State of Alaska • Department of Health and Social Services • Senior and Disabilities Services

Care Coordination Services and Long Term Services and Supports Targeted Case Management Conditions of Participation

Care coordinators assist individuals to gain access to home and community-based waiver services under 7 AAC 130; Community First Choice services under 7 AAC 127; and other state plan services, as well as medical, social, educational, and other services with funding sources other than Medicaid. Care coordinators do this through a person-centered process led by the recipient and the planning team of the recipient's choosing.

Care coordinators also perform targeted case management services, which include helping recipients to complete an application and then submitting the application for home and community-based waiver services, Community First Choice services, or both. Once an applicant is determined eligible, care coordinators assist applicants with identifying goals, planning for services and selecting service providers. Care coordinators then assist the recipient-directed team to develop an initial support plan. Finally, care coordinators assist recipients to direct the team in reviewing goals and renewing the support plan annually.

On-going care coordination is a home and community-based waiver service that includes monthly monitoring of services in the support plan. Care coordinators remain in contact with the recipient throughout the support plan year, in manner and with a frequency appropriate to the needs of the recipient.

For a recipient receiving only Community First Choice services, a care coordinator provides case management services during the recipient's support plan year.

To offer care coordination services, a provider must be certified as a provider of care coordination services under 7 AAC 130.220 (a)(2); meet the requirements of 7 AAC 130. 238 and 7 AAC 130.240; and operate in compliance with the Home and Community-based Waiver Services Provider Conditions of Participation. *To offer long term services and supports targeted case management, the provider must be certified under 7 AAC 128.010(b), and comply with the following standards:*

I. Program Administration

A. **Personnel**.

1. Care coordination services/targeted case management program administrator.
   a. The provider must designate a care coordination services program administrator who is responsible for the management of the program including the following:
      i. orientation, training, and supervision of care coordinators;
      ii. implementation of policies and procedures;
      iii. intake processing and evaluation of new admissions to the services;
      iv. participation in the development of support plans in collaboration with other providers of services;
      v. ongoing review of the delivery of services, including
         (A) monitoring the amount, duration, and scope of services to assure delivery as outlined in the support plan;
         (B) assessing whether the services assist the recipients to attain the goals outlined in the support plan and recommending changes as appropriate,
         (C) evaluating the quality of care rendered;
      vi. development and implementation of corrective action plans for identified problems or deficiencies in delivery of care coordination services; and
      vii. submission of required reports to Senior and Disabilities Services, including critical incident reports.
   b. The provider may use a title other than program administrator for this position, (e.g., program director, program manager, or program supervisor).
   c. The provider must ensure that the individual in the program administrator position is certified as a care coordinator, and renews that certification as required under 7 AAC 130.238.

d. The program administrator must
   i. be at least 21 years of age;
   ii. meet the following experiential requirements: one year of full-time or equivalent part-time experience providing services to individuals in a human services setting in a position with responsibility for planning, development, and management or operation of programs involving service delivery, fiscal management, needs assessment, program evaluation, or similar tasks.
   iii. meet the following education requirements:
      (A) Bachelor of Arts or Bachelor of Science degree from an accredited college or university in social work, psychology, rehabilitation, nursing or a closely related human services field; or
      (B) Associate of Arts degree from an accredited college or university in psychology, rehabilitation, nursing or a closely related human services field, and two years of full-time or equivalent part-time experience working with human services recipients, in addition to the required one year of experience as a supervisor; or
      (C) four years of full-time or equivalent part-time experience working with human services recipients in social work, psychology, rehabilitation, nursing, or a closely related human services field or setting, in addition to the required one year of experience as a supervisor; or
      (D) certification as a rural community health aide or practitioner, and one year of full-time or equivalent part-time experience working with human services recipients, in addition to the required one year of experience as a supervisor.

e. In addition to meeting education and experience requirements, the administrator must possess the knowledge base and skills necessary to carry out the care coordination services program.
   i. The administrator knowledge base must include:
      (A) the medical, behavioral, habilitative, and rehabilitative conditions and requirements of the population to be served; and
      (B) the applicable laws and policies related to Senior and Disabilities Services programs.
   ii. The administrator skill set must include:
      (A) the ability to evaluate and develop a support plan to meet the needs of the population to be served; and
      (B) the ability to supervise professional and support services staff.

