Please provide a brief general overview of the state's proposed Community First Choice (CFC) benefit, including but not limited to an overview of services, delivery method, impact on other long-term services and supports (LTSS) programs, and how services will be coordinated between the CFC program and other state services provided:

Services and delivery method: Alaska's Community First Choice (CFC) option offers personal attendant services, known as Community First Choice Personal Care Service (CFC-PCS), Chore Services, and Emergency Response Systems. These services are offered using provider agencies as the delivery method, including an option to select an *agency with choice* model for PCS (called *Consumer Directed PCS*) that allows participants to have more control over their services. The CFC-PCS package also includes services to assist individuals in acquiring, enhancing, and/or maintaining skills necessary for the individual to accomplish ADLs, IADLs, and health-related tasks, and a voluntary option for training on how to select, manage, and dismiss attendants.

Impact on other LTSS programs: The state makes the following alterations to current Long Term Supports and Services (LTSS) to prevent duplication of services:

1) the current State Plan PCS benefit is modified so that participants choose between CFC PCS and the State Plan PCS benefit.
2) The current 1915(c) waivers are amended to ensure there is not duplication.

Coordination between CFC and other State Services: The state coordinates CFC with other services by using:

1) integrated intake, triage, and assessment processes that allow all individuals potentially eligible for CFC to make an informed choice and experience a single assessment that determines eligibility for CFC and other state services; and
2) a person-centered support plan that includes all LTSS services, including Medicaid State Plan services.

Community First Choice Development Implementation Council

Name of State Development and Implementation Council: Inclusive Community Choices (ICC) Council

Date of first Council meeting: October 28, 2015

☒ The state has consulted with its Development and Implementation Council before submitting its CFC State Plan amendment.

☒ The state has consulted with its Development and Implementation Council on its assessment of compliance with home and community-based settings requirements, including on the settings the state believes overcome the presumption of having institutional qualities.

☒ The state has sought public input on home and community-based settings compliance beyond the Development and Implementation Council. If yes, please describe.

Since its first ICC meeting in October, 2015, the department coordinated monthly meetings of the ICC through 2016; the ICC agreed to meet quarterly in 2017 and into the future. Voting membership includes representatives from various affected constituencies across the state, including traumatic brain injury; senior citizens; people with intellectual and developmental disabilities; family members and caregivers; and the drug and alcohol advisory board. The ICC also includes non-voting representatives from affected provider groups. In addition to learning about and advising SDS on long term care reform initiatives, including the CFC State Plan Amendment, the state has consulted with ICC regarding provider compliance with home and community based settings requirements.

In addition to conducting regular briefings with the Inclusive Community Choices Council (ICC), the Division of Senior and Disabilities Services (SDS) meets monthly with several partners, including provider and advocacy

associations, to update each on settings compliance and other CFC activities. These partners then share the information with their respective memberships to keep them apprised of CFC topics and issues.

The department also sought public input on multiple versions of its Settings Transition Plan (STP), using a variety of outreach methods. CMS awarded initial approval of the state's STP in December 2016 and final approval in August, 2018.

As part of the systemic analysis contained in the STP, the department participated in meetings with external stakeholder workgroups comprised of provider and advocacy agencies. This group reviewed and suggested settings-related amendments to applicable regulations and Conditions of Participation, which detail the standards for each service. These amended regulations utilized a mandatory public comment period, which was announced using the approved outreach methods for amendments to regulations, primarily the state's Online Public Notice system and newspaper advertisements.

In addition to the outreach methods required of regulations amendments, the department also regularly solicits public comments on waiver amendments via its E-Alert system, which reaches over 1700 providers and participants. These E-Alerts are frequently forwarded to the mailing lists of the advisory groups, reaching many more consumers, family caregivers, and advocates. E-Alerts include information on updates and changes to the CFC program and other Medicaid reform goals, such as moving the chore services from 1915(c) waivers into the CFC program.

The department has a Communication Plan for the CFC program. The Communication Plan includes talking points and a list of "frequently asked questions and responses" for the governor, the commissioner of the Department of Health and Social Services (DHSS), and DHSS staff, to ensure a consistent message is shared with interested parties.

The department continues to hold webinars to explain how the CFC operates and how it affects both participants and providers. These webinars are advertised through the E-Alert system. And, to ensure the information is available at all times, the department updates its web page dedicated to the CFC program, which contains the department contact information if readers have questions or want to comment on the content.

Community First Choice Eligibility

☒ Individuals are eligible for medical assistance under an eligibility group identified in the state plan.

☒ Categorically Needy Individuals

☐ Medically Needy Individuals

- ☐ Medically Needy individuals receive the same services that are provided to Categorically Needy individuals
- ☐ Different services than those provided to Categorically Needy individuals are provided to Medically Needy individuals. (If this box is checked, a separate template must be submitted to describe the CFC benefits provided to Medically Needy individuals)

The state assures the following:

☒ Individuals are in eligibility groups in which they are entitled to nursing facility services, or

☐ If individuals are in an eligibility group under the state plan that does not include nursing facility services, and to which the state has elected to make CFC services available (if not otherwise required), such individuals have an income that is at or below 150 percent of the Federal poverty level (FPL)

Level of Care

☒ The state assures that absent the provision of home and community based attendant services and supports provided under CFC, individuals would require the level of care furnished in a long-term care hospital, a nursing facility, an intermediate care facility for individuals with intellectual disabilities, an institution providing inpatient psychiatric services for individuals under age 21, or an institution for mental diseases for individuals age 65 or over.

Recertification

No The state has chosen to permanently waive the annual recertification of level of care requirement for individuals in accordance with 441.510(c)(1) & (2).

Please indicate the levels of care that are being waived

☐ Long-term care hospital
☐ Nursing facility
☐ Intermediate care facility for individuals with intellectual disabilities
☐ Institution providing psychiatric services for individuals under age 21
☐ Institution for mental diseases for individual age 65 and over

Describe the state process for determining an individual's level of care:

- Nursing Facility Level of Care (NFLOC) determinations: Potential participants seeking a NFLOC determination are assessed, using the standardized Consumer Assessment Tool (CAT) tool by a qualified department assessor. The CAT is conducted in person when possible and at a time and place convenient to the participant. The participant may also be assessed using secure telehealth technology when appropriate. In addition to the CAT, the assessor also collects supporting documentation, such as components of the medical record, to determine NFLOC.
- Intermediate Care Facility for Individuals with Intellectual Disabilities Level of Care (ICF-IID LOC) determinations: Potential participants seeking an ICF-IID LOC determination are assessed using the Inventory for Client and Agency Planning (ICAP) adaptive behavior tool by a qualified department ICAP assessor. Whenever possible, the ICAP observation is conducted in person and at a time and place convenient to the participant. The department conducts a limited number of assessments using secure telehealth technology, to more quickly assess participants in remote locations. In addition to a qualifying score on the ICAP, the department must also have documentation that the participant has a qualifying intellectual or developmental disability diagnosis.
- Institution providing inpatient psychiatric services for individuals under age 21, or an institution for mental diseases for individuals age 65 or over: the department contracts with Comagine Health to gather documentation and make recommendations about the participant's eligibility, and the department reviews the recommendations and provides final approval. To meet this criterion, the participant must be in imminent risk of being placed in an institution because of a danger to the participant or others. If a participant does not meet either the NFLOC or ICF-IID LOC and the assessment indicates that there is a concern about a danger to the participant or others, the participant is referred to Qualis for a review to determine if he or she meets the IMD LOC.

Informing Individuals Potentially Eligible for the Community First Choice Option

Indicate how the state ensures that individuals potentially eligible for CFC services and supports are informed of the program's availability and services:

☒ Letter

☒ Email

☒ Other describe:

Agencies serving as access points for publicly funded LTSS

Please describe the process used for informing beneficiaries:

For the initial implementation of CFC, the department sent letters and emails to the following individuals informing them about CFC:

1) participants currently enrolled in State Plan PCS services for whom their most recent CAT assessment indicates that they meet an institutional LOC (which includes those individuals already enrolled on a waiver); and

2) participants on a waiver program who currently receive emergency response services. These letters provided information about the enrollment process, program benefits, and the assessment process. The department also provided briefings about CFC to other state agencies and stakeholders via emails, in person monthly meetings with the Provider Association, and the ICCs.

