receive. The following questions are to get an idea of how much help you might need in directing supports:

- 1. How well can the Participant make her/his wants and needs known? [Select one]**
- m Speech can only be understood by familiar people.
 - m Speech can be understood by unfamiliar people.
 - m Typed or written communication is legible and easily understood by others
 - m Can communicate with others who know sign language.
 - m Make wants and needs known through actions.
 - m Make wants and needs known through voice-output technology
 - m Unable to express wants and needs.

2. What kind of information would you need to help you make big decisions about your life?

[Pick two of the following examples to explore the Participant's understanding of "informed decision-making". These examples are open-ended questions – do not "prompt" the responses listed. Select the checkboxes only if the person mentions the item. Complete the text boxes for all other responses given.]

Example 1: What would you need to consider in deciding where to live?

- Monthly income
- Monthly rent / mortgage payments
- Accessibility
- Distance from work
- The safety of the neighborhood
- Chose not to answer

Additional responses: _____

Example 2: If you decided to stop taking a medication that you had been taking for many years, what information should you consider obtaining or sharing with others before you stop?

- How it will affect your health
- Having a discussion with your doctor, first, to get his/her advice
- Making a plan for taking medicine again, if your health suffers
- Having a discussion with your support team or family, first, to get their feedback on your decision
- Chose not to answer

Additional responses: _____

Example 3: If you decided to quit your job, what would you need to consider before telling your boss?

- How you would pay your bills until you got a new job
- What you would say if the boss asks you to stay or offers a raise
- How this decision might affect your health care or other benefits
- Chose not to answer

Additional responses: _____

Example 4: If you were having trouble with a co-worker or someone at home, what would you say or do?

- Would approach the person directly and ask him/her to talk about the problem
- Would ask another person to speak with that person for me
- Chose not to answer

Additional responses: _____

Example 5: If you need to train someone to help you, what kinds of things would you need to tell or show them?

- What kind of help I need with bathing, dressing, etc. (ADLs)
- What needs to be done to keep the house / apartment clean (IADLs)
- How to help me with health-related procedures
- Chose not to answer

Additional responses: _____

3. If you had the opportunity to supervise people who are paid to help you, which of the following could you do?

- Participate in their hiring – **how would you do this?**
- Tell them what needs to be done – **what would you have them do?** _____
- Evaluate their work – **how would you tell the person that you don't like something?** _____

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4. If you were given a set amount of money for services and you were responsible for figuring out how best to spend it, how would you keep track of your spending and how much money you had left?

[This is an open-ended question - do not prompt the responses listed. Mark the checkboxes only if the person mentions these items. Complete the text boxes for any other responses given]

- Unsure
- I would do it myself
- I would ask someone else to do it - **what is that person's name?** _____
- I would develop another solution - **please describe:** _____
- Chose not to answer

- Additional responses: _____

Assessor's Conclusions about the Participant's Capacity for Self-Direction

[This conclusion should also consider information gathered from the Section B. **Brief Person Centered Interview.**, Section C. **Participant Quality of Life Survey**, and Section D. **Identification of Person-Centered Goals**]

- m Very little or no support needed for self-direction
- m Can self-direct with support – **please explain:** _____
- m Needs another person to direct their services – **please explain:** _____
- m Don't have enough information to reach a conclusion
- m Not applicable – **please explain:** _____

Does the person and/or their representative, if applicable, agree with your conclusion?

- m Yes
- m No [describe]: _____

END OF ALASKA COMMUNITY CHOICES IN-HOME ASSESSMENT

[Inform the Participant that the assessment is complete and describe the next steps to determine the level of supports and development of support plan. A separate time to develop the support plan may need to be scheduled with the Participant. Document any closing notes or applicable comments.]

Assessor Notes:

G. ALASKA COMMUNITY CHOICES – REFERRAL

[Please record the outcome of the ACC in-home assessment, if the Participant was determined ineligible for ACC and a referral was made. Include applicable referral information.]

G1. Summary of Information and Referral Provided:

G2. Agency Accepting the Referral:

G3. Agency Staff Contact:

N/A

G4. Agency street address:

N/A

G5. City:

N/A

G8. Main: ()

N/A

G9. Fax: ()

G6. State:

G7. ZIP Code:

N/A

G10. Email:

N/A

[Please record the date that the referral was made.]