2. <u>Care coordinators.</u>
   a. Care coordinators shall be at least 18 years of age, and qualified through experience and education in a human services field or setting.
   b. Required education and additional experience or alternatives to formal education:
      i. Bachelor of Arts, Bachelor of Science, or Associate of Arts degree from an accredited college or university in social work, psychology, rehabilitation, nursing or a closely related human services field, and one year of full-time, or equivalent part-time experience working with human services recipients; or
      ii. two years of course credits from an accredited college or university in social work, psychology, rehabilitation, nursing or a closely related human services field, and one year of full-time, or equivalent part-time experience working with human services recipients; or
      iii. three years of full-time or equivalent part-time experience working with human services recipients in social work, psychology, rehabilitation, nursing, or a closely related human services field or setting; or
      iv. certification as a rural community health aide or practitioner and one year of full-time or equivalent part-time experience working with human services recipients.
   c. In addition to meeting education and experience requirements, care coordinators must possess, or develop before providing program services, the knowledge base and skills necessary to carry out the care coordination process.

i. The care coordination knowledge base must include:
(A) an understanding of person-centered planning, including how this applies not only to the development of the support plan but also to the on-going monitoring of services;
(B) the medical, behavioral, habilitative, and rehabilitative conditions and requirements of the population to be served by the care coordinator;
(C) the laws and policies related to Senior and Disabilities Services programs;
(D) the terminology commonly used in human services fields or settings;
(E) the elements of the care coordination process; and
(F) the resources available to meet the needs of recipients.

v. The care coordination skill set must include:
(A) the ability to support a recipient in directing the development of a support plan, based on his/her strengths and abilities, that leads to a meaningful life at home, at work, and in the community;
(B) the ability to effectively assist the recipient in communicating the recipient's choices and decisions and collaborating with supporters such as family members, guardians, or other decision-making assistants;
(C) the ability to organize, evaluate, and present information orally and in writing; and
(D) the ability to work with professional and support staff.

c. Senior and Disabilities Services may certify as care coordinator under 7 AAC 130.238 an applicant whose education was completed in a country other than the United States if the applicant can show that his/her foreign education is comparable to that received in an accredited educational institution in the United States.
i. Applicants licensed under AS 08 may submit a copy of a State of Alaska license to show the applicant's foreign education is comparable to education in the United States.
ii. Applicants not licensed under AS 08 are responsible for providing to Senior and Disabilities Services the following with an initial application for certification:
(A) a foreign educational credentials evaluation report from an evaluation service approved by the National Association of Credential Evaluation Services that includes, at a minimum, a description of each course and semester or quarter hour credits earned for that course, and a statement of degree equivalency to education in the United States; and
(B) certified English translations of any document submitted as part of the application, if the original documents are not in English.

B. **Training**.

1. An individual who seeks certification to provide care coordination services or targeted case management services
   a. must enroll in the Senior and Disabilities Services Beginning Care Coordination course;
   b. demonstrate comprehension of course content through examination; and
   c. provide proof of successful completion of that course not more than 365 days prior to the date of submission of an application for certification.
2. A certified care coordinator who wishes to renew his or her certification
   a. must successfully complete
      i. at least one Senior and Disabilities Services care coordination training course during the individual's one or two year period of certification;
      ii. 16 hours annually of continuing education that is relevant to a care coordinator's job responsibilities; and
   b. when submitting an application for recertification, provide proof of successful completion of the Senior and Disabilities Services training course and 16 hours annually of continuing education.
3. The provider agency must document attendance and successful completion by a care coordinator of 16 hours of continuing education annually in the care coordinator's personnel file; the provider agency's in-service training may qualify as continuing education if the training increases the knowledge, abilities, or skills of the care coordinator and the content of the in-service training, date, and time in attendance is documented.

II. Program operations

A. **Quality management**.

1. The provider agency must develop a system to monitor support plan development and implementation to ensure that support plans for recipients
   a. are developed and implemented as directed by the recipient;
   b. are complete and submitted within required timeframes;
   c. address all needs identified in the recipient's assessment;
   d. include the personal goals of the recipient; and
   e. address recipient health, safety, and welfare.
2. The provider agency must implement
   a. a protocol for analysis, annually at a minimum, of the data collected through its tracking system;
   b. a procedure for correcting problems uncovered by the analysis; and
   c. a process for summarizing the annual analysis and corrective actions for inclusion in a report to be submitted to Senior and Disabilities Services with the provider's application for recertification or to be made available upon request.
3 At a minimum, the provider agency must determine whether
   a. services meet the needs of the recipients;
   b. services are effectively coordinated among the various providers;
   c. recipients and their informal supports are encouraged to participate in the care coordination process;
   d. recipients make choices regarding their care; and
   e. services are integrated with informal care and supports.