As a waiver service is transitioned from the 1915(c) waivers into the CFC program, participants receiving that waiver service are notified by email and letter about transitioning to CFC in order to continue to receive that service. The letters and emails state that the agency provider and the direct care worker providing that service will continue to serve the recipient; the only change will be that the provider will bill a different code once the service is a CFC service.

The state's Aging and Disability Resource Centers (ADRCs), Developmental Disability Resource Centers (DDRCs), care coordinators, and intake staff at agencies providing HCB waiver services are given CFC program information to share with beneficiaries to ensure that all individuals seeking LTSS can make an informed decision about CFC regardless of where they enter the system.

Beneficiaries seeking LTSS have an opportunity to receive Person-centered Intake (PCI) from the State's ADRC and DDRC programs.

Assurances (All assurances must be checked).

☒ Services are provided on a statewide basis.

☒ Individuals make an affirmative choice to receive services through the CFC option.

☒ Services are provided without regard to the individual's age, type, or nature of disability, severity of disability, or the form of home and community-based attendant services and supports that the individual needs to lead an independent life.

☒ Individuals receiving services through CFC will not be precluded from receiving other home and community-based long-term care services and supports through other Medicaid state plan, waiver, grant, or demonstration authorities.

☒ During the five-year period that begins January 1, 2014, spousal impoverishment rules are used to determine the eligibility of individuals with a community spouse who seek eligibility for HCB waiver services provided under 1915(k).

CFC Service Models

Indicate which service models are used in the state's CFC program to provide consumer-directed home and community-based attendant services and supports (Select all that apply):

☐ Agency-Provider Model

☐ Self-Directed Model with Service Budget

☒ Other Service Model.

Describe:

Provider agency and provider agency with choice model, with different provider qualifications.

Please complete the following section if the state is using the Self-Directed Model with Service Budget or the Other Service Model if it includes a Service Budget

Financial Management Services

- The state must make available financial management services to all individuals with a service budget.

The state will claim costs associated with financial management services as:

☐ A Medicaid Service

☐ An Administrative Activity

☐ The state assures that financial management service activities will be provided in accordance with 42 CFR 441.545(B)(1). (Must check)

If applicable, please describe the types of activities that the financial management service entity will be providing, in addition to the regulatory requirements at 42 CFR 441.545(B)(1).

Specify the type of entity that provides financial management services:

☐ State Medicaid Agency

☐ Another State Agency – Specify _____

☐ Vendor organization, describe _____

Other Payment Methods

The state also provides for the payment of CFC services through the following methods:

☐ **Use of Direct Cash Payments -** The state elects to disburse cash prospectively to CFC participants. The state assures that all Internal Revenue Service (IRS) requirements regarding payroll/tax filing functions will be followed, including when participants perform the payroll/tax filing functions themselves.
Describe:

☐ **Vouchers-** Describe:

Service Budget Methodology

Describe the budget methodology the state uses to determine the individual's service budget amount. Also, describe how the state assures that the individual's budget allocation is objective and evidence-based utilizing valid, reliable cost data and can be applied consistently to individuals:

Describe how the state informs the individual of the specific dollar amount they may use for CFC services and supports before the person-centered service plan is finalized:

Describe how the individual may adjust the budget, including how he or she may freely change the budget and the circumstances, if any, which may require prior approval of the budget change from the state:

Describe the circumstances that may require a change in the person-centered service plan:

Describe how the individual requests a fair hearing if his or her request for a budget adjustment is denied or the amount of the budget is reduced:

Describe the procedures used to safeguard individuals when the budgeted service amount is insufficient to meet the individual's needs:

Describe how the state notifies individuals of the amount of any limit to the individual's CFC services and supports:

Describe the process for making adjustments to the individual's budget when a reassessment indicates there has been a change in his or her medical condition, functional status, or living situation:

Mandatory Services and Supports

a. Assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health -related tasks through hand-on assistance, supervision, and/or cueing.

Identify the activities to be provided by applicable provider type and describe any service limitations related to such activities.

☒ **Personal Attendant Services -** Describe:

Personal Attendant Services, known as Community First Choice Personal Care Services (CFC-PCS) under CFC, provides in-home personal care services to qualified Alaskan seniors and individual with disabilities. CFC-PCS is defined as providing assistance with Activities of Daily Living (ADL), such as eating, dressing, toileting, and Instrumental Activities of Daily Living (IADL), such as light meal preparation, main meal preparation in the individual's home in order to meet the health needs of the individual, housework in the individual's home to maintain a safe and sanitary environment, laundry services, shopping for items required for the health and maintenance of the individual, assistance with self-administration of medications, minor maintenance of respiratory equipment, dressing changes and wound care, and escorting an individual to and from medical appointments if the individual requires assistance with locomotion.

Provider type:

Agency-Based and Consumer-Directed Personal Care Services Agencies that are certified by the department and enrolled with Conduent to bill Medicaid, employing Personal Care Attendants (each with individual billing numbers issued by Conduent).

Personal care services may be provided through two different qualified Personal Care Agency Models:

Agency Based Personal Care Services (ABPCS): The beneficiary may choose a personal care agency in the agency-based program, which provides services through an agency that oversees, manages, and supervises the beneficiary's care. The ABPCS agency hires, trains, schedules, develops a backup plan if the regularly scheduled personal care assistant (PCA) is unavailable, and dispatches PCAs.

Consumer Directed Personal Care Services (CDPCS): Under the agency with choice model, the beneficiary may choose a consumer directed personal services program, which provides administrative support to the participant who manages his or her own care, or the participant's representative who manages the recipient's care, by hiring, firing, and supervising the PCA. The CDPCS administers payroll and Medicaid billing support.

License required No

Certification required Yes

Describe:

To qualify for certification as a PCS agency, the agency must meet the applicable certification criteria set out in the department's Personal Care Assistant Agency Certification Application packet. Both Agency Based Personal Care Services (ABPCS) and Consumer Directed Personal Care Services (CDPCS) agencies must employ a program administrator who has attended mandatory division training. For the ABPCS agency type only, the agency must employ a registered nurse.

Education-Based Standard: No

Describe:

Other qualifications required for this provider type: Yes

Describe:

At both CDPCS and ABPCS agencies, the personal care assistant must be at least 18 years of age, must be able to meet all the requirements of the program as described in state regulations, including successful completion of First Aid and CPR training within the last two years, must be individually enrolled to bill Medicaid, must pass a criminal background check, must not have been denied a health care provider license or certification for a reason related to patient services, and must be able independently to assist the participant with the specific Activity of

Daily Living (ADL), Instrumental Activity of Daily Living (IADL), and services.

To be a personal care assistant for an ABPCS, the assistant must be a licensed nurse, CNA, a community health aide, or have successfully completed a training approved by the state, or completed an equivalent training five years prior to applying to be employed as a PCA. In addition to the mandatory First Aid and CPR certification, training requirements for PCAs working in ABPCS agencies include at least 40 hours of instruction, given by a nurse licensed by the State of Alaska, in infection control, bowel and bladder care, nutrition and food planning and preparation, physical transfers, assistance with self-administration of medication, blood pressure, temperature, respiration, developmental disabilities and physical and mental illnesses, body systems, mechanics and disorders, death and dying, use of equipment necessary to perform the tasks of a PCA, universal precautions, and affecting PCAs such as record keeping, confidentiality, reporting Medicaid fraud.

For CDPCS, the agency must provide its personal care assistants information regarding the responsibilities of the recipient for training the PCA and management of his/her personal care services.

Both types of agencies must provide all personal care attendants training on critical incident reporting, restrictive interventions and assistance with self-administration of medication.

Additionally, both types of agencies must also attest to providing training to staff on acquiring and maintaining skills necessary for a participant to independently complete activities of daily living (ADLs), instrumental activities of daily living (IADLs) and health related tasks.

☐ **Companion Services**

Provider type

License required No

Describe

Certification required No

Describe

Education-Based Standard: No

Describe

Other qualifications required for this provider type: No

Describe

☒ **Homemaker/Chore Services:** (describe)

All services funded by the Division of Senior and Disabilities Services fall within the umbrella term “long term services and supports”. This term includes Medicaid waiver services, Community First Choice services, Medicaid State Plan personal care services, Medicaid State Plan targeted case management services, and grant services. Agencies providing any, or all, of these services are considered to be providing long term services and supports.

