Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
HCB Waiver Plan of Care

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- ☐ **Registered nurse, licensed to practice in the State**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

  Specify qualifications:

- ☐ **Social Worker.**

  Specify qualifications:

- ☑ **Other**

  Specify the individuals and their qualifications:

  While care coordinators (case managers, see above) have primary responsibility for the development of the plan of care, DSDS medical assistance administrators review and approve plans of care. Medical assistance administrators must have the following qualifications:
  A Bachelor's degree or the equivalent from an accredited college in public health, health sciences, health education, nursing, medical social work, health services administration, public administration, business administration or a closely related field.
  AND
  Two years of technical/paraprofessional level experience working with health care practices, services, delivery systems, terminology, financing, business practices and operations; or medical/public assistance programs and eligibility requirements; or health care claims evaluation and processing.

  Substitution: Additional technical/paraprofessional experience working with health care practices, services, delivery systems, terminology, financing, business practices and operations; or medical/public assistance program and eligibility requirements; or health care evaluation and processing may substitute for the education on a year-for-year basis

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b. **Service Plan Development Safeguards.** *Select one:*

- ○ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ◉ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

  The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

  Plan of cares are developed by a care coordinator, who may work independently or for the HCB Agency that is

permitted to provide other waiver services. The following safeguards assure the recipient's plan of care is in the best interest of the participant:
1. Participants are informed of their rights by the care coordinator and by the Client Rights Statement completed and signed by the participant at the time of their application, including the right to choose their providers, including choosing another care coordinator.
2. Participants participate in the development of and sign their plans of care.
3. Care coordinators must complete mandatory training that addresses their responsibilities to ensure plan of care development in the best interest of participants.
4. Division of Senior and Disabilities Services staff review the assessments, plans of care, medical certification, and other documentation for all participants to ensure appropriateness of plan of cares.

A care coordinator may not have a close familial or business relationship with a licensed assisted living facility providing residential supported living services to a participant in accordance with 7 AAC 43.1080.

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D-1: Service Plan Development (3 of 8)

c. **Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The Division of Senior and Disability Services provides participants with lists of care coordinators in their geographic area.

Participants are informed of their rights to choose their own providers, including care coordinators, participate in their plan of care development, refuse services, and contact DSDS for more information about plan of cares in the Clients Rights form. Participants are informed of their right to have others participate in the plan of care development process in the Client Choice of Services form.

Care Coordinators must complete mandatory training that addresses the requirements that they encourage participants to direct and be actively engaged in the plan of care development process and ensure that participants understand their right to have others participate in the process.

Participants must sign the Clients Rights form at time of application, and must sign plan of care, plan amendments, and Client Choice of Services forms each time a plan is changed. DSDS staff ensure that plan of cares and Client Choice of Services forms are signed before any waiver services are authorized.

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D-1: Service Plan Development (4 of 8)

d. **Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

A. The plan of care is developed by the participant, the care coordinator, and providers and others at the participant's request, in accordance with 7 AAC 43.1030. The care coordinator has primary responsibility for writing the plan. The plan of care is developed after a level of care evaluation has been completed, and must be completed within 60 days after completion of level of care evaluation, or within 30 days after the completion of a level of care

reevaluation, unless the care coordinator submits written documentation of unusual circumstances that would prevent timely completion of the plan of care.

B. The care coordinator uses the results of the Consumer Assessment Tool, the health professional's certification of medical condition, and other documentation or health assessments, e.g., physical therapy, occupational therapy. The plan of care must reflect the issues identified in the assessment, the preferences of the participant (or the participant's legal representative) and the health concerns of participant's medical care providers.

C. The care coordinator is required to inform the participant of the available services. Care coordinators receive instruction about services and their responsibilities to inform participants in mandatory training provided by DSDS.

D. Participants are informed of their rights to participate in the development of the plan of care, to choose or reject their services, and to obtain additional information about plan of cares from DSDS. The care coordinator has the primary responsibility to inform, but participants are also informed through the Client Rights Statement. DSDS staff review all plan of care signed by the participant in conjunction with assessments, certification of medical condition, other documentation, and the Client Choice of Services form to ensure the plan is consistent with the participant's needs and preferences prior to authorizing or reauthorizing waiver services.

E. The care coordinator is responsible for coordination of all the HCB Waiver services on the plan of care, as well as the regular Medicaid services (such as Personal Care Assistance (PCA)), and may plan coordination with grant services and other community resources the participant may utilize. Under 7 AAC 43.750, any recipient of both HCB Waiver and state plan PCA services will establish coordinated plans of care – using the same plan of care dates, and coordinating services to avoid any duplication. Care coordinators are required to complete mandatory training that addresses these responsibilities.

F. Monitoring the plan of care is the primary responsibility of the care coordinator. Concerns are discussed with the recipient or the recipient's legal representative in the (minimum) twice a month contacts; at least one of these contacts must be face-to-face.

The criteria to waive the face-to-face contact with the recipient is the rural community definition in 7 AAC 43.1054 (B) – which states that a rural community means a municipality or unincorporated population of not less than 25 and no more than 10,000, and is not connected by road or rail to Anchorage or Fairbanks; connected by road or rail does not include a connection by the Alaska Marine Highway system or by an international highway; or if not more than 1,600 people and is connected by road or rail to Anchorage or Fairbanks and is at least 50 miles outside of Anchorage or 25 miles outside of Fairbanks, and a connection by road or rail does not include a connection by the Marine highway or international highway.