B. **Billing for services**.

1. The provider agency may not submit a claim for reimbursement for
   a. development of an initial or renewal support plan for a recipient until the plan has been approved by Senior and Disabilities Services; or
   b. care coordination services or targeted case management until the services have been rendered.
2. The provider agency may not submit claims for monthly care coordination services or targeted case management, other than for program application, support plan development or support plan renewal, for recipients until the first day of the month following the month in which services were rendered.

C. **Conflicts of interest**.

1. The care coordinator must
   a. afford to the recipient the right to choose to receive services from any certified provider;
   b. inform the recipient in writing of any employment relationship or any other relationship with other provider personnel or owners who could be selected by the recipient to provide services; and
   c. facilitate the transfer process when the recipient chooses to receive care coordination services from another care coordinator.
2. The care coordinator may not
   a. solicit as clients any recipients known to be receiving services from another care coordinator or provider agency;
   b. after deciding to leave a provider agency for employment at another agency, attempt to influence any recipient to retain him or her as care coordinator or to initiate the process of transferring any recipient to the hiring agency for care coordination services or targeted case management; or
   c. offer, promote, or sell products or non-program services to, or engage in any commercial transaction with, recipients, their families, or their representatives.
3. The provider agency must develop a process for resolution of conflicts regarding needs, goals, or appropriate services that might arise between the care coordinator and the recipient, family, or informal supports.

D. **Backup care coordination/targeted case management**.

1. The provider agency must
   a. develop a plan for back-up care coordination services or targeted case management in collaboration with the recipient, and give a copy of the plan to the recipient; and
   b. ensure that a care coordinator identified as the backup care coordinator is currently and continues to be
      i. certified by Senior and Disabilities Services; and
      ii. associated with a certified provider agency in accordance with 7 AAC 10.900 (b).
2. The back-up plan must include
   a. the extent to which the primary care coordinator or the recipient is responsible for obtaining care coordination services or targeted case management if the primary care coordinator will be unavailable for a period that exceeds 72 hours;
   b. a contingency plan that defines the primary care coordinator's responsibilities to educate the recipient regarding a plan of action to ensure the health, safety, and welfare of the recipient if the primary care coordinator will be unavailable for a period that exceeds 30 days; and
   c. information about the potentials risks involved if back-up care coordination services are not secured.
3. The backup care coordinator may provide services to no more than the number of recipients, including that of the primary care coordinator's usual case load, for which service coordination and response to any recipient needs can be managed effectively.
4. The provider must inform each recipient affected by the end of the provider's association with a care coordinator employee, of the name and contact information for a care coordinator who will serve as backup until the recipient chooses another care coordinator to provide services.

E. **Care coordinator appointment and transfer**.

1. The care coordinator must notify Senior and Disabilities Services, on a form provided by Senior and Disabilities Services, of
   a. the care coordinator's appointment when selected by a recipient to provide services; and
   b. the transfer of care coordination services or targeted case management to another care coordinator.
2. The provider agency must send to each recipient affected by the end of the provider's association with a care coordinator employee, written notice that includes the name of the care coordinator ending employment and statements indicating
   a. the recipient's right to choose to receive care coordination services or targeted case management from any certified care coordination provider; and
   b. the provider agency will facilitate the transfer process if the recipient chooses to receive care coordination services or targeted case management from another provider agency.
3. The care coordinator must send to the new care coordinator, within five working days of notice of appointment of that care coordinator, the following materials:
   a. current support plan and amendments to the plan;
   b. most recent assessment;
   c. case notes for the past 12 months; and
   d. additional documents or information necessary for a safe transition.
4. The former and the new care coordinator must cooperate to ensure that all services outlined in the recipient's support plan continue during a transfer of care coordination services or targeted case management.
5. The newly appointed care coordinator must send a copy of the appointment form to all providers listed in the support plan to notify them of the change in care coordination services.

III. The care coordination/targeted case management process.

A. Care coordination goals.

The provider must operate its care coordination services and targeted case management program for the following purposes:

1. to assist the recipient in accessing and directing the support needed to live the life that the recipient chooses at home, at work, and in the community;
2. to foster the greatest amount of independence for the recipient;
3. to encourage the development of meaningful relationships and natural (unpaid) supports;
4. to assist the recipient with access to community-based services as directed by the recipient;
5. to enable the recipient to remain in the most appropriate environment in the home or community;
6. to build and strengthen family and community supports;
7. to treat recipients with dignity and respect in the provision of services;
8. to secure for recipients appropriate, comprehensive, and coordinated services that will promote rehabilitation and maintenance of current abilities;
9. to serve as a link to increase access to community-based services; and
10. to improve the availability and quality of services.