Chore services assist the participant to maintain a clean, sanitary and safe environment. Chore services consist of regular cleaning of the residence used by the participant including washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture, snow shoveling or snow plowing

in order to provide safe access and egress, hauling water, hauling or disposing of human excreta, collecting and chopping firewood, if firewood is used as a heat source for the participant's home, and other services that the state determines necessary to maintain a healthy and safe residence.

Payment for chore services will not be made if any other relative or caregiver, or any community or volunteer agency or third-party payer is capable of or responsible for the provision of chore services, or if the participant's residence is a rental property, and the state determines those services to be the responsibility of the landlord under the lease or applicable law. In addition, the state will not authorize chore services if the certified chore provider resides in the same residence as the recipient of chore services.

The definition of Chore does not change as the service transfers from being a 1915(c) waiver service to a Community First Choice service. Conversion to CFC Chore will not affect current recipients of waiver Chore services, unless they opt not to be part of CFC, in which case they will not receive Chore services. Agencies currently certified to provide Chore as a waiver service will continue certification as CFC Chore providers; direct service workers for waiver Chore will continue to provide CFC Chore. A modifier will be used with the billing procedure code when providers submit a claim, to indicate that Chore expenditures are now part of CFC.

If an agency certified to provide CFC Personal Care Services (either agency-based or consumer-directed) wishes to add Chore to the array of services offered to recipients of PCS, that agency needs to separately certify as an HCBS Agency in order to provide CFC Chore. If an HCBS agency certified to provide Chore services wishes to provide either agency-based or consumer-directed personal care services, that agency will need to separately certify as a PCS/CFC PCS agency.

All chore services must be prior authorized.

Provider type:

Describe: HCBS Agency

License required No

Describe

Certification required Yes

Describe:

To qualify for certification as a provider of CFC chore services, the agency must meet the applicable certification criteria set out in the department's Chore Services Certification Application Packet. The HCBS agency must employ a program administrator who has attended mandatory division training. HCBS agencies do not certify as agency-based or consumer-directed (those designations are specific to agencies providing personal care services.

Education-Based Standard: No

Describe:

Other qualifications required for this provider type: Yes

Describe:

1) Chore services workers must be at least 18 years of age; qualified through education or experience; and possess, or develop before providing services, the skills necessary to perform, as requested by the

recipient, the tasks included in the chore services plan.

2) Required education and alternatives to formal education:
   A) high school or general education development (GED) diploma; or
   B) demonstration to the provider of the ability to read written instructions and to make entries regarding services in the recipient record or file.

Other Services.

Describe:

Provider type:

License required: No

Describe:

Certification required: No

Describe:

Education-Based Standard: No

Describe:

Other qualifications required for this provider type:

Describe:

2. The acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health-related tasks.

Identify the activities to be provided by applicable provider type and any describe any service limitations related to such activities:

To foster greater independence among the participants enrolled in CFC, the program supports the acquisition, maintenance, and enhancement of skills that allow participants to be more independent in completing ADLs, IADLs, and health related tasks. This support includes the following:

- **The participant's person-centered support plan will identify skills the participant would like to address and the plan for addressing them**: This section of the Support Plan includes any ADLs, IADLs, or health-related tasks that the participant or the participant's representative chooses.

Provider type: Skill Building Personal Care Attendant Services (SB-PCA)

SB-PCA providers are certified PCA providers who have been trained on acquiring and maintaining skills necessary for a participant to independently complete activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health related tasks.

License required: No

Describe:

Certification required: Yes

Describe:

Qualifications required for this provider SB-PCA are the same as required for PCAs.

Education-Based Standard: Yes

Describe:

Qualifications required for this provider SB-PCA are the same as required for PCAs.

Other qualifications required for this provider type: Yes

Describe:

Qualifications required for this provider SB-PCA are the same as required for PCAs.

3. Individual back-up systems or mechanisms to ensure continuity of services and supports. Identify the systems or mechanisms to be provided and limitations for:

Identify the systems or mechanisms to be provided and limitations for:

- [x] Personal emergency response systems
- [ ] Pagers
- [ ] Other mobile electronic devices
- [ ] Other, describe:

The department will consider an item to be an emergency response system if that item is:

1) A device, control, or appliance that summon help in the event of an emergency; and

2) Identified in the department's Specialized Medical Equipment Fee Schedule.

Describe any limitations for the systems or mechanisms provided:

Under CFC, the department pays for emergency response systems that:

1) are supported by a prescription or other written documentation required by the department's Specialized Medical Equipment Fee Schedule
   - A) from an individual with an active license under AS 08 to practice as
     - i) a physician, including an osteopath;
     - ii) a physician assistant;
     - iii) an advanced nurse practitioner;
     - iv) an occupational therapist; or
     - v) a physical therapist; and
   - B) stating that the emergency response system requested is appropriate for the recipient and consistent with the person-centered support plan;
2) is supported by a written cost estimate; and
3) is approved as part of the participant's person-centered support plan.

The department will pay under this section subject to the following:

1) the unit cost of equipment is determined by including the cost of
   - A) training in the equipment's proper use; and
   - B) routine fitting of and maintenance on the equipment necessary to meet applicable standards of manufacture, design, and installation;

2) the department will not pay, as a CFC service, the cost of any medical equipment or supplies payable under 7 AAC 120.200 - 7 AAC 120.299;

3) emergency response systems shall be rented unless the department determines that purchasing the equipment is more cost-effective than renting it;

4) once purchased, specialized medical equipment becomes the property of the participant;

5) the department does not give prior authorization to replace emergency response systems before the expiration of the time period identified in the department's Specialized Medical Equipment Fee Schedule unless the department determines that replacement is more cost-effective than repairing that equipment.

Provider type: Medical Supply Provider

License required Yes

Describe: Alaska business license under AS 43.70 and 7 AAC 12

Certification required No

Describe:

Education-Based Standard: No

Describe:

Other qualifications required for this provider type: Yes

Describe: Medical supply provider enrolled with the State Medicaid Agency Claims Payment System.

4. Voluntary training on how to select, manage, and dismiss attendants.

The state will claim costs associated with voluntary training as (check one):

☐ Medicaid Service

☒ An Administrative Activity

Describe the voluntary training program the state will provide to individuals on selecting, managing, and dismissing attendants:

Individuals receive a brochure that includes website links that direct them to training resources on how to select, manage, and dismiss PCAs. They will be given this information again by care coordinators, when their person-centered support plan is updated or renewed. The department training staff provides electronic training videos on the department website via YouTube/Vimeo. The modules are designed to teach CFC participants how to select, manage, and dismiss attendants.

Provider type:

License required No

Describe:

Certification required No

Describe:

Education-Based Standard: No

Describe:

Other qualifications required for this provider type: No

Describe:

Operational Services and Supports

Indicate which of the following optional services and supports the state provides and provide a detailed description of these benefits and any limitations applicable to them.

☐ Transition Costs (Provided to individuals transitioning from a nursing facility, Institution for Mental Disease, Intermediate care facility for Individuals with Intellectual Disabilities to a community based home setting) – Check all of the following costs that apply:

☐ Rental and Security Deposits-

Description and Limitations:

☐ Utility Security Deposits

Description and Limitations:

☐ First Month's Rent

Description and Limitations:

☐ First Month's Utilities

Description and Limitations:

☐ Basic Kitchen Supplies

Description and Limitations:

☐ Bedding and Furniture-

Description and Limitations:

☐ Other Household Items –

Description and Limitations:

☐ Other coverable necessities linked to an assessed need to enable transition from an institution to the community

Description and Limitations:

☐ Goods and Services - Services or supports for a need identified in the individual's person-centered plan of services that increase an individual's independence or substitute for human assistance, to the extent that

expenditures would otherwise be made for the human assistance. Include a service description including provider type and any limitations for each service provided.

Home and Community Based Settings

☒ Each individual receiving CFC services and supports must reside in a home or community-based setting and receive CFC services in community settings that meet the requirements of 42 CFR 441.530.