G11. Referral Date Made:

____/____/____ (month/day/year)

Appendix E: Examples that can be Used to Build the ACC Support Plan Tool

DRAFT ALASKA COMMUNITY CHOICES – SUPPORT PLAN EXAMPLES

A. ADMINISTRATIVE INFORMATION			
Participant Contact Information [Populated from Participant record, verify information]			
First Name	Last Name	Middle Name	
Address			
City	State, Zip Code	Telephone: (home) (cell)	Email
Support Plan Type [Complete and verify]			
Plan Type <input type="checkbox"/> Initial Plan <input type="checkbox"/> Revision Due To Change In Status <input type="checkbox"/> Annual or General Review			
Substitute or Supplemental Decision-Makers and Contact Information [Complete and verify]			
Status of Substitute or Supplemental Decision-Maker <input type="checkbox"/> No Substitute or Supplemental Decision-Maker <input type="checkbox"/> Participant has designated a supplemental decision maker <input type="checkbox"/> Participant has designated a substitute decision maker <input type="checkbox"/> There is a legally appointed substitute decision-maker: [Please indicate the type(s) of legal representation.] <input type="checkbox"/> Guardianship <input type="checkbox"/> Conservator <input type="checkbox"/> Representative Payee <input type="checkbox"/> Power of Attorney			
Contact information for Substitute or Supplemental Decision-Maker [Complete and verify]			
Name			
Street Address			
City	State, Zip Code	Telephone: (home) (cell)	Email

B. GOALS & EXPECTATIONS FOR SUPPORT PLAN

[Populated from Draft ACC Initial Intake, Section G. ACC Assessment Logistics, G1. Participant Goals & Expectations. Reference this information in developing the support plan.]

Participant specified areas to address in support plan:

Finding assistance for:

- | | |
|--|---|
| <input type="checkbox"/> Financial planning for long-term care needs | <input type="checkbox"/> Assistance with qualifying for programs that fund long-term care needs |
| <input type="checkbox"/> Health care needs | <input type="checkbox"/> Housing needs |
| <input type="checkbox"/> Personal needs | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Environment (including home modifications) | <input type="checkbox"/> Caregiver support |
| <input type="checkbox"/> Other (described in narrative) | |

[Populated from Draft ACC Initial Intake, Section G. ACC Assessment Logistics, G2. Participant Goals & Expectations. Review and confirm Participant's goals.]

What do you want to happen as a result of your plan?

How will you know if the plan is working well? [Completed during support planning]

What customs or traditions should we keep in mind as we talk about your supports? [Completed during support planning]

How would you like to address any health concerns or safety concerns? [Completed during support planning]

How often do you want someone from ACC to contact you to talk about how things are going? [Completed during support planning]

C. REVIEW & REFINEMENT OF PERSON CENTERED GOALS

[Populated from Draft ACC In-home Assessment, Section D. Identification of Person-Centered Goals based on the Participant's responses in Section B. **Brief Person-Centered Interview** and Section C. **Participant Quality of Life Survey**.]

[Review and discuss Person Centered Goals.]

Participant Goal A.

Participant Goal B.

Participant Goal C.

Participant Goal D.

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D. IDENTIFICATION OF SUPPORTS NECESSARY TO MEET GOALS

Goals and Support Activities

[Using information gathered from the Section B. Goals & Expectations of Support Plan and Section C. Review and Refinement of Person Centered Goals; identify the goal(s), type of support/intervention necessary to meet goals needed, and a brief description of the activities to be performed.]

Goals based from Section B. & Section C.	Type of Support/Intervention Necessary	Description of Activities
Goal 1	[Selectable Listing of Support Types/Interventions]	Description of activities to achieve goal
Goal 2	[Selectable Listing of Support Types/Interventions]	Description of activities to achieve goal
Goal 3	[Selectable Listing of Support Types/Interventions]	Description of activities to achieve goal
...	[Selectable Listing of Support Types/Interventions]	Description of activities to achieve goal
...	[Selectable Listing of Support Types/Interventions]	Description of activities to achieve goal

E. STRATEGIES TO MEET GOALS

[Describe what strategies (resources) will be used to satisfy the activities and support/interventions in Section D. The supports list include unpaid, paid, and public supports]

Type of Unpaid Support	Identify the available unpaid support	Describe the type of help that this support can provide	Identify how much help this support can provide
Spouse/Partner			
Adult Child			
Other Family			
Friend/Neighbor			
Community Resource			

Any problems or potential issues that the Participant may have in accessing these identified supports.

The worker should consider potential concerns such as:

- Location of the person's home (distance and ease of access)
- Need for training/instruction
- Availability of the support (due schedule or other responsibilities)
- Interpersonal issues

Personal Resource Available

How much can you and your family afford to pay toward your costs for long term care supports each month?