B. Person-centered planning process.

1. Recipient orientation. The care coordinator must
   a. ensure the planning process is timely and at a time and in a place determined by the recipient;
   b. orient the recipient, the recipient's family, and informal supports to the care coordination or targeted case management process;
   c. advise the recipient of and support the recipient's right to lead the planning process where possible and to define the role of other individuals that the recipient chooses for participation in the process;
   d. provide information about home and community-based service settings and options for medical, social, educational, employment, and other services;
   e. affirm the recipient's right to choose to receive services from any qualified provider and offer assistance in identifying potential providers for the recipient;
   f. discuss conflict-of-interest guidelines and develop strategies for resolving disagreements among planning participants; and
   g. if providing targeted case management for Community First Choice recipients, discuss the right of the recipient to contact the care coordinator when the recipient feels contact is necessary, and a method for such contact.
2. Comprehensive needs assessment. The care coordinator must complete a comprehensive needs assessment that includes
   a. the recipient's history;
   b. the recipient's strengths, preferences, goals, and interest; and
   c. identification and documentation of the recipient's needs.
3. Planning team.
   a. The care coordinator must
      i. facilitate the recipient's role as the leader of the planning process to the maximum extent possible;
      ii. with direction from the recipient, identify, meet with, and consult each member of the planning team for the purposes of developing an individualized, person-centered support plan;
      iii. provide an opportunity for the recipient and family
         (A) to express outcomes they wish to achieve,
         (B) to request services that meet identified needs, and
         (C) to explain how they would prefer the services to be delivered.

b. The planning team must identify
   i. the recipient's strengths, and focus on understanding needs in the context of those strengths;
   ii. risk factors and measures to minimize those risks;
   iii. cultural considerations to be included in the planning process;
   iv. the overarching purpose of the support plan; and
   v. strategies for solving disagreements during the planning process.

4. Integrated program of services. The planning team must
   a. incorporate the findings of the most recent evaluation or assessment in the support plan;
   b. recommend services that support and enhance, but do not replace, unless necessary, care and support provided by family and other informal supports;
   c develop an integrated program, including
      i. individually-designed activities, experiences, services, or therapies needed to achieve goals and objectives or identified, expected outcomes;
      ii. supports that will assist the recipient to become gainfully employed in the general workforce in an integrated workplace; and
   d. write a support plan that meets program requirements and specifies the responsibilities of the care coordinator, the recipient, and the recipient's informal and formal supports.

C. Support plan implementation.

The care coordinator must

1. deliver a copy of the approved support plan to the recipient and to each provider of services for the recipient within 10 business days of receiving the support plan from Senior and Disabilities Services;
2. arrange for the services and supports outlined in the support plan and coordinate the delivery of the services as directed by the recipient;
3. support the recipient's independence by encouraging the recipient, family, and informal supports to be responsible for care to the greatest extent possible;
4. teach the recipient and family how to direct the services, including evaluating the quality and appropriateness of services; and
5. if necessary, write and submit an amendment to the support plan.

D. Recipient and provider contacts.

1. Recipient contacts for the Adults Living Independently Waiver, Children with Complex Medical Conditions Waiver, Adults with Physical and Developmental Disabilities Waiver and the People with Intellectual and Developmental Disabilities Waiver:

   The care coordinator must
   a. contact each waiver recipient in person at least once a month, and contact the recipient or the recipient's representative in person or by phone at least once a month and as frequently as necessary, to evaluate whether
      i. services are furnished in accordance with the support plan and in a timely manner;
      ii. services are delivered in a manner that protects the recipient's health, safety, and welfare;
      iii. services are adequate to meet the recipient's identified need; and
      iv. changes in the needs or status of the recipient require adjustments to the support plan or to arrangements with providers;
   b. meet in-person with the recipient at least once in each setting during the plan year; and
   c. document the content of each contact with the recipient, including
      i. the method used to make that contact meaningful in terms of monitoring the health, safety, and welfare of the recipient;
      ii. a summary of the meeting and the names of those in attendance;
      iii. whether services are adequate, delivered safely, respectfully, and acceptably to the recipient; and
      iv. whether the support plan should be amended.

2. Recipient contacts: Individualized Support Waiver
The care coordinator must
   a. contact the waiver recipient in person at least once every three months, and contact the recipient by telephone at least once in each month in which in-person contact is not made, to evaluate whether
      i. services are furnished in accordance with the support plan and in a timely manner;
      ii. services are delivered in a manner that protects the recipient's health, safety, and welfare;
      iii. services are adequate to meet the recipient's identified need; and
      iv. changes in the needs or status of the recipient require adjustments to the support plan or to arrangements with providers;
   b. ensure that at least one of the in-person contacts made according to 2(a) above is accomplished in one of the settings where Individualized Supports Waiver services are provided; and
   c. document the content of each contact with the recipient as required in this subsection, including:
      i. the method used to make that contact meaningful in terms of monitoring the health, safety, and welfare of the recipient;
      ii. a summary of the meeting and the names of those in attendance;
      iii. whether services are adequate, delivered safely, respectfully, and acceptably to the recipient; and
      iv. whether the support plan should be amended.