Setting Types (check all that apply):

☒ CFC services are only provided in private residences and are not provided in provider - owned or controlled settings.

☐ CFC services may be provided in private residences and in provider owned or controlled settings.

☐ The CFC benefit includes settings that have been determined home and community-based through the heightened scrutiny process.

Provider –owned or controlled settings:

1. Please identify all residential setting types in which an individual may receive services under the CFC benefit.

2. Please identify all non-residential setting types in which a person may receive services under the CFC benefit.

Setting Assurances – The state assures the following:

☒ CFC services will be furnished to individuals who reside in a home or community setting, which does not include a nursing facility, institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, or a hospital providing long-term care services.

☒ Any permissible modifications of rights within a provider owned and controlled setting is incorporated into an individual's person-centered service plan and meets the requirements of 42 CFR 441.530(a)(vi)(F).

Additional state assurances:

CFC Support Systems, Assessment, and Service Plan

Support System

☒ The support system is provided in accordance with the requirements of §441.555.

Provide a description of how the support system is implemented and identify the entity or entities responsible for performing support activities:

The state provides the following supports to each CFC participant:

1) Each applicant for CFC services is assessed by a qualified assessor employed by the department, using the appropriate assessment tool. Applicants that are eligible for CFC services are notified and receive pre-enrollment counseling from a care coordinator.
2) Each applicant is provided pre-enrollment counseling; information is communicated in a manner that is understandable to the participant and in a manner sensitive to the participant's culture.
    A) Pre-enrollment counseling includes the following topics:
        i) a review of all Medicaid services available to the participant;
        ii) discussion of the participant's right to choose services, providers, or no services;
        iii) the responsibilities of the participant when choosing an agency with choice approach for PCS, (including the responsibility to participate in risk management [Quality Assurance] plans) and the risks associated with those responsibilities;
        iv) an explanation of the participant's right of freedom of choice, rights to control information rights to reasonable accommodation when accessing information and rights to appeal;
        v) ways to identify and access services, supports and resources including a printed list of all CFC service providers and their contact information and information on the advocacy systems and groups including a printed list of each advocacy group and their contact information.
3) All participants choosing to enroll in CFC must work with a care coordinator to develop the person-centered support plan and to initiate services. The support planning conference is conducted as directed by the participant with the assistance and oversight of the care coordinator, who ensures that all communications take place in a manner that is understandable to the participant and in a manner that is sensitive to the participant's culture.
    A) The support planning conference establishes:
        i) the participant's choices of services and supports specific to the participant's needs and will set goals and expected outcomes for each service and support;
        ii) a personal safety and backup plan, including information on the participant's responsibility for reporting critical incidents and the method by which critical incidences are reported;
        iii) a schedule for reassessment and revision of the person-centered support plan.

Specify any tools or instruments used as part of the risk management system to identify and mitigate potential risks to the individual receiving CFC services:

The department's risk management approach for CFC includes the following components:

- The care coordinator reviews the assessment for information and documents any potential risks in the person-centered support plan. This plan also documents plans for mitigating those risks. The participant and/or her or his representatives than acknowledge that they understand and accept the risks and this is documented in the plan.
- The care coordinator, as part of the person-centered planning process, is responsible for discussing with the participant whether the level of risk in the plan indicates that more frequent monitoring by the care coordinator should be part of the risk mitigation strategy.
- Mandatory reporting of suspected cases of abandonment, exploitation, abuse, neglect, or self-neglect of vulnerable adults pursuant to AS 47.24 and mandatory reporting of suspected cases of child abuse and neglect pursuant to AS 47.14 through the Alaska State Centralized Reporting system.
- Maltreatment reports and provider complaints received by Centralized Reporting are routed to the unit or program (Adult Protective Services, Program Integrity and Licensing unit) that is relevant to the report or complaint. The Harmony Centralized Reporting electronic portal captures and stores information for each entity. This information can be analyzed to identify prevalence and patterns of adverse events. All units

collaborate on investigations when needed, and may refer to other investigative authorities such as law enforcement, Medicaid Fraud Control Unit, Elder Fraud, and Program Integrity.

- Adult Protective Services is responsible for the protection of vulnerable adults from abuse, neglect, and exploitation. Investigation findings may lead to appointing a surrogate decision maker, a petition for services, conservator or guardian, and applying for benefits or providing protective placement.
- Quality Assurance, in collaboration with Provider Certification and Compliance, is responsible for ensuring quality providers are certified and enrolled and maintain ongoing compliance. Investigation findings may result in providing technical assistance, requiring corrective actions, and imposing sanctions up to and including termination from the Medicaid program.
- Residential Licensing is responsible for oversight of facilities that serve adult populations, however, State Plan services are not allowed in those facilities. Licensed foster homes for children are overseen by the Office of Children's Services (OCS). OCS conducts investigations into any allegations of the licensed entity, or any harm reported for recipients. OCS issues plans of corrections and sanctions, up to and including termination from the program for providers, and protective placements for children at risk for harm.

Provide a description of the conflict of interest standards that apply to all individuals and entities, public or private to ensure that a single entity does not provide the assessments of functional need and/or the person-centered service plan development process along with direct CFC service provision to the same individual:

The individual conducting the level of care assessment is a state employee. The care coordinators helping to support the development of the person-centered support plan are conflict-free. The state assures that conflict of interest standards required in CFR 441.555(c), for the functional needs assessment and development of the person-centered support plan applies to all individuals and entities, both public and private. The state ensures that the individual conducting the functional needs assessment and person-centered service plan is not:

A) related by blood or marriage to the participant, or to any paid caregiver of the participant;
B) financially responsible for the participant;
C) empowered to make financial or health-related decisions on behalf of the participant;
D) someone who would benefit financially from the provision of assessed needs and services;
E) a provider of state-funded services for the participant, or has an interest in or is employed by, a provider of state funded services for the participant.

☒ Conflict of Interest Exception: The only willing and qualified entity performing assessments of functional need and or developing the person-centered service plan also provide home and community based waiver services.

Provide a description, including firewalls, to be implemented within the entity to protect against conflict of interest, such as separation of assessment and/or planning functions from direct service provision functions, and a description of the alternative dispute resolution process:

The state adheres to the CFC regulations conflict of interest standard. 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 home and community-based services for the individual, or those how have an interest in or are employed by a provider of State Plan home and community-based services 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 home and community-based services.

The state will grant exceptions to the conflict-free requirements for care coordinators, who conduct person-centered service plan development, in areas of the state for which no willing and qualified conflict-free care coordinator is available. In these cases, the state will verify that a) no conflict-free care coordinator is enrolled as a Medicaid provider [other than for the service of care coordination] and serves that geographic area, or b) if a conflict-free case manager is enrolled and serves that geographic area, that provider has indicated that it is not willing or able to serve the individual.

If an exception is granted, the agency receiving the exception must demonstrate it has conflict of interest protections by submitting the following documentation:

1) description of the administrative separation of State Plan home and community-based services from care coordination that includes a description of the duties of the State Plan home and community-based services supervisor(s) and the care coordination supervisor(s) and explains how the agency ensures that the care coordinator is free from influence of direct service providers regarding participant care plans.

2) evidence of administrative separation on organizational chart that includes position titles and names of staff.

3) the plan/policy/procedure used to ensure administrative separation of State Plan home and community-based services from care coordination. This plan/policy/procedure ensures that choice of all available State Plan home and community-based services providers.

Assessment of Need

Describe the assessment process or processes the state will use to obtain information concerning the individual's needs, strengths, preferences, and goals:

Department staff currently conducts a level of care assessment using the Alaska Consumer Assessment Tool (CAT) or the Inventory for Client and Agency Planning (ICAP), both of which collect information on functioning, behavior issues, medical concerns, and other needs. The participant's care coordinator reviews this information and collects additional information about the participant's strengths and preferences to assess functional need, then works with the participant and her or his representative to identify needed and preferred services and person-centered goals. CAT and ICAP assessments are conducted face-to-face or by telehealth as described in the section below.

