

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
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:

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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:*

The Plan of care is developed by a care coordinator who may work for the HCB Agency that is permitted to provide other waiver services. The following safeguards assure the recipient or the recipient's legal guardian has free choice of providers :

1. At the same time the family is given a list of care coordinators to choose from, they are also given a list of all other providers certified and enrolled to perform HCB waiver services service.
2. Recipients of waiver services or their legal representatives are included in the assessment process, determination of services to be provided, frequency and duration of services, receive a cost sheet which summarizes this along with the cost of each service. State staff provide assistance to families to determine which agencies have specific skills to meet the technological requirements for a participant.

Each plan of care is individually tailored to the requirements of the waiver recipient.

Every Plan of Care under this waiver is reviewed and approved by State MRDD staff who meet federal QMRP standards prior to the issuance of authorizations.

Alaska has a small population and large geographic area. Every attempt is made to let families know of their right to choose providers. But it is a reality that in some small, geographically isolated communities, there may well be very few providers. In some communities, there may be only one or two. Under these circumstances every attempt is made to accommodate a family's choice of providers. The MRDD staff will train providers who meet certification standards, who are identified by families.

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- 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.

Either the recipient or recipient's legal representative are required to be present and/or part of the planning team meetings. It is expected that the recipient will be actively engaged in selecting the care plan teams and development of the Plan of care. When the care plan document is complete, the recipient and/or legal guardian are required to sign the plan of care document in agreement with, or with noted disagreements. The recipient and/or legal representative are given a copy of the plan of care and the cost sheet which lists their chosen provider(s), frequency, scope, duration and costs of all services.

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- 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. By regulation, the care coordinator is required to convene a comprehensive, person centered planning team consisting of the recipient, recipient's family or legal guardian, and providers chosen by the recipient who are expected to provide services. The care coordinator convenes the person centered planning team prior to developing the Plan of Care. The Plan of Care is written by the care coordinator in accordance with the requests of the recipient or recipient's legal representative and the team. Each member verifies participation of the agency they represent by signing the plan of care. Any disagreement in the kind of services, frequency, scope or duration of services among participants is to be noted on the plan of care prior to submission for the departments' review. After DSDS staff review the Plan of Care and resolve any conflicts noted on the POC, the MRDD nursing staff approves the Plan of Care. (The POC is reviewed again prior to issuance of authorizations for billing). A new Plan of Care must be submitted annually – reflecting changes in the recipient's health, life plans and goals. It may be updated throughout the year with amendments reflecting changes in the recipient's condition(s). The ICAP assessment tool is used to evaluate the functional capacities of all MRDD applicants. As part of the assessment process the Care coordinators obtain documentation of the recipient's health condition(s) from physicians and other health care providers, HCB service providers, as well as information about the applicant's strengths, capacities, needs, preferences, and desired outcomes, health status and risk factors.

B. Participants are at the center of the planning process, so a Plan of Care does not progress from the planning stage to DSDS without the consent of the applicant or the applicant's legal representative. Alaska has a small population and large geographic area. It is a reality that there may be few providers in some communities. Under these circumstances, every attempt is made to accommodate the family's preferences. HCB Agencies will train people who meet the qualifications as a service provider and agrees to work for the enrolled HCB agency. Many times

families refer the best person for the job – someone who cares about the individual to be served, who has a commitment to stay on the job for a long time. Thus, the recipient truly has the service provider of their choice, and the agency has a long term employee.

C. The Plan of Care must reflect the recipient's needs as identified in the ICAP assessment, the preferences of the applicant, the applicant's legal representative and the health concerns of applicant's medical care providers.

D. 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, physical therapy or speech therapy), as well as coordination with grant services and other community resources the family may utilize. Under 7 AAC 43.750 Personal Care Assistance, a recipient of both HCB Waiver and PCA services will establish coordinated plans of care – using the same plan of care dates, and coordinating services to avoid any duplications.

E. 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.

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

G. Plans of Care are updated at least annually and may be amended as often as needed according to 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.

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.

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. In spite of this, families are encouraged to attend “family waiver training” which is held approximately 6 times a year in different communities around the state. Family centered training is provided by DSDS staff to families about the types of services and quality of providers of HCB Waiver services.

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- 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):

The MRDD plan of care completed by the care coordinator, is reviewed and signed by the recipient or the recipient’s legal representative, reviewed for program content and adequacy of services to meet the needs of the applicant, and approved by a DSDS/QMRP staff in the Anchorage office.

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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*):

- Medicaid agency
- Operating agency
- Case manager
- Other

Specify:

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

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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.

Care Coordinators are responsible for monitoring the implementation of the plan of care. 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 rural location of the recipient).

Care coordinators conduct twice monthly contacts. 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/MRDD staff meeting federal QMRP standards review and approve the program content of 100% of the MRDD Plans of Care and do a home visit with review of health and welfare of 10% of MRDD recipients annually.

In addition, every plan of care is given a second programmatic and fiscal review by State staff.

- 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:*

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:*

100% of Plans of Care are reviewed annually by DSDS/MRDD staff who meet the federal QMRP standards for program content, adequacy of services to meet the recipient's identified needs, state statutes and regulation compliance.

100% of Plans of Care are reviewed by a different DSDS Program staff who also meets federal QMRP standards in a second review to assure the recipient's health and welfare are best served by the frequency, scope and duration of services in the recipient's Plan of Care.

10% of total (unduplicated) number of recipients receive home visits by DSDS/MRDD State staff who meet federal QMRP standards, to monitor plan of care, client/family satisfaction with services and providers. Then, the Plan of care and agency documentation are reviewed for accuracy and proper chart notations, as well as

service use and billings.

Care Coordinators meet twice a month with recipients/families (as specified under 7 AAC 43.1030. Case notes document each meeting. A written report of services received, health and welfare status of the recipient to DSDS/MRDD Regional Program Specialist to review is included in the annual plan of care renewal package.

DSDS/Quality Assurance section, Child or Adult Protective Services are notified in each case of abuse (See sections G & H),