3. Recipient contacts: Community First Choice.
The care coordinator providing targeted case management must provide the following:
   a. assistance with an individual's Community First Choice application;
   b. pre-enrollment counseling to discuss the range of services and supports available to the individual;
   c. with the recipient and planning team, development of an initial support plan and annual renewal support plan;
   d. monitoring the recipient and services received by the recipient on a schedule that is approved in the support plan; monitoring may occur more frequently when requested by the recipient or when an issue is identified by the care coordinator, a service provider, or the state.

4. Provider contacts: All Waivers and Community First Choice.
The care coordinator must
   a. contact each provider of services for a recipient as needed to
      i. ensure coordination in the delivery of multiple services by all providers;
      ii. address problems in service provision or goal achievement;
      iii. consult regarding need to alter support plans;
      iv. intervene to make providers more responsive to the recipient's needs; and
      v. verify service utilization in the amount, duration, and frequency specified in the support plan.
   b. Within one business day of learning of a recipient's death, termination of a service, or move to another residence, the care coordinator must notify every provider affected by such change in recipient status.

V. Environmental modification projects for Home and Community-based Waiver Services recipients

A. Environmental modification evaluation

1. The care coordinator must review the need for physical adaptations to the recipient's residence with the recipient and the home owner, and obtain preliminary permission from the home owner to proceed with the environmental modification project.
2. The care coordinator must verify that the environmental modification project can be accommodated within the funding limits set by 7 AAC 130.300 (c).

B. Request for cost estimates

1. The care coordinator must notify all certified and enrolled environmental modification service providers of the proposed project by electronic mail in a format provided by Senior and Disabilities Services.
2. The care coordinator's notification to environmental modification providers must include
   a. the care coordinator's name and contact information;
   b. the location of the proposed project, and a statement indicating providers may arrange with the care coordinator for on-site viewing of the area to be modified;
   c. the *Request for Cost Estimate* form or forms appropriate to the type of physical adaptation included in the environmental modification project;
   d. photographs of the area to be modified with sufficient detail for provider review; and
   e. notice of a time limit of at least 14 days for submission of estimates, unless different timeframe was approved by Senior and Disabilities Services.
3. The care coordinator may not disclose, except to Senior and Disabilities Services, financial information regarding the project or competing estimates, or the identity or number of providers expressing interest in the project.

C. Selection of the project provider

1. The care coordinator must
   a. review all *Request for Cost Estimate* forms received by the date specified for submission to determine
      i. which environmental modification provider submitted the lowest cost estimate for the project; and
      ii. whether that provider can complete the project in time to meet the recipient's needs; and
   b send to Senior and Disabilities Services
      i. a support plan that includes
         (A) a description of proposed physical adaptations with a photograph of the area to be modified, and any measurements, sketches, or other relevant representations developed by the environmental modifications provider to show the project plan;
         (B) justification for the project based on the recipient's functional or clinical needs;
         (C) the name of the environmental modification provider recommended for the project;
         (D) if applicable, a *Waiver of Requirement for Provider Selection* form with an explanation regarding the need to select an environmental modification provider other than the one submitting the lowest cost estimate; and
         (E) the *Property Owner's Consent to Environmental Modification* form; and
      ii. all *Request for Cost Estimate* forms received in regard to the project.
2. Upon written notice of approval by Senior and Disabilities Services, of selection of the environmental modification provider, the care coordinator must notify
   a. the provider selected of that provider's approval for the project; and
   b. any other providers that submitted estimates of that provider's selection.

D. Collaboration with interested parties

1. The care coordinator must advise the environmental modification provider of any recipient conditions or needs to ensure that the health, safety, and welfare of the recipient are protected throughout the project.
2. The care coordinator must review, with the environmental modification provider, any proposed changes for equivalent facilitation to ensure that the needs of the recipient will be met; the care coordinator may contact Senior and Disabilities Services regarding questions.
3. The care coordinator must work with the recipient, the home owner, and the environmental modification provider to resolve any disagreements regarding dissatisfaction with the project or work performance.
4. The care coordinator may contact Senior and Disabilities Services if unable to resolve any issues that remain after discussion with the parties.