☒ The state will allow the use of telemedicine or other information technology medium in lieu of a face-to-face assessment in accordance with §441.535. The individual is provided with the opportunity for an in-person assessment in lieu of one performed via telemedicine. Include a description about how an individual receives appropriate support including access to on-site support staff during the assessment:

The state has developed telehealth policy for conducting level of care assessments and reassessments, using video conference technology. These assessments occur where signed agreements with approved conferencing centers exist. The agreements outline the procedures and secure technology requirements for all parties. The state may conduct assessments and reassessments, and to allow care coordinators to conduct functional assessments, in a participant's own home using telehealth methods once secure technology and connectivity is in place.

Following person-centered practices, the individual being assessed or reassessed is offered a choice of a face-to-face assessment in lieu of a telehealth assessment. If all parties agree to a telehealth assessment, the individual must sign the Consent for Telehealth Assessment form prior to the scheduled assessment. The individual is involved in the scheduling of the assessment and may choose a date and time that is best for them from a list of available dates and times offered by the state. Individuals may choose to invite their care coordinator, direct care provider, service agency representative, family member, or friends to be present during the assessment. This is especially

important if the individual requires assistance or support with locomotion, transferring and/or other activities of daily living that are a vital part of the assessment process.

The state's pre-assessment protocol includes contacting the participant, caregiver, and rural health clinic at least one week prior to the scheduled assessment to coordinate an escort or other assistance needed for the individual to access the assessment. The state assessor explains to the individual that the telehealth assessment may be stopped at any time if the participant or any family member becomes uncomfortable with the video assessment process, and allows the individual or family members to ask questions before and after the assessment.

The state will claim costs associated with CFC assessment activities as:

- ☐ A Medicaid Service
- ☒ An Administrative Activity

Indicate who is responsible for completing the assessment prior to developing the CFC person-centered service plan. Also, specify their qualifications:

- ☒ Social work. Specify qualifications: Bachelor or Master's prepared
- ☒ Registered Nurse, licensed to practice in the state, acting within scope of practice under state law.
- ☐ Licensed Practical Nurse or Vocational Nurse, acting within scope of practice under state law.
- ☐ Licensed Physician (M.D. or O.D.), acting within scope of practice under state law.
- ☐ Case manager. Specify qualifications: _____
- ☒ Other. Specify provider type and qualifications:

1) Licensed, psychologist (Master's prepared); licensed physician (MD or DO);
2) occupational therapist;
3) physical therapist;
4) speech pathologist or audiologist;
5) professional recreation staff (an individual with a Bachelor's in a recreation specialty (art, music, physical education);
6) individual with a Bachelor's in a human services field (sociology, special education, rehabilitation, counseling, psychology);
7) professional that holds a Master's degree from an accredited college in health, public health, behavioral health, health care services, health practice, senior health care, developmental disabilities, health sciences, health care administration, or a closely related field and has at least one year of advanced professional level experience performing health program planning, development, coordination, evaluation, or implementation, technical health care assistance and consultation; health care utilization or quality assurance examination; and/or health care service delivery;
8) Bachelor's degree from an accredited college in biological, health or behavioral science; health practice; education; public, healthcare, or business administration; or a closely related field with two years of advanced professional level experience performing health program planning, development, coordination, evaluation, or implementation; technical health care assistance and consultation; health care utilization or quality assurance examination; and/or health care service delivery; or
9) diploma or associate's degree from a school of nursing accredited by the National League for Nursing and has four years of advanced professional level experience performing health program planning, development, coordination, evaluation; or implementation; technical health care assistance and

consultation; health care utilization or quality assurance examination; and/or health care service delivery.

The reassessment process is conducted every:

☒ 12 months

☐ Other (must be in increments of time less than 12 months)

Describe the reassessment process the state will use when there is a significant change in the individual's needs or the individual requests a reassessment. Indicate if this process is conducted in the same manner and by the same entity as the initial assessment process or if different procedures are followed:

When there is significant change in the individual's needs or the individual requests a reassessment, the reassessment process is conducted in the same manner and by the same entity as the initial assessment process.

Person-centered Service Plan

The CFC service plan must be developed using a person-centered and person-directed planning process. This process is driven by the individual and includes people chosen by the individual to participate.

The state will claim costs associated with CFC person-centered planning process as:

☐ A Medicaid Service

☒ An Administrative Activity

Indicate who is responsible for completing the Community First Choice person-centered service plan.

☒ Case manager. Specify qualifications:

Case management is provided by conflict-free care coordinators employed by a certified care coordination agency. Care coordination may be provided by an agency employing multiple care coordinators or an agency that is a sole practitioner; however, both must meet the certification requirements and be enrolled with Medicaid as a care coordination agency. Every care coordination agency must have a qualified program administrator to manage the day to day operations of the agency's services. A care coordinator must be at least 18 years of age. All care coordinators must complete the department's Basic Care Coordination training course, and demonstrate comprehension of course content prior to certification. Training may be completed up to two years prior to application. To maintain or renew certification, a care coordinator must attend the department's care coordination training every two years.

☒ Social work. Specify qualifications: BA, BS, or AA degree from accredited college or university

☒ Registered Nurse, licensed to practice in the state, acting within scope of practice under state law.

☒ Licensed Practical Nurse or Vocational Nurse, acting within scope of practice under state law.

☐ Licensed Physician (M.D. or O.D.), acting within scope of practice under state law.

☒ Other. Specify provider type and qualifications:

Have one of the following combinations of education or experience:

1) BA, BS, or AA degree from an accredited college or university in psychology, rehabilitation, or a closely related human services field, and one year of full-time, paid experience working with human services participants; or
2) 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, paid experience working with human services participants; or
3) Three years of full-time paid experience working with human services participants in social work, psychology, rehabilitation, nursing, or a closely related human services field or setting; or
4) Certification of a rural community health aide or practitioner and one year of full-time, paid experience working with human services participants.

Person-centered Service Plan Development Process: Use the section below to describe the process that is used to develop the person-centered service plan.

Specify the supports and information that are made available to the individual (and/or family or authorized representative, as appropriate) to direct and be actively engaged in the person-centered service plan development process and the individual's authority to determine who is included in the process:

The following processes help the individual (and/or family or authorized representatives) direct and be actively engaged in the development of the person-center support plan:

- The care coordinator is trained to ask the individual (and/or family authorized representatives as appropriate) who should be included in the process. The care coordinator documents who was included and verifies this choice was given.
- The care coordinator educates the individual (and/or family authorized representatives as appropriate) about person-centered support plan process. This includes discussing the Participant Rights and Responsibilities form with the individual/representative and obtaining the recipient's signature during the initial development of the support plan and when plans are updated. The form explains the right to participate in planning and making choices about services received from all sources.
- The state has prepared handouts and other training materials to assist individuals in taking a leading role in the process.
- The state has structured the support plan so that the individual's personal goals will play a central role in designing supports.
- The support plan format addresses whether the individual would like to make changes to his or her living situation, employment, and/or ability to perform tasks more independently.

Indicate who develops the person-centered service plan. Identify what individuals, other than the individual receiving services or their authorized representative, are expected to participate in the person-centered service plan development process. Please explain how the state assures that the individual has the opportunity to include participants of their choice:

The participant can include any individuals they choose in the planning process according to the Participant Rights and Responsibilities form and the choice statement in the person-centered support plan. The care coordinator facilitates this involvement. The care coordinator develops the person-centered service plan with the individual. All service providers agreeing to give service are expected to participate in the plan development. All certified CFC service providers must sign the plan document. Other supports as invited by the individual to participate also sign.

Describe the timing of the person-centered service plan development to assure the individual has access to services as quickly as possible; describe how and when it is updated, including mechanisms to address changing circumstances and needs or at the request of the individual:

After an initial Level of Care and program eligibility is established, care coordinators have 60 days to submit, via the state's database, a person-centered support plan. Care coordinators can submit a plan any time prior to that deadline. The state has 30 days to notify the participant of approval or disapproval once a complete plan is received.

The person-centered service plan is reviewed, and revised upon reassessment of functional need, at least every 12 months.
The person-centered service plan is reviewed, and revised when the individual's circumstances or needs change significantly, and at the request of the individual. Any support plan review or revision request that addresses health and safety concerns can receive expedited review of the person-centered support plan changes. The department will respond within 10 days of receiving and expedited request and complete the person-centered support plan or amendment. Regulations ensure the department responds in a timely manner. Fair hearing rights are provided to participants on all disapproval of person-centered support plans.

Describe the state's expectations regarding the scheduling and location of meetings to accommodate individuals receiving services and how cultural considerations of the individual are reflected in the development of the person-centered service plan:

Care Coordinator (CC) Conditions of Participation (COP) require that the care coordinator maintain contact with the individual in a timely manner and frequency appropriate to the individual's needs and that the meeting times and locations be acceptable for the individual. The care coordinator must communicate in a method appropriate to the abilities of the individual and representative to assure contend is understood. These expectations are included in the required care coordinator training curriculum. Care coordinators must attend training before certification and renewal.

Describe how the service plan development process ensures that the person-centered service plan addresses the individual's goals, needs (including health care needs), and preferences and offers choices regarding the services and supports they receive and from whom. Please include a description of how the state records in the person-centered service plan the alternative home and community based settings that were considered by the individual:

A person-centered support plan document is required for each participant. The support plan includes a segment to identify the individual's personal goal(s) and to document that services are requested that match those goals. The person-centered support plan documents the outcomes of a structured discussion that addresses the participant's personal goals, needs, including health care needs, and preferences and how services and other supports will help achieve those goals. The document captures information regarding the participant's preference for skills training to acquire, maintain, or enhance their ability to perform ADLs, IADLs, and health related tasks; the participant's or a representative's desire to receive training on how to manage direct care workers; the participant's preferences related to employment; and alternative home and community based settings available to the participant that were considered by the individual.

Describe the strategies used for resolving conflict or disagreements within the process:

The care coordinator is required to submit in writing, within the person-centered support plan, information about any disagreement in the kind of services, frequency, scope, or duration of service among individuals who participate in the support planning process.

Department staff reviews the person-centered support plan and work with the care coordinator to resolve any disagreements or conflicts, then approve the plan and issue prior authorizations for billing. In addition, the participant must initial and sign the department's Participant Rights and Responsibilities form that outlines participant's rights including the right to make choices about their care, to participate in support planning and to receive a copy of the person-centered support plan, to change providers at any time, and to submit a complaint through a grievance procedure established by the service provider. Fair hearing rights are provided to participants on all disapproval of person-centered support plans.
All participants receive a written denial or decision of conflict resolution plan of care notice (POC) informing them of actions taken by the department. The notice is sent via certified mail with the accompanying fair hearing rights enclosed.

Please describe how the person-centered service plan development process provides for the assignment of responsibilities for the development of the plan and to implement and monitor the plan.

The state encourages the participant and/or her or his representative to take the lead in developing the Person-centered Support Plan. This is achieved by:

A) educating the participant/representative about the process.
B) identifying supports or accommodations the participant may need to play a more active role in the process.
C) the care coordinator will coach the participant throughout the process.
D) department staff reviews the person-centered support plan and obtains feedback from the participant or representative about his or her perception about being involved in the process.

A conflict-free care coordinator facilitates the support planning process to ensure that the person-centered support plan is completed according to the state's requirements, including reflecting the participant's person-centered goals and preferences. If the participant or a representative cannot or prefers not to lead the process, the care coordinator will assume the lead. The care coordinator will file all necessary documents with the department and track their status.

The care coordinator works with the participant and/or representative to select service providers. The care coordinator translates these selections into requests for services, which are then prior authorized if approved by the state. Department staff then review all person-centered support plans to ensure compliance, including addressing person-centered requirements.

The case manager has the responsibility to monitor the plan according to the schedule included in the support plan. The participant may contact the department or care coordinator at any time if she or he has a concern about services. The department may proactively contact individuals for whom overbilling or chronic under billing is noted or in response to a critical incident. If these contacts suggest the need for ongoing monitoring, the support plan may be adjusted or the participant will be offered enrollment in a program that provides more care coordination.

☒ The state assures that assessment and service planning will be conducted according to 441.540(B) 1-12.

The person-centered service plan is reviewed and updated every:

☐ 3 months

☐ 6 months

☒ 12 months

☐ Other: [ ] (must be less than 12 months)

AND

☒ When an individual's circumstances or needs change significantly or at the individuals request.

Describe the person-centered service plan review process the state will use. In the description, please indicate if this process is conducted in the same manner and by the same entity as the initial service plan review process or if different procedures are followed:

Updates to the person-centered support plan will follow the same development and review process as described for the initial plan.

CFC Service Delivery System

Identify the service delivery system(s) that will be used for individuals receiving CFC services:

☒ Traditional State-Managed Fee-for-Service (4.19(b) page is required)

☐ Managed Care Organization

☐ Other: [ ]

Quality Assurance System

Please describe the state's quality improvement strategy:

The department Continuous Quality Improvement plan (CQI) is one element of the department's Quality Improvement Strategy (QIS) that provides for systematic evaluation of department activities to ensure health, safety, and welfare of participants, facilitates discovery activities through collection of data necessary for remediating individual problems and implementing system improvements, and provides a reporting mechanism for department performance to the DHSS leadership. Work involved in the implementation of the CQI plan is done within Quality Improvement Task Committees, comprised of department Unit Managers and the Quality Improvement Workgroup (QIW) comprised of department Unit Managers and the Division's Executive Team. Activities of the QWI are overseen by the DHSS Quality Improvement Steering Committee (QISC) led by the department's commissioner and deputy commissioner.

The CQI plan incorporates input from stakeholders, participants, providers and the public as necessary. The Department holds occasional information sharing teleconferences open to all stakeholders and covering a variety of topics and issues impacting CFC participants and CFC services, specifically when changes are made to operations or there are noted issues to address. The department uses these opportunities to report department performance status, changes in CFC program administration and anticipated system changes resulting from discovery activities. The department also gathers and shares information regularly at meetings of provider professional associations.

The QIS and Task Committees perform discovery and remediation activities for CFC. Data is separately aggregated and analyzed for CFC.

The QIW establishes Task Committees charged with discovery and remediation responsibilities associated with operation of CFC and measured by established performance measures. Task Committees meet monthly to review performance measure data, identify performance deficiencies, implement and report on corrective action on

individual cases, and recommend system improvement to QIW. The following Task Committees are currently in operation:

- **Mortality Review Team-** the Mortality Review Team identifies and reviews all deaths reported throughout the centralized intake reporting system. Membership includes the Quality Assurance Unit Manager (Chair) and department staff including a Qualified Intellectual Disability Professional (QIDP), a Registered Nurse (RN), the department Mortality Review Coordinator, an Adult Protective Services (APS) Unit representative, a Residential Licensing Unit representative, and an Office of Long Term Care Ombudsman(OLTCO) representative. The team reviews information on participant deaths obtained through the department critical incident reporting process, medical records, vital statistics, Medical Examiner's office and law enforcement reports and determines if the death is the result of an action or omission (or inaction) on the part of a provider agency or the department. The team also compares department findings with information obtained from the Bureau of Vital Statistics to discover additional deaths not reported by providers. Untimely deaths, or deaths involving unusual circumstances of CFC service participants, are vetted carefully by the committee and may trigger an investigation.
- **Level of Care Review Task Committee-** the Level of Care Review Task Committee discovers and remediates department performance including timeliness of initial and annual assessments and LOC determinations and other administrative factors identified in the department's LOC performance measures. On a weekly basis, the unit manager's review LOC status reports generated by the Research and Analysis Unit, identifies deficiencies in performance and plans and implements remediation activities. On a monthly basis, the committee reviews, aggregated monthly, quarterly and annual data, analyzes trends, and makes recommendations for systems improvement to the QIW.
- **Qualified Providers Review Task Committee-** the Qualified Providers Task Committee gathers and reviews data from department performance measures regarding provider qualifications to determine whether certification standards, including required training, are met. Membership includes the Managers of the Provider Certification and Compliance Unit (Chair), Research and Analysis Unit, Operations Integrity Unit (OIU), Policy and Program Development, Grants, Certification Unit staff, and the department Training Coordinator. On a monthly basis, the committee reviews certification and training records and aggregated data to discover the status of provider compliance with certification standards, and plans and implements remediation activities.
- **Service Plan Review Task Committee-** the Service Plan Review Task Committee gathers and reviews data from department performance measures that reveal if service plans are timely, person centered, identify personal goals and address needs identified in the assessments and provide choices to the participant. The committee reviews results of monthly service plan record reviews and reports findings to the manager of the CFC program services unit. The manager identifies and initiates remediation activities needed to cure identified deficiencies. The committee also submits reports on remediation completed to the Quality Assurance unit for inclusion in the monthly QIW meetings and makes system improvement recommendations to QIW.
- **Policy and Procedure Task Committee-** the Policy and Procedure Task Committee develops and reviews department policies and procedures with input from department staff content experts." Before finalizing, all department policies are reviewed by participants, stakeholders, providers and the public. Input is collected and analyzed by the committee, and incorporated whenever possible. The committee also oversees policy implementation including staff and provider training and communication plans pertaining to new or revised policy and procedures.
- **Health and Welfare Review Task Committee-** the Health and Welfare Review Task Committee monitors performance measures related to reports of harm and other critical incidents. The committee reviews reports of harm, critical incident and complaint reports, discovers deficiencies and plans, and conducts individual and system remediation.

- **Information Technology Task Committee-** the Information Technology (IT) Task Committee monitors the coordination and integration of department information technology and supports data collection and analysis activities of all the task committees. The committee supports and coordinates development and functionality of the department management information system, Harmony, including identification of system performance enhancements and coordination with other DHSS and partner systems.
- **Financial Accountability Task Committee-** the Financial Accountability Task Committee ensures that CFC services claims for reimbursement are coded and paid in accordance with the reimbursement methodology. The committee monitors regulations, policy, and procedure regarding claims and service utilization, and reviews DHSS audit reports and other surveillance reports generated by the department to discover deficiencies in provider billing compliance. The committee addresses deficiencies that can be remediated at the department level, and supports the department efforts to recoup overpayments and sanction providers as needed to maintain the financial integrity of the CFC program.
- **Quality Improvement Workgroup (QIW) -** The QIW reviews and analyzes aggregated data collected through activities of Task Committees and determines if system changes are necessary to meet performance targets. The QIW drafts the CQI plan and performance measures, reviews findings and first level remediation activities, and determines the need for remediation. QIW meets monthly to develop plans of action that include a statement of the problems/risk to be corrected, desired results/changes, specific action steps, identification of person/s responsible, timeframe for completion of the corrective action plan, and plans for monitoring the effectiveness. Additional responsibilities include comparison of monthly, quarterly, and annually aggregated data to identify trends or potential system changes and recommendations for system change activities.

The CQI plan also includes requirements for providers including submitting to independent audits conducted by the department. In addition, CFC services providers are expected to perform an internal evaluation including client satisfaction surveys, which are reviewed by department QA staff and considered when the agency seeks recertification.

Describe the methods the state will use 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:

The state operates a formal, comprehensive system that includes an ongoing process of discovery, remediation, and improvement. The state assures the health and welfare of participants by monitoring:

a) LOC determinations;
b) individual plans and services delivery;
c) provider qualifications;
d) participant health and welfare;
e) financial oversight; and
f) administrative oversight.

The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. This system will be integrated with the CQI system for the state's CFC program.

All service providers are mandatory reporters for abuse, neglect, or exploitation and are required to report these types of incidents in accordance with AS 47.17.010 for children and AS 47.24.010 for adults. For incidents of abuse, neglect, or exploitation in an assisted living home, service providers are required to report these incidents to the department pursuant to AS 47.24.013.

All providers are required to report critical incidents. Within 24 hours or one business day of observing or learning of an incident involving a participant for whom services are provided under a service plan, the provider agency, or the incident reporter is required to file a department Critical Incident Report (CIR). For medication errors, this timeframe must be met only when the error results in the need for medical intervention; all other medical errors must be reviewed and documented by the provider on a quarterly basis, and submitted to the department upon request.

The department's Central Intake Unit receives and routes all reports of physical and sexual abuse, neglect, self-neglect, exploitation, including financial exploitation, and abandonment as well as critical incidents involving CFC participants. Providers, participants, care coordinators, family members, advocates or any citizen may submit a "report of harm" through the department-sponsored "Centralized Reporting" electronic portal accessed through the department web at http://dhss.alaska.gov/dsds/Pages/CentralizedReporting.aspx. APS reviews all reports of harm and critical incidents within 24 hours of receipt and investigates allegations of abuse neglect or exploitation.

Describe how the state 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.)

Care coordinators have responsibility for implementation and ongoing monitoring of the participant's person-centered support plan. Using telephonic and in-person contacts, the care coordinator ensures that services are provided as identified in the person-centered support plan, monitors the effectiveness and quality of services received from providers, evaluates the need for specific services or changes in services, and, with the participant, revises the person-centered support plan as needed. In addition, the care coordinator coordinates multiple services and providers, including non-CFC services, such as primary health care. The care coordinator also reviews and modifies the participant's service back-up plan as needed to ensure participant health, safety and welfare, and to ensure that participants have free choice of providers, responds to participant requests for changes in providers by providing service options, linking the participant with a new provider, and facilitating the transition as needed.

The state also takes a role in monitoring implementation of the person-centered support plan through a review of the care coordinator's efforts. After each visit with a participant, the care coordinator completes a provider "record of service" as required by regulations that include annotated case notes signed and dated by the care coordinator. The department Provider Quality Assurance Unit requests the participant contact form when needed in response to a participant complaint, when the state's discovery efforts reveal problems with a participant's care, or for safety investigations and/or audit and program integrity reviews. When a care coordinator is identified as deficient in any of these areas, the department remediates the problem by providing training and technical assistance. If the care coordinator's performance does not improve, the department will respond with progressive disciplinary actions, culminating in loss of provider certification.

The department uses the same performance indicators, including the health and welfare performance indicators. The department collects and aggregates data for these measures for a statistically significant and representative sample of individuals enrolled in CFC. For CFC, the department supplements these indicators with performance indicators utilizing data collected directly from participants after the support planning process. These indicators monitor the participant's experience with services and the assessment and support planning process.

Describe the standards for all service delivery models for training, appeals for denials and reconsideration procedures for an individual's person-centered service plan:

Training: Training standards for individual services, care coordinators, and department staff are discussed in the earlier sections, as is the voluntary training being offered to participants and/or representatives. The department Training Unit will oversee compliance with all training standards.

Denials and Fair Hearings: Alaska's Administrative Code at 7 AAC 49 provides applicants and participants in programs the right to notice of adverse actions, an appeal of such adverse actions, and a fair hearing. A notice of adverse action must be given to individuals when their request for services is not acted upon with reasonable promptness, if not given the choice of CFC services as an alternative to institutional care, are denied the service(s) of their choice or the provider(s) of their choice; or, whose services are denied, suspended, reduced or terminated.

During the initial application process, an applicant for CFC services is informed of their rights to dispute, through the fair hearing process, any adverse action from the state. This information is given to the individual by the care coordinator assisting them with the application process in the Notice of Adverse Actions, Hearings and Appeals information sheet. The department ensures that the applicant receives the Notice of Adverse Action by requiring the department's Program Participant Rights form as part of the complete application. The form requires the applicant to read and initial 18 statements attesting to the fact that they understand their rights under the program. The final statement confirms that they have received a copy of the Notice of Adverse Actions, Hearings and Appeals information sheet. The state offers a process for mediation in advance of fair hearing to address disputes in regards to all services provided through the department.

All fair hearings in the State of Alaska are centralized and conducted by the Alaska Department of Administration and heard before an administrative law judge. Fair hearing representatives are responsible for preparing the case for adverse action and representing the department at the hearing.

The applicant or participant may choose to represent him or herself at the fair hearing, or may choose representation by a guardian, attorney, friend, or family member. Due to conflict of interest concerns the participant's care coordinator or other service providers may not represent the participant at the fair hearing, but may accompany the participant to the hearing, act as an advocate, offer assistance throughout the process, and refer the participant to additional sources of assistance as appropriate. In addition, upon oral or written request from the applicant or participant, the department will provide assistance in obtaining representation, preparing the case, and gathering witnesses and/or documents to be used in presenting the claim.

Describe the methods used to monitor provider qualifications:

Alaska monitors provider qualifications using the certification process and ongoing provider monitoring.

Provider Certification: the provider choosing to offer Medicaid-reimbursable CFC services must be certified as a provider of those services and operate in compliance with the State's certification criteria. The provider must demonstrate, through documents describing provider operations, readiness to provide services and comprehension of Medicaid regulations, Community First Choice regulation and the Provider Conditions of Participation.

Provider Monitoring: As part of monthly discovery activities, the Provider Certification and Compliance Unit manager reviews the department training database against a list of certified CFC services providers. For those providers who are out of compliance with department training requirements, including Critical Incident Reporting training, the manager directs staff to issue a "report of findings". The report must include a description of the evidence supporting the finding of noncompliance as well as the specific standard, policy, regulation, or statute that is the basis for the finding. In addition, the report specifies the remediation action required to achieve compliance, the date by which compliance is required and the method of provider confirmation of compliance. The department may also perform targeted reviews and conduct agency onsite visits, including document reviews and participant or provider staff interviews. The department then monitors remediation requirements through review and analysis of provider reports, information provided by participants, and reviews of complaints. The department continues to

review progress until the deficiencies are corrected, and reports on the performance of department certification and oversight process activities to the departmental Quality Improvement Steering Committee on a quarterly basis.

Describe the methods for assuring that individuals are given a choice between institutional and community based services:

The person-centered support plan includes a section called Participant Choice of Services that requires the participant or legal representative to initial a series of statements indicating that they understand the choices available– either receiving Medicaid funded care in an institution, through state funded community based services, only non-Medicaid services, or receiving no services at all. The section also outlines the assistance the department and/or the participant's care coordinator provide after a choice is made. Finally, the section requires the participant and/or their legal representative to indicate their choice. The person-centered support plan is then signed by everyone involved in the planning effort. The Participant Choice of Services section of the person-centered support plan is updated and reviewed with the participant at least annually.

Participants are also given materials listing all the Medicaid LTSS available to them.

Describe the methods for assuring that individuals are given a choice of services, supports, and providers:

Prior to person-centered support plan development, the care coordinator, chosen by the participant from an official list of care coordinators (provided after a person-centered intake by the Aging and Disability Resource Center or Developmental Disability Resource Center specialist) in their geographic area, provides a list of CFC, relevant HCB waiver services, and State plan LTSS. The care coordinator then assists the participant to explore the range of services offered, and to make decisions regarding which services meet their person-centered goals, needs, preferences, and desires.

Participants take the lead in their person-centered support plan development, may refuse services, and are given information on how to contact the department for more information or to lodge complaints regarding services, service providers, or any other aspect of CFC participation.

Participants sign the Participant Rights and Responsibilities form at time of application, and sign annual service plans and when needed changes are identified, plan amendments.

The department Standards for Care Coordinators requires care coordinators to help participants explore options when choosing service providers. The care coordinator provides the participant with a list of certified and enrolled providers who offer services in their area and the participant picks those providers that fit her or his needs as outlined in the person-centered support plan and have the capacity to serve them. The Participant Choice of Service section of the person-centered support plan confirms that the care coordinator fulfilled these requirements. If the care coordinator has been granted an exemption by the department and is not conflict-free, the care coordinator is required to disclose this conflict of interest and ensure that the participant understands that they still have the right to choose a provider other than the care coordinator's agency.

The department reviews the person-centered support plans to ensure these requirements are met. In addition, the department will be surveying participants to ensure they believed they were given a choice of services, supports, and providers.

Describe the methods for monitoring that the services and supports provided to each individual are appropriate:

The department ensures that services and supports provided under CFC are appropriate by:

1. issuing guidance and training to care coordinators that require that all services and supports must be related to a documented assessed need or person-centered goal.

2. reviewing all person-centered support plans to ensure that services and supports are appropriate given assessed needs and person-centered goals.
3. ensuring that the care coordinator discusses the provision of services with the participant or the participant's legal representative telephonically or during participant requested contact and reports to department staff.
4. ensuring that the person-centered support plan is updated annually or when needed to reflect changes in the participant's condition, desires, goals, or needs. Annual updates take place after the reassessment and redetermination of the participant's Institutional LOC.

Describe the state process for ongoing monitoring of compliance with the home and community-based setting requirements, including systemic oversight and individual outcomes:

Services are only provided to individuals living in private residences and not in provider owned or controlled settings. Services are not provided in any residential foster care for children. The department has incorporated settings compliance into its existing monitoring processes.

Choice and Control

Describe the quality assurance system's methods to (1) maximize consumer independence and control, (2) provide information about the provisions of quality improvement to each individual receiving CFC services and supports

The department's CQI process, which is described in greater detail in earlier sections, includes the following components that help maximize participant independence and control:

1. Department staff monitors data collected by the ADRCs during the person-centered intake to ensure that individuals are able to make an informed choice about whether to enroll in CFC.
2. Department staff review all the person-centered support plans to ensure that care coordinators followed the proscribed policies and procedures designed to maximize participant independence and control.
3. Department staff will review the results of a survey of all participants regarding their experience in completing a person-centered support plan. This survey, the Questionnaire for Initial and Renewal Plans of Care, includes items addressing independence and control. These reviews result in interventions both at the individual and programmatic level.

Each CFC participant receives a document that explains how the CFC quality management strategy works. The care coordinator explains this document when initial and annual person-centered support plan updates are finalized.

Stakeholder Feedback

Describe how the state will elicit feedback from key stakeholders to improve the quality of the community-based attendant services and supports benefit:

The department elicits and incorporates stakeholder feedback into its quality improvement strategy in the following ways:

1. The department elicits feedback from all CFC participants during the support planning process using the "Questionnaire for Initial and Renewal Plans of Care". This questionnaire collects information about services and the support planning process and is used as a key data source in the department's quality management strategy that was described earlier.
2. The department holds at least quarterly meetings of the Inclusive Community Choices Council (ICC) to present information about CFC and HCB waiver services and elicit feedback from program participants. The ICC includes individuals with disabilities, older adults, their advocates, and providers and other stakeholders who impact

and/or are impacted by CFC and HCB waiver services. During these meetings, summary information from the Questionnaire and other key CQI information is presented.
3. The department participates in meetings held by associations and other groups, such as the Governor's Council on Disabilities and Special Education and the Alaska Commission on Aging, to inform them about how CFC and HCB waiver services are working and to obtain input.
4. The department makes summary information about the program available on its website.
5. The department also holds webinars and community forums when major changes are being considered or are in the process of being implemented.

Identify the stakeholders from whom the state will elicit feedback:

☒ The state will elicit feedback from the following stakeholders: (1) Individuals receiving CFC services and, if applicable, their representatives, (2) disability organizations, (3) providers, (4) families of elderly individuals or individuals with disabilities, (5) and members of the community

☐ Other, describe:

State Assurances

☒ The state assures there are necessary safeguards in place to protect the health and welfare of individuals provided services under this state Plan Option, and to assure financial accountability for funds expended for CFC services.

☒ With respect to expenditures during the first full year in which the state plan amendment is implemented, the state will maintain or exceed the level of state expenditures for home and community-based attendant services and supports provided under section 1905(a), section 1915, section 1115, or otherwise to individuals with disabilities or elderly individuals attributable to the preceding year.

☒ The state assures the collection and reporting of information, including data regarding how the state provides home and community-based attendant services and supports and other HCB WAIVER SERVICES , the cost of such services and supports, and how the state provides individuals with disabilities who otherwise qualify for institutional care under the state plan or under a waiver the choice to instead receive HCB WAIVER SERVICES in lieu of institutional care, and the impact of CFC on the physical and emotional health of individuals.

☒ The state shall provide the Secretary with the following information regarding the provision of home and community-based attendant services and supports under this subsection for each fiscal year such services and supports are provided:

(i) The number of individuals who are estimated to receive home and community-based attendant services and supports under this option during the fiscal year.
(ii) The number of individuals that received such services and supports during the preceding fiscal year.
(iii) The specific number of individuals served by type of disability, age, gender, education level, and employment status.
(iv) Whether the specific individuals have been previously served under any other home and community based services and support program under the state plan or under a waiver.

☒ The state assures that home and community-based attendant services and supports are provided in accordance with the requirements of the Fair Labor Standards Act of 1938 and applicable Federal and state laws.