In the event the face to face contact is waived by DSDS, the care coordinator must document one face-to-face visit per calendar quarter with each recipient whom the care coordinator serves, to monitor service delivery; and if the purpose of a contact is to develop the annual plan for the recipient, that contact must be face-to-face.

Incident reporting systems are addressed in appendix G. Participants are provided with DSDS phone numbers and encouraged to contact them as needed.

G. Plan of cares are updated at least annually and may be amended as often as needed in accordance with 7 AAC 43.1030.

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e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The state assessment licensed registered nurse administering the Consumer Assessment Tool also identifies

risks. As part of the care planning team, Care Coordinators, identify and address potential risks to the applicant and their families as one part of the planning process. Applicant needs and preferences in service providers are incorporated into the plan of care. Each service is reviewed to determine the relevance of the service and the risks that may be encountered with delivery. If the risks are seen by the family as too great, another service may be chosen. The care planning team develops a backup plan, to cover times when waiver service providers are unable to meet the needs of recipients because of staff that who are temporarily away on leave, and contingency plans for when emergencies arise that may leave the recipient without a provider. Each backup and contingency plan is unique to meet the needs and circumstances of each recipient. Copies are located in the DSDS central office files, the files of the agency providing services, as well as in the home of the recipient. Licensed providers are required to have backup plans as part of their licensing requirements with the State. Participants in home settings may use personal emergency response systems as part of their backup plan.

People who choose to live in remote Alaskan communities aware of the risks of living there and find HCB Waivers a means to allow an alternative health care choice while continuing a lifestyle others may not wish to assume. These are people who are usually life long residents – who have family and communities they choose not to leave. The State enters into HCB Waiver agreements to help facilitate their health and lifestyle choices. The care coordinator discusses all options for care with every applicant or the applicant's representative(s). These strategies are incorporated into the Plan of Care.

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f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Care coordinators have a list of service providers available in their communities. Each applicant is assisted to learn about the different services offered and the providers who offer those services. Alaska has a small population and large geographic area –thus the pool of providers is limited. DSDS also provides provider lists to participants and others upon request. The Client Rights Statement informs participants they may obtain information on services directly from the Division.

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D-1: Service Plan Development (7 of 8)

g. **Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

Every plan of care completed is reviewed prior to approval by DSDS staff. Plans are reviewed for adequacy of documentation, appropriateness of services, and compliance with statutes, regulations, and program policy.

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h. **Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. **Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies):*

- [x] **Medicaid agency**
- [ ] **Operating agency**
- [x] **Case manager**
- [x] **Other**

Specify:

Completed plan of care is given to HCB and RL Agencies providing services and the recipient by the care coordinator.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. **Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

a) Care Coordinators have primary responsibility for monitoring the implementation of the plan of care. The state contract assessor's licensed registered nurses also monitor implementation of the plan of care through the level of care reevaluation process.

b) Care coordinators use a combination of direct contact and observation of participants and communications with service providers. The state contract assessor uses direct contact and observation and other documentation provided in the level of care reevaluation process.

c) Care coordinators must have at least twice a month contact with the recipient, once of which must be face to face unless waived under conditions specified in 7 AAC 43.1030. The criteria to waive the face-to-face contact with the recipient is the rural community definition in 7 AAC 43.1054 (B) – which states that a rural community means a municipality or unincorporated population of not less than 25 and no more than 10,000, and is not connected by road or rail to Anchorage or Fairbanks; connected by road or rail does not include a connection by the Alaska Marine Highway system or by an international highway; or if not more than 1,600 people and is connected by road or rail to Anchorage or Fairbanks and is at least 50 miles outside of Anchorage or 25 miles outside of Fairbanks, and a connection by road or rail does not include a connection by the Marine highway or international highway.

In the event the face to face contact is waived by DSDS, the care coordinator must document one face-to-face visit per calendar quarter with each recipient whom the care coordinator serves, to monitor service delivery; and if the purpose of a contact is to develop the annual plan for the recipient, that contact must be face-to-face.

During monthly visits, the care coordinator monitors service delivery, evaluates the need for changes in specific home and community-based waiver services, coordinates the services of multiple providers and adequacy of the Plan of Care.

DSDS review and approve the program content of 100% of the APD Plans of Care; Every plan of care is given a second programmatic and fiscal review by DSDS State staff before prior authorizations are issued.

b. **Monitoring Safeguards.** *Select one:*

- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- (•) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Care coordinators have a responsibility under 7 AAC 43.1030 to monitor plan of care implementation and may work for agencies that provide other direct waiver services to the participant. However, care coordinators may not work for (or have a close familial relationship with) providers of residential supported living services serving the participant.

Care coordinators must complete mandatory training that addresses their responsibilities to monitor plan of cares, ensure participant health and welfare, and act in the best interest of the participant.

State contract assessor licensed registered nurses visit and observe the participant at least once annually as part of the level of care reevaluation.

Every plan of care and amendment completed is reviewed prior to approval by DSDS staff. Plans are reviewed for adequacy of documentation, appropriateness of services, and compliance with statutes, regulations, and program policy.

10% of all APD Plans of Care are reviewed for accuracy and proper notation, each year by DSDS staff who also to compare with usage and billings.

Recipients are informed of their right to consult with DSDS on their plan of care, and DSDS staff will investigate complaints regarding plan of cares.

All service providers are mandatory reports of abuse and neglect. DSDS Adult Protective Services are notified in each case of abuse (See sections G & H).