[Identify any privately paid supports the Participant may be currently paying for.]

Publically Paid Supports

Health or Long Term Care Supports purchased through public sources	Identify if the Participant is Eligible, Potentially Eligible, or Not Applicable (N/A) for publically paid support			Description of potential supports and any limitations to accessing these resources. (e.g., waiting lists, limitations, etc.)
Medicare	m Eligible	m Potentially Eligible	m N/A	
Community First Choice	m Eligible	m Potentially Eligible	m N/A	
State Plan HCBS	m Eligible	m Potentially Eligible	m N/A	
Waivers – CCMC/MRDD/APD/OA	m Eligible	m Potentially Eligible	m N/A	
Veterans Affairs	m Eligible	m Potentially Eligible	m N/A	
State Grant Programs	m Eligible	m Potentially Eligible	m N/A	
Other (specify):	m Eligible	m Potentially Eligible	m N/A	
Other (specify):	m Eligible	m Potentially Eligible	m N/A	
Other (specify):	m Eligible	m Potentially Eligible	m N/A	

F. ABILITY TO SELF-DIRECT & MONITORING OF SUPPORTS

[Populated from Draft ACC In-home Assessment, Section F. Participant Capacity for Self-Direction]

Assessor's Conclusions about the Participant's Capacity for Self-Direction

- m Very little or no support needed for self-direction
- m Can self-direct with support – **please explain:** _____
- m Needs another person to direct their services – **please explain:** _____
- m Don't have enough information to reach a conclusion
- m Not applicable – **please explain:** _____

Identify individuals will be directing/monitoring supports: [This may be the Participant, representatives, family members, etc.]

Name/Entity: _____ Relationship to Participant: _____

Name/Entity: _____ Relationship to Participant: _____

Name/Entity: _____ Relationship to Participant: _____

G. SELECTION OF SERVICES

Who will provide supports [Provider Directory]	Amount/Frequency [Authorized Budget Calculation]	Actions Needed to Implement	Service Description [Description of Activities Section D.]	Support Source/Service Model [Support Sources identified from Section E.]	Who will monitor/direct supports [Names/Entities identified from Section F.]
Type of Support/Intervention Necessary [Identified From Section D.]					
1...
2...
3...
Type of Support/Intervention Necessary [Identified From Section D.]					
4...
5...
6...
Type of Support/Intervention Necessary [Identified From Section D.]					
7...
8...
9...

H. SUPPLEMENTAL SUPPORT PLANNING

Risk Management Plan: [Describe any issues or concerns that represent a risk to the Participant. These may include items noted by the Participant, a representative, the assessor, or the worker responsible to assist with the development of the support plan.]

1. Describe any special conditions, concerns, or issues associated with the Participant if these support needs are not met.

2. Describe any steps to manage potential risk of unmet supports.

Backup Plan:

1. Describe any steps for the Participant to access backup supports in the event that the primary support is not available. (e.g., inclement weather prevents a provider to deliver service to the Participant)

Emergency Plan:

Does the person have an emergency/disaster safety plan? Yes No

[If no, the worker should assist the Participant in developing a disaster safety plan.]

List of Resources Available to Assist in the Event of a Disaster

Name	Relationship to Participant	Address	Phone/Email	Order of Contact [primary/secondary/backup]

Evacuate To (in order of preference)	Medication/Equipment to bring	Info To Be Transported with the Participant	Special Instructions to be shared

Transition Plan:

1. Describe any steps and supports necessary for the Participants to transition from the institution back to the community.

Actions/Supports Necessary for Transition:

1. _____
2. _____
3. _____
4. _____

I. SIGNATURES & AUTHORIZATIONS

Acknowledgement and Review of Support Plan

Participant Signature & Date:

_____ Date ____/____/____

Support Planner Signature & Date:

_____ Date ____/____/____

Provider Signatures/Authorizations: [Providers Identified in Section G.]

- | | | | |
|----|-------|------|----------------|
| 1. | _____ | Date | ____/____/____ |
| 2. | _____ | Date | ____/____/____ |
| 3. | _____ | Date | ____/____/____ |
| 4. | _____ | Date | ____/____/____ |
| 5. | _____ | Date | ____/____/____ |
| 6. | _____ | Date | ____/____/____ |
| 7. | _____ | Date | ____/____/____ |
| 8. | _____ | Date | ____/____/____ |
| 9. | _____ | Date | ____/____/____ |

Notes/Comments:

