HMA

HEALTH MANAGEMENT ASSOCIATES

Alaska Department of Health and Social Services

HCBS 1915(i) and 1915(k)

TASK 11
IMPLEMENTATION PLAN

SEPTEMBER 29, 2016

Table of Contents

1. Executive Summary

In the fall of 2015, the Alaska Department of Health and Social Services (DHSS), with support from the Mental Health Trust Authority, issued a Request for Proposal (RFP) #06-60000002 for *Home and Community-Based Services; 1915(i) and 1915(k) Implementation.* Through a competitive bid process, Health Management Associates, Inc. (HMA) was awarded the contract to conduct the study on behalf of DHSS and the Division of Senior and Disabilities Services (SDS). The 2016 Alaska Legislature passed Medicaid reform bill Senate Bill 74 (SB74), which tasked SDS with further exploring and implementing options identified in that RFP. The Division's work with HMA aligned with the Legislative language in SB74.

Project Scope and Approach

HMA conducted an in-depth study and analysis of 1915(i) and 1915(k) Medicaid Home and Community Based Services (HCBS) options for four targeted populations in Alaska — individuals with intellectual and developmental disabilities (I/DD), individuals with Alzheimer's Disease and related dementia (ADRD), individuals with traumatic or acquired brain injury (TABI) and individuals with serious mental illness (SMI). This project included the following scope of work:

- Gathering stakeholder input through a series of forums and public meetings in nine venues across the State, as well as one statewide webinar.
- Collaborating with SDS to establish a Development and Implementation Council of key stakeholders to provide input and feedback on work throughout the course of the project (a core requirement for 1915(k) programs).
- Reviewing the federal and State regulations for HCBS programs and the potential changes required to implement new 1915(i) and 1915(k) programs.
- Reviewing and documenting current Alaska Medicaid HCBS waiver programs, Medicaid State Plan services, and State-funded services and grants.
- Reviewing current data and information technology systems supporting eligibility, enrollment and management of individuals in all of these programs.
- Identifying the options for eligibility, possible service packages, resource allocation, and potential cost impacts for each of the four target populations for 1915(i) and (k).
- Scanning current functional assessment tools used by Alaska, as well as those used by other states.
- Reviewing current quality assurance and improvement plans for HCBS programs and services and making recommendations for changes needed for 1915(i) and (k) programs.
- Summarizing lessons learned and best practices from several other states that have implemented 1915(i) and (k) programs.
- Developing a high-level Implementation Plan with recommendations for policy and operations based on information and findings from the above scopes.

Over the course of approximately a year, HMA worked with numerous SDS and DHSS staff, via phone and e-mail, as well as in person, to gather information about current HCBS, State Plan and State Grant-funded programs, and to understand the current operations, staffing, quality assurance and data/information systems used for each. Additionally, HMA and SDS conducted multiple stakeholder meetings in nine locations across Alaska. At each site, the teams held one community forum, between one and four provider forums, plus individual meetings with selected provider organizations, especially those serving seniors, individuals with Developmental Disabilities (I/DD), individuals with Alzheimer's

Disease and related dementia (ADRD), individuals with Serious Mental Illness (SMI), and individuals with Traumatic or Acquired Brain Injury (TABI). All sessions were open to the public.

The team further conducted extensive research on federal regulations and state administrative code for existing programs and identified gaps in Alaska's regulatory structure that are important for 1915(i) and (k) programs. HMA identified four states to profile for lessons learned and best practices based on their recent experiences implementing 1915(i) and (k) programs and interviewed key state officials who helped with those implementations; these states included: Maryland, Montana, Oregon, and Texas. A comprehensive review of functional assessment tools also was conducted to ascertain potential options for Alaska to consolidate its multiple current assessment tools into a more streamlined and aligned single tool or set. Finally, HMA worked with SDS to develop enrollment estimates for each target population and developed a detailed analysis of the eligibility, service packages and resource allocations recommended for each target population and the estimated costs to the State to implement such changes.

General Findings

The result of this study and analysis include documentation related to current programs and new program options; important feedback from a diverse set of stakeholders across the State; lessons learned and best practices from other states; and a cost analysis of eligibility and service packages for each of the target populations. One important change in scope during the course of the project was the decision by DHSS, SDS and the Division Behavioral Health (DBH) to pursue an 1115 demonstration waiver to support services for individuals with behavioral health needs, including those with SMI. Due to this change, HMA did not pursue further study or analysis of this population.

Stakeholders across the State generally agreed on a number of themes, including:

- The need to consider Alaska's unique geography and cultures for any new programs that are implemented.
- The impacts of conflict-free case management (care coordination) requirements, especially on smaller, more remote communities.
- The need for overall operational efficiencies and ways to make it easier for both providers and clients to participate – such as eligibility and enrollment processes, coordination across divisions, reporting requirements, and assessment tools.
- Workforce issues and ensuring there are enough of the right kinds of providers to support new programs.

There are some operational gaps that HMA identified in the course of research, such as the need to pilot new assessment tools. Additionally, SDS will need to build up the existing infrastructure for quality assurance, participant support, and staffing.

HMA reviewed existing Alaska Administrative Code to understand what authority DHSS might need from the Alaska State Legislature to pursue State Plan Amendments (SPA) for either 1915(i) or 1915(k). Based on this review, per AS 47.07.030(a), DHSS is authorized to provide all services as mandated under Title XIX (Medicaid), as well as being required to provide optional benefits as listed in AS 47.07.030(b). However, language in (b) suggests that *only* those services listed in this section can be offered; optional benefits include "personal care services in a recipient's home" and "long-term care non-institutional services."

Additionally, AS 47.07.036(a) allows DHSS to implement cost containment measures to reduce anticipated program costs. HCBS State Plan Benefit -1915(i) and Community First Choice -1915(k) offer potential opportunities to reduce state expenditures and bring in new federal match. Finally, there do not appear to be any requirements for DHSS to have new or different statutory authority to develop and submit State Plan Amendments for 1915(i) or 1915(k) programs.

This Implementation Plan and other project reports submitted to SDS reflect the decision-making process for drawing conclusions and recommendations. By and large, HMA recommends that Alaska and DHSS <u>not</u> move forward with some of the new HCBS program options because of the financial risk associated with the implementation of these programs for the outlined populations. There are, however, other initiatives that SDS can and should consider both as cost-saving measures and to improve access and care for target populations.

Program Recommendations for SDS Consideration

Through this engagement HMA developed a set of recommendations for SDS to implement programs and services that will most cost-effectively and efficiently support the remaining three target populations it had identified: individuals with (I/DD), those with ADRD, and those with TABI. The recommendations are broken down by population type for 1915(i), while 1915(k) includes a global recommendation. SDS and HMA presented these recommendations to the Inclusive Community Choices Council (ICC Council), which had been established as the project's stakeholder feedback workgroup - a core requirement for 1915(k) programs.

In summary, the recommendations include:

- 1915(k) – SDS should move forward with implementing a 1915(k) option to include Personal Care Services (PCS) and Consumer-Directed Personal Care Services (CDPCS) services. The 1915(k) program must also include emergency back-up systems and a consumer-directed training program.
- I/DD 1915(i) – SDS should not move forward with a 1915(i) option for individuals with I/DD. Instead, SDS should explore a limited Supports 1915(c) waiver program to serve individuals with a lower level of need than is required for the existing 1915(c) I/DD waiver.
- ADRD 1915(i) – SDS should not move forward with a 1915(i) option for individuals with ADRD. There are no obvious program options at this time to achieve the goal of cost savings and program expansion for individuals with ADRD and as such SDS should continue to explore options with the ICC Council and other key stakeholder groups.
- TABI 1915(i) – SDS should not move forward with a 1915(i) option for individuals with TABI. SDS should consider moving forward with a Targeted Case Management service for individuals with TABI.
- SMI 1915(i) – SDS should not move forward with a 1915(i) option for individuals with SMI. The Division of Behavioral Health (DBH) should incorporate all of the SMI population, including those served under the SDS General Relief (GR) program into the existing effort to redesign the behavioral health system through an 1115 waiver.

Through a series of motions, the ICC Council voted to accept these recommendations at its meeting in late July. The Council also agreed to continue to work with SDS and other stakeholders to explore the various alternatives to identify options that could effectively serve participants without creating significant budget issues for the State. HMA agrees that further discussion and analysis is warranted to make the appropriate fiscal policy decisions on the direction of services for these populations. This

Implementation Plan, along with the other project reports, provide SDS and DHSS with the foundational information to make important decisions about the future of HCBS programs and services in Alaska. Recommendations related to approvals and rules, planning and operations infrastructure, and information technology and systems, as well as recommendations for transitioning services and communicating to participants and providers are contained in their respective sections herein.

Additional Suggestions for SDS Consideration

There are several additional factors that HMA suggests Alaska explicitly address as it moves forward with its final design and implementation of the above-recommended HCBS programs.

- Considering how Alaska's geography - including urban, rural and frontier areas of the State - will impact the logistics of implementing and managing any new HCBS programs.
- Engaging with representatives from all of Alaska's unique ethnic and cultural groups, in particular ensuring appropriate consultation with Tribal leaders and Tribal health leaders.
- Assessing the impact of conflict-free case management (care coordination) requirements on providers and participants, especially in small, more remote communities.
- Analyzing existing and potential workforce challenges for ensuring sufficient and appropriate providers to support new programs.
- Identifying ways to maximize administrative and operational efficiencies such as eligibility/enrollment processes, coordination across the Department and other State agencies, reporting requirements, and assessment tools.

2. Cost Impact Analysis

The Federal Medical Assistance Percentage (FMAP) match rate for Alaska Medicaid is 50 percent – meaning the State receives one federal dollar for every State dollar it contributes, an important factor in the fiscal analysis for these programs. Other key components of the cost impact analysis for the 1915(i) and 1915(k) options were the development of program eligibility requirements, program service packages, and program cost analyses.[1] HMA worked closely with SDS staff, the DHSS HCBS Steering Committee, the Inclusive Community Choices Council (ICC Council) and other stakeholders to develop these components. The result was a set of recommendations on whether or not to move forward with 1915(i) and 1915(k) programs for the targeted populations. Below is summary information of the cost impact analysis conducted for each of the target populations:

- Individuals with Intellectual and Developmental Disabilities (I/DD)
- Individuals with Alzheimer's Disease and Related Dementia (ADRD)
- Individuals with Traumatic or Acquired Brain Injury (TABI)

Based on the Department of Health and Social Services' (DHSS) decision to pursue an 1115 waiver for behavioral health that would incorporate individuals with Serious Mental Illness (SMI), HMA provided only a brief analysis of this group related to the SDS General Relief (GR) program. Details of that analysis are covered in a separate project deliverable; they are not presented here.[2]

Individuals with Intellectual and Developmental Disabilities (I/DD)

SDS asked HMA to analyze the options for eligibility, service package, and estimated costs for implementing a 1915(i) Medicaid program for individuals with I/DD. Working with both SDS and stakeholders such as the ICC Council, HMA identified eligibility criteria and a service package that would maximize the benefit for individuals who do not currently qualify for the existing I/DD 1915(c) waiver. Using this information, HMA conducted a cost impact analysis of implementing a 1915(i) option for this population.

Eligibility

HMA developed the following eligibility criteria with input from the SDS and the ICC Council, as well as the Alaska HCBS Steering Committee. Based on 1915(i) federal regulations, the eligibility criteria is less than the institutional level of care requirement of the 1915(c) waiver program.

To maximize the number of participants currently receiving Grant-funded services who would qualify for the new program, HMA set the "floor" of eligibility as the definition of Developmental Disability (which opens the program to any Medicaid-eligible individual who meets the definition of Developmental Disability). Adding any other criteria would have restricted access and minimized potential General Fund offsets. To be eligible for 1915(i) requires a severe, chronic disability that:

- Is attributable to a mental or physical impairment or combination of mental and physical impairments.
- Is manifested before the individual attains age 22.
- Is likely to continue indefinitely.
- Results in substantial functional limitations in <u>three</u> of the following areas of major life activity:

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[1] This information is included in a combined Project Deliverable document submitted to SDS that reflects information for Task 4.e, Task 5, Task 7 and Task 10.
[2] Information can be found in the combined Project Deliverable Tasks 5,7 and10 – *Cost Impact Analysis*.

- o self-care
- o receptive and expressive language
- o learning
- o mobility
- o self-direction
- o capacity for independent living
- o economic self sufficiency
- Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic assistance, supports or other services that are of lifelong or extended duration and are individually planned and coordinated.

Services

HMA created a 1915(i) service package that paralleled the service structure of the current Grant-funded program and maximized opportunities in the community, as well as employment; however, the residential component was removed as a service. The existing Medicaid service definitions and rates also were used in the development of the services.

Supported Employment

Providers: Certified home and community-based service agency, SDS-Certified Supported Employment Provider under 7AAC 130.214.

Rates: Supported Employment-Individual per 15 min., $12.12; Supported Employment-Group per 15 min., $8.49

Day Habilitation

Providers: Certified home and community-based service agency, SDS-Certified Day Habilitation provider under at 7AAC 130.214.

Rates: Day Habilitation-Individual 15 min., $10.71; Day Habilitation-Group 15 min., $7.50.

Respite Care
Providers:

Agency: General Acute Care Hospital, State of Alaska license under AS 47.32 and Alaska Administrative Code at 7 AAC 12.610.

Individual: Foster Home, State of Alaska Foster Home License under AS 47.33 and Alaska Administrative Code at 7 AAC 50, Community care licensing.

Agency: Skilled Nursing Facility, State of Alaska license under AS 47.32 and Alaska Administrative Code at 7 AAC 12.610.

Agency: Assisted Living Home, State of Alaska Assisted Living Home License under statute at AS 47.33 and Administrative Code at 7 AAC 75. Licensing of assisted living homes, SDS-Certified Respite Provider under 7AAC 130.214, Provider certification and enrollment, "SDS Standards for Respite Services" under 7AAC 130.280.

Agency: Certified home and community-based service agency, SDS-Certified Respite Provider under 7AAC 130.214, Provider certification and enrollment, "SDS Standards for Respite Services" under 7AAC 130.280.

Rates: Respite per 15 min., $6.26; Respite-Family Directed per 15 min., $4.22; Respite per Day, $299.78; Respite-Family Directed per Day, $202.68.

Intensive Active Treatment

Providers: Certified home and community-based service agency, Professional license under AS.08, and SDS-Certified IAT Provider under 7AAC 130.214.

Rates: Time-limited intervention, treatment or therapy per 15 min. local (recipient within 200 miles of provider), $22.38; Time-limited intervention, treatment or therapy per 15 min. non-local (recipient greater than 200 miles from provider), $44.77.

Cost Estimates

Through a review of several state programs and population data statistics, HMA conducted a population analysis to estimate the number of individuals that would be eligible for the program, and those that would access the program. State programs that are currently available for individuals with I/DD include the I/DD 1915(c) waiver, the Community Developmental Disabilities Grant (CDDG) program, and the registry for the I/DD 1915(c) waiver. Based on this analysis, HMA estimated a total of 868 individuals who would participate in the I/DD 1915(i) program in year one. Applying historical service access factors to the estimated population, HMA derived the following five-year service access estimate:

Table 1-Section 2

Service	Estimated Number of Unduplicated Participants				
	Year One	**Year Two**	**Year Three**	**Year Four**	**Year Five**
Case Management	868	894	921	948	977
Screening	868	26	27	28	28
Plan of Care Development	868	894	921	948	977
Supported Employment - Individual	130	134	138	142	146
Supported Employment - Group	87	89	92	95	98
Day Habilitation - Individual	685	706	727	749	772
Day Habilitation - Group	243	250	258	265	273
Respite	260	268	276	284	293
Respite	104	107	110	114	117
Intensive Active Treatment - Local	26	27	28	28	29
Intensive Active Treatment - Non Local	1	1	1	1	1

Given these service access estimates, there are basically two ways to analyze utilization in the I/DD 1915(i) program:

1. Using CDDG utilization data.
2. Using 1915(c) waiver utilization data.

From historical CDDG utilization data, HMA established the following utilization estimates:

Table 2-Section 2

Service	Average Units per Participant				
	Year One	**Year Two**	**Year Three**	**Year Four**	**Year Five**
Case Management	12	12	12	12	12
Screening	1.2	1.2	1.2	1.2	1.2
Plan of Care Development	1	1	1	1	1
Supported Employment - Individual	1200	1200	1200	1200	1200
Supported Employment - Group	1200	1200	1200	1200	1200
Day Habilitation - Individual	800	800	800	800	800
Day Habilitation - Group	600	600	600	600	600
Respite	63	63	63	63	63

Service		Average Units per Participant			
	Year One	Year Two	Year Three	Year Four	Year Five
Respite	9	9	9	9	9
Intensive Active Treatment - Local	59	59	59	59	59
Intensive Active Treatment - Non Local	1	1	1	1	1

From historical I/DD 1915(c) waiver utilization data, HMA established the following utilization estimates:

Table 3-Section 2

Service		Average Units per Participant			
	Year One	Year Two	Year Three	Year Four	Year Five
Case Management	12	12	12	12	12
Screening	1.2	1.2	1.2	1.2	1.2
Plan of Care Development	1	1	1	1	1
Supported Employment - Individual	1600	1600	1600	1600	1600
Supported Employment - Group	1300	1300	1300	1300	1300
Day Habilitation - Individual	2050	2050	2050	2050	2050
Day Habilitation - Group	1250	1250	1250	1250	1250
Respite	63	63	63	63	63
Respite	9	9	9	9	9
Intensive Active Treatment - Local	59	59	59	59	59
Intensive Active Treatment - Non Local	1	1	1	1	1

These variances have a significant impact on cost, as can be seen in the table below. To develop these service cost estimates, HMA applied current Medicaid rates and units for the services being recommended for the I/DD 1915(i) program:

Table 4-Section 2

Service	Rate	Unit
Case Management	$240.77	Monthly
Screening	$90.33	One Initial
Plan of Care Development	$384.81	Annual
Supported Employment - Individual	$12.12	15 minute
Supported Employment - Group	$8.49	15 minute
Day Habilitation - Individual	$10.71	15 minute
Day Habilitation - Group	$7.50	15 minute
Respite	$6.26	15 minute
Respite	$299.78	Daily
Intensive Active Treatment - Local	$22.38	15 minute
Intensive Active Treatment - Non Local	$44.77	15 minute

Historical CDDG utilization data yields the following cost estimates:

Table 5-Section 2

Service	Cost per Service				
	Year One	Year Two	Year Three	Year Four	Year Five
Case Management	$2,506,949.05	$2,582,157.53	$2,659,622.25	$2,739,410.92	$2,821,593.25
Screening	$94,053.54	$2,821.61	$2,906.25	$2,993.44	$3,083.25
Plan of Care Development	$333,893.71	$343,910.52	$354,227.84	$364,854.67	$375,800.31
Supported Employment - Individual	$1,892,940.72	$1,949,728.95	$2,008,220.81	$2,068,467.44	$2,130,521.46
Supported Employment - Group	$883,997.07	$910,516.98	$937,832.49	$965,967.47	$994,946.49
Day Habilitation - Individual	$5,873,114.11	$6,049,307.53	$6,230,786.75	$6,417,710.36	$6,610,241.67
Day Habilitation - Group	$1,093,282.60	$1,126,081.07	$1,159,863.51	$1,194,659.41	$1,230,499.19
Respite	$102,659.24	$105,739.01	$108,911.18	$112,178.52	$115,543.87

Service	Year One	Year Two	Cost per Service Year Three	Year Four	Year Five
Respite	$280,923.65	$289,351.36	$298,031.90	$306,972.86	$316,182.04
Intensive Active Treatment - Local	$34,371.24	$35,402.38	$36,464.45	$37,558.39	$38,685.14
Intensive Active Treatment - Non Local	$44.77	$46.11	$47.50	$48.92	$50.39
	$13,096,229.70	$13,395,063.05	$13,796,914.94	$14,210,822.39	$14,637,147.06

Historical I/DD 1915(c) utilization data yields these cost estimates:

Table 6-Section 2

Service	Year One	Year Two	Cost per Service Year Three	Year Four	Year Five
Case Management	$2,506,949.05	$2,582,157.53	$2,659,622.25	$2,739,410.92	$2,821,593.25
Screening	$94,053.54	$2,821.61	$2,906.25	$2,993.44	$3,083.25
Plan of Care Development	$333,893.71	$343,910.52	$354,227.84	$364,854.67	$375,800.31
Supported Employment - Individual	$2,523,920.96	$2,599,638.59	$2,677,627.75	$2,757,956.58	$2,840,695.28
Supported Employment - Group	$957,663.49	$986,393.40	$1,015,985.20	$1,046,464.76	$1,077,858.70
Day Habilitation - Individual	$15,049,854.90	$15,501,350.54	$15,966,391.06	$16,445,382.79	$16,938,744.27
Day Habilitation - Group	$2,277,672.08	$2,346,002.24	$2,416,382.30	$2,488,873.77	$2,563,539.99
Respite	$102,659.24	$105,739.01	$108,911.18	$112,178.52	$115,543.87
Respite	$280,923.65	$289,351.36	$298,031.90	$306,972.86	$316,182.04
Intensive Active Treatment - Local	$34,371.24	$35,402.38	$36,464.45	$37,558.39	$38,685.14
Intensive Active Treatment - Non Local	$44.77	$46.11	$47.50	$48.92	$50.39
	$24,162,006.63	$24,792,813.29	$25,536,597.69	$26,302,695.62	$27,091,776.49

There is significant cost variance related to these different approaches, as demonstrated in the above tables, most notably, with the Day Habilitation – Individual service. Using CDDG utilization factors the cost is approximately $5.9 million, while with 1915(c) waiver utilization factors the cost is approximately $15.0 million. There is significant risk associated with basing cost estimates on CDDG utilization data, as shown for the Day Habilitation – Individual service. Overall the year-one program cost variance is approximately $9.1 million. Using CDDG factors there is potential for the I/DD 1915(i) program to net the State a small savings; using the 1915(c) waiver factors there is no circumstance in which the I/DD 1915(i) program would net the State a savings, regardless of the refinancing savings.

Applying the best-case scenario of CDDG utilization rates, HMA estimated the total net savings to the State (without factoring in administrative costs) would be:

Table 7-Section 2

I/DD 1915(i) spend estimate	$13,096,229.70
State matching funds	$6,548,114.85
Total State savings	**$152,834.67**

This shows that under the best case scenario, with no administrative costs included, the estimated total net State savings would be approximately $150,000. Thus, HMA recommends that SDS not move forward with a 1915(i) option for individuals with I/DD. However, as an alternative to 1915(i), HMA does recommend that SDS explore developing a limited Supports 1915(c) I/DD waiver with a cap on services. Although it was not part of the scope of this project to thoroughly analyze and vet such a limited

Supports 1915(c) option, HMA did conduct a cursory review and concluded it could generate cost savings while providing services for individuals who would benefit from day and employment services but do not need residential care at this time. Essentially, this option would allow SDS to establish a cap on the number of individuals served and services provided, which would provide the State with savings, as well as more budget predictability.

Individuals with Alzheimer's Disease and Related Dementia (ADRD)

HMA worked with stakeholders and SDS staff to develop an eligibility criteria and service package that would create a benefit for individuals with ADRD who do not currently qualify for the existing ALI 1915(c) waiver, some of whom use State-funded Grant programs. HMA analyzed this eligibility criteria and service package information to determine what, if any savings might be associated with the implementation of the 1915(i) option for individuals with ADRD.

Eligibility Criteria

The following eligibility criteria was developed with input from the ICC Council, as well as the Alaska HCBS Steering Committee and SDS staff. Because Alaska's current Nursing Facility Level of Care (NFLOC) criteria does not include cognitive impairment and, therefore, excludes the majority of individuals with ADRD, the eligibility criteria is less than the institutional level of care requirement of the 1915(c) waiver program. The 1915(i) eligibility states:

Dementia is a loss of cognitive abilities in two or more areas such as memory, language, visual and spatial abilities, or judgment, severe enough to interfere with daily life. There are different types of dementia because the root causes of the symptoms are different. Alzheimer's disease is the most common form of dementia.

Individuals meeting the criteria of this 1915(i) target group have a severe, chronic disability that:

- Is attributable to ADRD, and
- Is manifested after the individual attains age 22, and
- Results in the individual, who lives alone or is at risk of living alone or becoming homeless, having significant difficulty with memory, using information, daily decision making, or exercising judgement that requires intervention to maintain health and ensures the individual does not put themselves or their surrounding's in danger, and
- Is determined, based upon an approved functional assessment, to require assistance in activities of daily living and instrumental activities of daily living to live in the least restrictive living situation.

Key to the above criteria is that an individual must "live alone or be at risk of living alone or becoming homeless." HMA added this to capture individuals most in need of services, while attempting to control program costs. However, in discussing this option when it was presented by HMA and SDS, the ICC Council noted that this was too limiting and their preference would be to open eligibility to all individuals with ADRD, regardless of their living situation.

Services

The service package was designed to parallel the service structure of the current Grant-funded program; thus, the residential component was removed from the 1915(i) program. HMA used existing Medicaid service definitions and rates in the development of these services.

Chore

Providers: Certified home and community-based service agency, SDS-Certified Chore Provider under 7AAC 130.214, Provider certification and enrollment, "SDS Standards for Chore Services" adopted by reference at 7AAC 130.245.

Rates: Chore Services per 15 min., $6.70.

Respite and Extended Respite

Providers:

Agency: Assisted Living Home, State of Alaska Assisted Living Home under AS 47.33 and Alaska Administrative Code at 7AAC 75.020, "SDS Standards for Respite Services" adopted by reference at 7AAC 130.280.

Individual: Foster Home, State of Alaska Foster Home License under AS 47.33 and Alaska Administrative Code at7 AAC 50, Community care licensing.

Agency: Skilled Nursing Facility, Licensed by State of Alaska under AS 47.32 and Alaska Administrative Code at 7 AAC 12.610.

Agency: General Acute Care Hospital, licensed by State of Alaska under AS 47.32 and Alaska Administrative Code at 7 AAC 12.610.

Agency: Certified home and community-based service agency, SDS-Certified Respite Provider under 7AAC 130.214, Provider certification and enrollment, "SDS Standards for Respite Services" adopted by reference at 7AAC 130.280.

Rates: Respite per 15 min., $6.26; Respite-Family Directed per 15 min., $4.22; Respite per Day, $299.78; Respite-Family Directed per Day, $202.68.

Adult Day Care

Providers: Certified home and community-based service agency, SDS-Certified Adult Day Service Provider under 7AAC 130.220, "SDS Standards for Adult Day Services."

Rates: ½ day $84.11; 15 min., $5.25

Cost Estimates

HMA conducted a population analysis to determine the number of individuals who would be eligible for the program, **and also** access the program. This process involved looking at a number of State programs and population data statistics to determine an estimate of the ADRD population in Alaska. For example, the State programs that are currently available for individuals with ADRD include the Adults Living Independently (ALI) 1915(c) waiver, the Senior In-Home Grant Program, as well as the Adult Day Grant Program.

To determine the ADRD population not currently captured by these programs, HMA used prevalence and population data to estimate the number of individuals outside of those programs.

Table 8-Section 2

Estimated # of Alaskans with ADRD	6,500
Estimated # not living w/caregiver*	3,400
***Alaska Roadmap estimates 60% of individuals with ADRD reside with caregiver**	
Number of Medicaid recipients age 21-59*	54,269
Number of Medicaid recipients age 60+*	15,164

*according to Alaska Medicaid 2015 Annual Report	
Number of Alaskans age 18-64*	186,085
Number of Alaskans age 65+*	73,843
*According to 2015 US Census data	
Estimated % of Alaskans age 18-59 Medicaid recipients	29.2%
Estimated % of Alaskans age 60+ Medicaid recipients	20.5%
Rate of Dementia of Alaskans age 22-59	0.3%
Rate of Dementia of Alaskans age 60+	8.7%
Estimated ADRD rate of Medicaid recipients age 18-59	163
Estimated ADRD rate of Medicaid recipients age 60+	1,314
Estimated number of ADRD Medicaid recipients not living with caregiver age 18-59	41
Estimated number of ADRD Medicaid recipients not living with caregiver age 60+	986
Estimated # of Alaskans not on Medicaid with ADRD age 18-59	2,037
Estimated # of Alaskans not on Medicaid with ADRD age 60+	4,986
Estimated grant funded individuals with ADRD	315
Adult Day grants	114
Senior In-home grants	123
General Relief	78
Current grantees not on Medicaid*	63
*Assuming 80% are currently on Medicaid	
Number of Alaskans not currently on Medicaid accessing Medicaid benefit (5% take up rate)	351
Estimated number of Alaskans accessing ADRD 1915(i) program	1,378

Because of the broader service offerings under the ALI waiver and the limited dollar allocation under the Grant programs, HMA assumed utilizations would be higher in the 1915(i) program. These estimates are represented below.

Table 9-Section 2

	Number of Unduplicated Participants				
	Year One	**Year Two**	**Year Three**	**Year Four**	**Year Five**
Case Management	1378	1419	1461	1505	1550
Screening	1378	41	43	44	45
Plan of Care Development	1378	1419	1461	1505	1550
Chore	827	851	877	903	930
Respite	69	71	73	75	78
Adult Day Service	964	993	1023	1054	1085
Adult Day Service	344	355	365	376	388

Next, utilizing ALI waiver service unit utilization rates, HMA estimated the 1915(i) utilization rates as referenced below.

Table 10-Section 2

	Average Units per Participant				
	Year One	**Year Two**	**Year Three**	**Year Four**	**Year Five**
Case Management	12	12	12	12	12
Screening	1.2	1.2	1.2	1.2	1.2

	Average Units per Participant				
	Year One	Year Two	Year Three	Year Four	Year Five
Plan of Care Development	1	1	1	1	1
Chore	1232	1232	1232	1232	1232
Respite	1406	1406	1406	1406	1406
Adult Day Service	107	107	107	107	107
Adult Day Service	587	587	587	587	587

Additionally, HMA used the ALI waiver rates and units for each service.

Table 11-Section 2

	Rate	Unit
Case Management	$240.77	Monthly
Screening	$90.33	One Initial
Plan of Care Development	$384.81	Annual
Chore	$6.70	15 minute
Respite	$6.26	15 minute
Adult Day Service	$84.11	Half Day
Adult Day Service	$5.25	15 minute

By multiplying the rate by the number of participants and by the number of service units, HMA calculated estimated costs.

Table 12-Section 2

	Cost per Service				
	Year One	Year Two	Year Three	Year Four	Year Five
Case Management	$3,980,072.63	$4,099,474.81	$4,222,459.06	$4,349,132.83	$4,479,606.81
Screening	$149,320.91	$4,479.63	$4,614.02	$4,752.44	$4,895.01
Plan of Care Development	$530,095.02	$545,997.88	$562,377.81	$579,249.15	$596,626.62
Chore	$6,822,509.35	$7,027,184.63	$7,238,000.17	$7,455,140.18	$7,678,794.38
Respite	$606,229.46	$624,416.34	$643,148.83	$662,443.30	$682,316.60
Adult Day Service	$8,678,343.37	$8,938,693.67	$9,206,854.48	$9,483,060.11	$9,767,551.92
Adult Day Service	$1,061,316.20	$1,093,155.68	$1,125,950.35	$1,159,728.86	$1,194,520.73
	$21,827,886.95	$22,333,402.65	$23,003,404.72	$23,693,506.87	$24,404,312.07

Using this information, HMA estimated the total cost of an ADRD 1915(i) would be approximately $21.8 million. Looking at the potential savings of implementing a 1915(i) program for individuals with ADRD, there does not appear to be a clear path forward for Alaska to develop a program for this population and achieve a cost savings.

Table 13-Section 2

Total SIH grant awards	$2,823,643.68
Total SIH grant participants	1,327
Average SIH cost per participant	$2,127.84
Estimated number of grant participants participating in 1915(i)	123
Estimated grant funds shifted to Medicaid	$261,724.32
Total Adult Day grant awards	$1,757,010.87
Total Adult Day participants	423
Average Adult Day cost per participant	$4,153.69
Estimated number of grant participants participating in 1915(i)	114
Estimated grant funds shifted to Medicaid	$473,520.66

Medicaid funds matching grant funds	$1,470,489.96

Working through the cost estimates in the above table, HMA estimates there is approximately $1.5 million in potential savings from shifting current Grant participants to the 1915(i) program. However, implementing this program would result in a <u>cost</u> to the State of approximately $20.3 million. HMA did also explore the option suggested at an ICC Council meeting that there could be offset Medicaid savings to make up some of the State cost estimates. Although HMA did not have access to data on dually-eligible populations in Alaska, because of the age and disability status of this population, HMA expects that the majority of participants would be dually-eligible and therefore the Medicaid savings would be minimal.

Based on this analysis, HMA determined that a 1915(i) option would not generate any cost savings and, in fact, would cost the State a substantial amount of money. Therefore, implementing a 1915(i) program for individuals with ADRD would not be a prudent path forward for Alaska. Additionally, because there are not many potential cost savings, HMA found no obvious alternative(s) to 1915(i). HMA recommends SDS continue to work with the ICC Council and other stakeholders to explore program options for individuals with ADRD.

This analysis does not consider other State-funded programs/services that may benefit from expansion of HCBS to this population (for example, if there would be a decrease in nursing facility or hospital costs if HCBS options were available to this target group). The ICC Council did discuss these limitations at its meeting in July when it voted on the initial recommendations from HMA; it was noted that there is a dementia care initiative and a stakeholder group with whom they might have the opportunity for further discussion on this issue.

Individuals with Traumatic or Acquired Brain Injury (TABI)

HMA created eligibility criteria, a service package, and cost estimates for developing a 1915(i) Medicaid option for individuals with TABI. HMA worked with stakeholders and SDS staff to establish eligibility criteria and service package that would create a benefit for those individuals who do not currently qualify for 1915(c) waivers. Building on this work, HMA conducted a cost impact analysis to determine what, if any, savings would be associated with the implementation of the 1915(i) option for individuals with TABI.

Eligibility Criteria

Alaska's current Nursing Facility Level of Care (NFLOC) criteria does not include cognitive impairment and therefore excludes the majority of individuals with TABI. For this reason, the eligibility criteria are less than the institutional level of care requirement of the 1915(c) waiver program. The 1915(i) eligibility states:

The State of Alaska targets Medicaid-eligible individuals with a traumatic brain injury (TBI) who may not have sufficient deficits to qualify for an institutional level of care, but meet the following criteria:

- Are between the ages of 19-64.
- Show the capacity to make progress in rehabilitation and independent living skills.
- Are determined, based upon an approved functional assessment, to require assistance in activities of daily living and instrumental activities of daily living to live in the least restrictive living situation.

For purposes of the 1915(i) target group, a traumatic brain injury is a trauma that has occurred as a closed or open head injury by an external event that resulted in damage to brain tissue, with or without injury to other body organs. The extent of the injury must be certified by a physician. The insult or damage caused a decrease in cognitive, behavioral, emotional, or physical functioning resulting in a substantial need for assistance.

Services

HMA focused its analysis on individuals with TABI using the General Relief (GR) program. However, in conjunction with SDS, HMA determined this ultimately was not a good path, as the service package would be primarily limited to assisted living services - not the best use of a 1915(i) Medicaid option. Additionally, there is a lack of data in Alaska related to the TABI population and their needs, which made it difficult to develop a service package for a 1915(i) option. For these reasons, HMA and SDS determined that a Targeted Case Management (TCM) service would help fill some need for the population, while allowing the State to develop a better understanding the population and their needs.

No service definition has been developed for TCM due to a lack of discussion on the topic. SDS should continue to work with the ICC Council and other stakeholders to develop a TCM service definition. For this analysis, however, HMA looked at other state TABI programs and suggests some service offerings that should be considered if Alaska does decide to move forward with a TCM for this population, including:

- Behavior Management
- Tenancy Supports
- Community Transition Supports
- Respite Care
- Residential Supports

Cost Estimates

To estimate the costs associated with refinancing State General Fund services for TABI, HMA conducted a population analysis to determine the number of individuals who would be eligible for the program and access it. This process involved looking at a number of State programs and population data statistics to determine an estimate of the TABI population in Alaska. State programs that are currently available for individuals with TABI include the TBI Case Management Grant Program, which is not contemplated for 1915(i) refinancing.

To determine the TABI population <u>not</u> currently captured by these programs, HMA used prevalence and population data to estimate the number of individuals outside of those programs. HMA has a number of questions and concerns around the baseline data used to estimate the TABI population, and while the analysis was conducted based on available data, HMA strongly recommends that SDS work with the Alaska Brain Injury Network (ABIN) to develop better population data before moving forward with any program for the TABI population.

Table 14-Section 2

Estimated # of Alaskans with TBI diagnosis	10,000
Estimated number of TBI diagnosed individuals requiring on-going care*	1,000
*ABIN study from 2004-2008 estimated 10%	
Number of Medicaid recipients age 21-59*	54,269
Number of Medicaid recipients age 60+*	15,164

*according to Alaska Medicaid 2015 Annual Report	
Number of Alaskans age 18-64*	186,085
Number of Alaskans age 65+*	73,843
*According to 2015 US Census data	
Estimated % of Alaskans age 18-59 Medicaid recipients	29.2%
Estimated % of Alaskans age 60+ Medicaid recipients	20.5%
Rate of TBI of Alaskans	3.8%
Estimated TBI rate of Medicaid recipients over age 18	2,671
Estimated TBI rate of Medicaid recipients requiring ongoing care	267
Estimated # of Alaskans not on Medicaid with TBI	7,329
Estimated # of Alaskans not on Medicaid with TBI requiring ongoing care	733
Estimated grant funded individuals with TBI	105
TBI mini grants	43
General Relief	62
Current grantees not on Medicaid*	21
*Assuming 80% are currently on Medicaid	
Number of Alaskans not currently on Medicaid accessing Medicaid benefit (10% take up rate)	73
Estimated number of Alaskans accessing TBI 1915(i) program	340

Because of the lack of current TABI services available in the Medicaid program, HMA also estimated a take-up rate of individuals not currently on Medicaid who would access the Medicaid 1915(i) program. Combining that number with the number of Medicaid recipients with TABI requiring ongoing care produced an estimate of 340 individuals who would potentially access a TABI 1915(i) or TCM program. Given the uncertainty of the data, HMA estimated all 340 eligible individuals would access this program and would use 12 monthly units annually.

Because a service definition was not developed, applying an appropriate rate is not possible at this time. So, for purposes of this analysis, HMA applied the current case management rate of $240. However, it should be noted that the TCM rate likely would be higher than the current case management rate.

Using those population, rate, and utilization factors, HMA estimated the cost of moving forward with a TCM program for TABI, as shown in the table below.

Table 15-Section 2

	Cost per Service				
	Year One	**Year Two**	**Year Three**	**Year Four**	**Year Five**
Targeted Case Management	$982,341.60	$1,011,811.85	$1,042,166.20	$1,073,431.19	$1,105,634.13

The estimated cost of implementing a TCM program for individuals with TABI is approximately $982,000; although, as noted above, changes in the number of individuals accessing this program and the rate of the service could have a significant impact on this estimate. HMA also tried to estimate program cost should Alaska move forward with a 1915(i) program that is inclusive of some of the services discussed

above. Because there isn't rate or utilization information in Alaska on any of these services, HMA used estimates from other states, noted in the table below.

Table 16-Section 2

	Rate	Unit
Targeted Case Management	$240.77	Monthly
Respite	$6.26	15 minute
Behavior Management	$18.20	15 minute
Chore	$7.14	15 minute

This table shows the estimated number of service participants.

Table 17-Section 2

	Average Units per Participant				
	Year One	Year Two	Year Three	Year Four	Year Five
Targeted Case Management	12	12	12	12	12
Respite	1406	1406	1406	1406	1406
Behavior Management	280	280	280	280	280
Chore	1275	1232	1232	1232	1232

While this table shows the estimated service utilization.

Table 18-Section 2

	Cost per Service				
	Year One	Year Two	Year Three	Year Four	Year Five
Targeted Case Management	$982,341.60	$1,011,811.85	$1,042,166.20	$1,073,431.19	$1,105,634.13
Respite	$2,112,374.40	$2,175,745.63	$2,241,018.00	$2,308,248.54	$2,377,496.00
Behavior Management	$509,600.00	$524,888.00	$540,634.64	$556,853.68	$573,559.29
Chore	$3,604,316.00	$3,712,445.48	$3,823,818.84	$3,938,533.41	$4,056,689.41

The year one cost estimate for implementing these programs is approximately $3.6 million. There is no General Fund offset for either TABI program, and as such, each of these programs would represent <u>new</u> cost to the State. **Based on this analysis, HMA concluded that a 1915(i) option would not generate any cost savings and would, instead, <u>cost</u> the State substantially. For this reason, HMA recommends that Alaska not implement a 1915(i) program for individuals with TABI, but instead explore a TCM program for these individuals.**

1915(k) – Community First Choice (CFC)

In addition to analyzing 1915(i) options, HMA also conducted cost analysis on implementation of the CFC program, or 1915(k) option. Again, HMA worked closely with SDS and stakeholders such as the ICC Council on factors such as eligibility criteria and service package.

Eligibility Criteria

The 1915(k) option requires that individuals be eligible for Medicaid under an existing eligibility group; it does not create a new eligibility group. Therefore, individuals not currently meeting the eligibility criteria for a group covered under the State Medicaid Plan, or who are not eligible as a result of continuing participation in a Section 1915(c) waiver, are not eligible for 1915(k). For this reason, some states have chosen to maintain a section 1915(c) waiver with at least one waiver service delivered at least monthly to make the 1915(k) benefit available to the group of individuals who today qualify for HCBS under special income eligibility criteria (usually 300 percent of SSI).

Individuals who meet financial eligibility requirements for medical assistance are eligible for 1915(k) if they also meet the State's established institutional level of care requirement, as determined on an annual basis. The standard for functional eligibility for this group is:

> "[i]n the absence of the home and community-based attendant services and supports…the individual would otherwise require the level of care furnished in a hospital, a nursing facility, an intermediate care facility [for the developmentally disabled], an institution providing psychiatric services for individuals under age 21, or an institution for mental diseases for individuals age 65 or over, if the cost could be reimbursed under the State plan."[3]

The State may waive the requirement for annual recertification of each participant's level of care eligibility if the State determines there is no "reasonable expectation" of improvement or change in an individual's condition.[4]

In addition to the State's institutional level of care assessment for 1915(k) program eligibility determinations, the federal 1915(k) regulations also require an annual face-to-face assessment of functional needs. The State may choose to meet this assessment requirement via telehealth or other approved mechanism, as long as the assessment is performed by someone who meets State-defined qualifications and individuals have the option to choose a face-to-face assessment if they prefer.[5],[6] The functional assessment information must support the development of a person-centered service plan.[7] This assessment must be conducted at minimum annually, but should be done more frequently if there is a significant change in condition or upon request of the individual.[8]

Service Package

States opting to offer 1915(k) to eligible participants must provide the following services:

- Assistance with ADLs/IADLs and health-related tasks through hands-on assistance, supervision, and/or cueing.
- Acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs/IADLs and health related tasks.
- Back-up systems to ensure continuity of services and supports.
- Voluntary training on how to select, manage, and dismiss attendants.

The State <u>may</u> also choose to provide one or both of the following optional services if connected to an assessed need:

- Coverage of transition costs, such as rent and utility deposits, bedding, basic kitchen supplies, and other necessities connected to a transition from an institutional setting.
- Coverage of items identified in a participant's service plan that increase the individual's independence or substitutes for human assistance, to the extent the expenditures would otherwise be made for human assistance.

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[3] §441.505(c)
[4] §441.510(c)(1)
[5] §441.535
[6] §441.535(a)(1)
[7] §441.535(b)
[8] §441.535(c)

The federal statute expressly <u>excludes</u> certain services and supports from being covered under 1915(k):

- The costs of room and board.
- Services that would be covered under the Individuals with Disabilities Education Act or the Rehabilitation Act of 1973.[9]
- The costs related to assistive devices, medical supplies and equipment, or home modifications.

There are specific exceptions to some of these exclusions, such as some costs related to room and board may be allowed for transition services, if the State chooses to cover them.[10] Similarly, assistive devices and other related services may be covered if they are specified in a participant's person-centered care plan as necessary to increase independence or substitute for human assistance.[11,12]

Alaska may choose one or more of the following service models to provide self-directed HCBS attendant services and supports:[13]

- Agency-provider model - Services and supports are delivered by an agency that either provides services directly or arranges the services provided to the participant, which may include agency hiring of personal care attendants who are chosen by the individual and meet state provider qualifications.
- Self-directed model with service budget - The participant has a person-centered service plan and a service budget and the participant hires, trains, and directs their personal care attendant (PCA) directly. In this model, the state must provide financial management services to all participants who choose to self-direct.[14]
- Other service delivery models that the state might propose to the Centers for Medicare and Medicaid Services (CMS), such as "agency of choice" model, in which the participant selects the direct care worker and refers them to be hired by an agency that will manage their employment-related activities.

The services offered under 1915(k) must be provided on a statewide basis without regard to age, type/severity of disability, or the form of PCS attendant model used (e.g., agency vs. consumer-directed). Alaska may <u>not</u> target specific populations for inclusion or exclusion. However, the State <u>can</u> set limits on the amount, duration, and/or scope of services available to a participant, as long as those limits are applied without regard to age, type/severity of disability, or the form of PCS attendant model that a participant needs to live the most integrated and independent life possible.

Based on these rules, HMA recommends that Alaska move forward with the following services offered through a 1915(k) option.

<u>Personal Care Services (PCS)</u>
PCS is a service currently offered under the Alaska Medicaid State Plan and represents little risk in terms of cost exposure, as anyone who would qualify under the 1915(k) option would also qualify under the

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[9] §441.525(b)
[10] §441.525(a)
[11] §441.525(c)
[12] §441.525(d)
[13] §441.545
[14] The State may choose to provide direct cash payments or vouchers but the requirement to provide financial management services would still remain in effect.

regular State Plan benefit. The PCS would satisfy the requirement of offering services under the 1915(k) option that provide:

- Assistance with ADLs/IADLs and health-related tasks through hands-on assistance, supervision, and/or cueing.
- Acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs/IADLs and health-related tasks.

Personal Emergency Response System (PERS)

HMA also recommends that Alaska offer a PERS service under 1915(k). PERS is an electronic communication device that allows a participant to communicate the need for immediate assistance in case of an emergency. The PERS service would satisfy the requirement of offering services under the 1915(k) option that provide:

- Back-up systems to ensure continuity of services and supports.

Voluntary Training

Finally, HMA recommends that Alaska work with The Alaska Training Cooperative, Aging and Disability Resource Centers (ADRC), Independent Living Centers, and Care Coordinators to establish a voluntary training program for self-directed service offerings. This would satisfy the requirement of offering services under the 1915(k) option that provide:

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

Cost Analysis

To estimate the cost of the recommended 1915(k) program, HMA had to first determine the number of eligible individuals, which was done by cross-referencing the participants on the existing PCS program that are currently receiving waiver services and therefore meet the 1915(k) level of care eligibility requirement. The number of participants receiving PCS that are also on a 1915(c) waiver in FY 2015 was 1,603. HMA examined whether these participants were using agency PCS or consumer-directed PCS and their average service utilizations.

HMA used current Medicaid PCS rates for the analysis. Because Alaska does not today offer PERS and Voluntary Training, HMA estimated rates and participants based on other state experiences with these services. This analysis is shown in the tables below:

Table 19-Section 2

	Unit	Rate
Personal Care - Attendant	15 minute	$6.10
Personal Care - Consumer Directed	15 minute	$6.10
Personal Emergency Response Systems	Annual	$1,000.00
Voluntary Training	Annual	$100.00

Table 20-Section 2

	Number of Unduplicated Participants				
	Year One	Year Two	Year Three	Year Four	Year Five
Personal Care - Attendant	205	211	217	224	231
Personal Care - Consumer Directed	1398	1440	1483	1528	1573
Personal Emergency Response Systems	80	83	85	88	90
Voluntary Training	500	515	530	546	563

Table 21-Section 2

	Average Units per Participant				
	Year One	Year Two	Year Three	Year Four	Year Five
Personal Care - Attendant	4275	4275	4275	4275	4275
Personal Care - Consumer Directed	4275	4275	4275	4275	4275
Personal Emergency Response Systems	1	1	1	1	1
Voluntary Training	1	1	1	1	1

Table 22-Section 2

	Cost per Service				
	Year One	Year Two	Year Three	Year Four	Year Five
Personal Care - Attendant	$5,345,887.50	$5,506,264.13	$5,671,452.05	$5,841,595.61	$6,016,843.48
Personal Care - Consumer Directed	$36,456,345.00	$37,550,035.35	$38,676,536.41	$39,836,832.50	$41,031,937.48
Personal Emergency Response Systems	$80,150.00	$82,554.50	$85,031.14	$87,582.07	$90,209.53
Voluntary Training	$500,000.00	$515,000.00	$530,450.00	$546,363.50	$562,754.41
	$42,382,382.50	$43,653,853.98	$44,963,469.59	$46,312,373.68	$47,701,744.89

HMA estimated the total cost of the 1915(k) in year one at approximately $42.4 million. The savings from implementing the 1915(k) option comes largely from the enhanced 6 percent FMAP. To calculate this, HMA used the current cost of the services and applied the current FMAP of 50 percent, then applied the 56 percent FMAP to the 1915(k) costs. The net of these two numbers is the estimated total State savings from implementing 1915(k).

Table 23-Section 2

Total PCA Spend (FY 2015)	$85,200,043.36
Total PCA Spend 1915(k)	$41,802,232.50
Total PCA Spend non-1915(k)	$43,397,810.86
State Share PCA (FY 2015)	$42,600,021.68
State Share PCA 1915(k)	$18,392,982.30
State Share PCA non-1915(k)	$21,698,905.43
Total State Share with 1915(k)	$40,091,887.73
Net State Share	$2,508,133.95
PERS Estimated Cost	$80,150.00
Voluntary Training Estimated Cost	$500,000.00
State Share PERS 1915(k)	$35,266.00
State Share Voluntary Training 1915(k)	$220,000.00
Total 1915(k) Savings	$2,252,867.95

Based on these calculations and analyses, HMA estimated a $2.25 million in savings for Alaska if it implements the recommended 1915(k) option.

Maintenance of Expenditures/Maintenance of Effort

Under 1915(k) there is a Maintenance of Expenditure (MOE) requirement, sometimes referred to as "Maintenance of Effort," to assure that states don't use this State Plan option to reduce their commitment to providing HCBS. For the *first full year* of 1915(k) operation, a state must *maintain or exceed the level of state expenditures* for HCBS attendant services and supports provided to individuals

with disabilities and to older adults under Section 1905(a), 1915(c), 1115, or other sections of the Social Security Act, in the *preceding 12-month* period.

To determine the MOE required, HMA analyzed current expenditure levels for the services on the existing 1915(c) waivers and the PCS program. CMS requires that states consider all expenditures comparable to attendant services, including personal care, attendant care, residential habilitation services and any other comparable services.

Table 24-Section 2

	2015 Expenditures
PCA	$85,200,043.36
ALI	$73,228,326.88
CCMC	$17,257,866.93
APDD	$6,430,549.55
IDD	$158,160,333.00
Total	$340,277,119.72

Based on this analysis, the estimated savings associated with the enhanced FMAP from shifting PCS to 1915(k) was $2,252,867.95. To meet the MOE requirement, Alaska will have to maintain the current expenditure level of $340,277,120 - which amounts to $170,138,551 in State share. Given normal growth in these programs, this may not be an issue for Alaska, with a few considerations. This includes ensuring that the timing of implementing each new program aligns in the most advantageous way.

The paradoxical situation facing Alaska is that there likely is greater opportunity for savings in the short run by implementing tighter controls on service utilizations within these programs than what can be gained from the six percent enhanced FMAP from the 1915(k) program in the first year. During the 2014 legislative session, the Alaskan State Legislature required SDS to review the PCS program and improve monitoring and oversight procedures. As a result of this effort, SDS is in the last stages of finalizing program and administrative code changes to achieve program integrity and consistency in utilization controls, and expects to implement these rules in 2017. The resulting cost savings from these changes, anticipated to be approximately $4 million, could jeopardize the State's ability to meet the 1915(k) MOE requirements if the implementation of 1915(k) occurs on an overlapping timeframe with reductions in expenditures in the current PCS program. SDS should proceed cautiously with the timing of the rollout of 1915(k) and may need to consider delaying the implementation date until at least 12 months <u>following</u> the complete implementation of the program changes and any resulting reductions in expenditures.

Given these factors, if the State chooses to implement the 1915(k) during 2017, it is likely there will be no cost savings in the first year of the program, since the MOE requirement essentially would compel Alaska to reinvest the six percent enhanced FMAP into services for this population to maintain expenditure levels.

Additionally, HMA has recommended that the State pursue approval of a limited Supports 1915(c) waiver for persons with I/DD because the State can specify a maximum number of participants and can cap the total amount of money it will spend for each participant. One option for the State to ensure it can meet MOE requirements would be to pursue implementation of the limited Supports 1915(c) waiver at the same time as the 1915(k), since some of the expenditures for the 1915(c) would count towards the MOE requirement and could potentially offset any cost savings resulting from other program changes implemented by SDS.

HMA recommends that Alaska move forward with the 1915(k) option, with a thoughtful and deliberate plan for the timing of a rollout with regard to any forthcoming expenditure reductions, as well as the rollout of any new HCBS programs such as a limited Supports 1915(c) I/DD waiver.

Summary Cost Analysis and Impacts for 1915(k)

As noted in the analysis of this section, any total baseline savings to the State due to implementing the recommended 1915(k) option would be the net of the enhanced FMAP from transitioning PCS services into a 1915(k) option - estimated at $2.25 million. However, dependent upon timing and sequencing, due to the MOE requirements for 1915(k), the State might not realize these savings until year two.

Additionally, there will be costs associated with implementing the 1915(k). The State will be required to make changes to the MMIS system, and there would be other structural changes necessary for implementation. If SDS continues to move down the path of implementing a new assessment tool, there will be costs associated with development and implementation of the tool. These costs are estimated to be approximately $1 million for the build-out with ongoing maintenance and licensing fees applied separately. HMA was not able to get an estimate on those costs from the State's Automated Service Plan (ASP) vendor, Mediware, but suggests those costs be factored into overall State costs prior to moving forward.

When the costs associated with assessments, updating MMIS, and other needed changes are included (estimated at $1 million), the topline savings for implementing a 1915(k) State Plan option as recommended are reduced to around $1.25 million ($2.25 million in savings minus $1 million in one-time implementation costs). Again, depending upon timing and sequencing, in year one those savings may be reduced further as the State must meet MOE requirements during the first 12 months of implementation.

Summary of HMA Recommendations for Alaska HCBS Programs

Based on the cost analysis conducted on the three distinct target populations, (individuals with I/DD, individuals with ADRD, individuals with TABI), HMA found the following savings/costs to the State:

- Implementing a 1915(i) for individuals with I/DD would save the State only $150,000.
- Implementing a 1915(i) for individuals ADRC would <u>cost</u> the State approximately $20.3 million.
- Implementing a 1915(i) for individuals with TABI would <u>cost</u> the State approximately $3.6 million for the first year in <u>new</u> cost (there is no current GR fund offset).
- Implementing the 1915(k) option for individuals who meet the institutional level of care criteria would result in an estimated savings of $2.25 million (6% increase in FMAP) annually. However, there would be approximately $1 million in one-time implementation costs at roll-out, and depending on timing and sequencing of the 1915(k) relative to other expenditure reductions, the MOE requirements may further reduce the savings in the first year.

Given our findings from the financial analysis, to achieve maximum savings and minimize current and future cost, HMA recommends that the State seek approval for the following:

- A limited Supports 1915(c) waiver which would be capped at a maximum number of participants and at a maximum dollar amount for participants with I/DD who would benefit from limited day and employment supports without needing residential care.
- Targeted Case Management services for individuals with TABI.

- A 1915(k) State Plan option for individuals who meet the institutional level of care criteria and require personal care services, back-up plans for continuity of care and voluntary training to manage staff.

3. Approvals and Rules

This section of the report includes a summary analysis of the State regulatory environment and offers suggestions to create a regulatory pathway for the 1915(k) implementation and potential future HCBS programs. HMA reviewed existing Alaska Administrative Code and statute to identify any changes DHSS may have to make to ensure authority from the Alaska State Legislature to pursue State Plan Amendments (SPAs) for additional 1915 authority. The regulations and commensurate recommendations for changes are spelled out in much greater detail in other project deliverables.[15]

Based on HMA's review of AS 47.07.030(a), DHSS is authorized to provide all services as mandated under Title XIX (Medicaid). DHSS also is required to provide optional benefits, as listed in AS 47.07.030(b). Language in (b) suggests that *only* those services listed in this section can be offered. Optional benefits include "personal care services in a recipient's home" and "long-term care non-institutional services."

Additionally, AS 47.07.036(a) indicates that if DHSS determines that the cost of Medical Assistance "will exceed the amount allocated in the State budget for a fiscal year, the department may implement cost containment measures to reduce anticipated program costs for that fiscal year as authorized under this section." Community First Choice (1915(k)) and the HCBS State Plan Benefit (1915(i)) do offer opportunities to reduce State expenditures and bring in new federal match; therefore, these programs may be considered as cost saving measures. HMA does not find a requirement that DHSS must pursue statutory authority to develop and submit SPAs under the authority granted by Sections 1915(i) and 1915(k) of the Social Security Act.

After a thorough review of the federal regulations guiding 1915(k) and the HCBS State Plan Benefit, HMA examined existing State administrative code and has offered recommendations for revision to ensure State regulations comply with federal requirements for these programs. **HMA's recommendations focus primarily on the Alaska Administrative Code regarding the Personal Care Services (PCS) benefit (7 AAC 125) and those guiding waiver services (7 AAC 130).** For 1915(k), HMA examined both the PCS and waiver regulations in light of the potential migration of selected waiver benefits into the 1915(k) SPA. Finally, HMA also reviewed related Conditions of Participation based on guidance relevant to 1915(k) and potential 1915(i) implementation. Unless regulatory language has already been proposed elsewhere, HMA offers recommendations on the type of regulatory additions, deletions, or corrections that may be needed; however, there are no suggestions for specific language changes to the Administrative Code, as it is expected such language will need to be developed by DHSS in consultation with its legal team and key stakeholders.

Community First Choice – 1915(k)

Federal requirement §441.500: Basis and Scope
State statute: 7 AAC 125.020(e) *excludes* from eligibility for personal care services (PCS) those individuals who only need "assistance with supervision, cueing, and setup in order to independently perform an ADL or IADL."

This requirement will need to be clarified to reflect that under the 1915(k) State Plan option, the benefits that must be authorized include **assistance with ADLs, IADLs, and health-related tasks through hands-on assistance, supervision, and/or cueing. Individuals eligible for the 1915(k) who have been**

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[15] This information is in the Project Deliverable for *Task 3 – Review of Regulations.*

assessed and determined to need assistance with 'supervision and cueing' must be provided such assistance; this clarification will not affect level of care eligibility.

Federal requirement §441.510: Eligibility

State statute: PCS are available to any individual who meets the minimum criteria defined at 7 AAC 125.020. The 1915(k) option requires that the individual meet an institutional level of care, which can be found in the administrative code governing the HCBS 1915(c) waivers in Alaska at 7 AAC 130.205. Reauthorization of PCA benefits currently is governed by 7 AAC 125.012.

There is no mention in section 7 AAC 125.012 that recertification must occur "at least annually;" however, the administrative code on 1915(c) assessment and reassessment (7 AAC 130.213) do reflect that reassessment will occur "not later than one year after the date of the previous assessment" (subsection (d)).

Recommendation: HMA recommends the State amend 7 AAC 130.213 to include the requirement for reassessment at least annually and remove language that this requirement is for 1915(c) waivers only; alternatively, the State could address this requirement by adding level of care assessment requirements, including annual recertification, to 7 AAC 125.020.

Federal requirement § 441.520: Included Services

State statute: Federal guidance clearly states that health-related tasks delegated by licensed professionals must conform to State law governing the licensed professional. 7 AAC 125.030(d) and (e) govern health-related tasks in the existing PCS benefit. 12 AAC 44.950 governs standards for delegation of nursing duties to other persons, 12 AAC 44.955 further defines the scope of "routine nursing duties" that may be delegated, 12 AAC 44.960 defines the scope of "specialized nursing duties", 12 AAC 44.965 defines the scope of delegation for the administration of medication, and 12 AAC 44.966 defines the scope of delegation for injectable medications. The current health-related tasks authorized under 7 AAC 125.030(d) are a subset of the tasks that can be delegated by a licensed nurse under 12 AAC 44 and some can only be delegated under the model of self-direction. The State may consider revisiting the standards for delegation under the existing PCS benefit as Alaska Administrative Code for 1915(k) are developed. Per 7 AAC 125.130(f), a back-up plan is only required for the consumer-directed PCS program.

Recommendation: HMA recommends that the State revise this administrative code to expand the back-up systems to cover participants regardless of whether they are participating in the agency-based or the consumer-directed model. **Otherwise, only participants using CDPCS will qualify for 1915(k), and backup systems or mechanisms to ensure continuity of services and supports are federally-required in 1915(k) programs regardless of the delivery model.**

Federal requirements § 441.525: Excluded Services

State statute: Currently, 7 AAC 130.300 governs the provision of environmental (home) modification services for those eligible for the 1915(c) waiver. Under 1915(k), home modifications are excluded *except* as available under §441.520(b), which details benefits that may be provided at the State's option.

The 1915(k) requirements allow the State to choose if it wants to offer environmental modifications. It is a service the State *may* offer but is not required to offer, such as PCS to everyone who meets the program eligibility criteria.

Recommendation: HMA recommends that Alaska implement the 1915(k) <u>mandatory services only</u> and continue to provide for environmental modifications under the 1915(c) waiver programs because the 1915(c) gives the State greater control over service utilization.

Federal requirements § 441.535: Assessment of Functional Need

State statute: 7 AAC 125.020 states the requirements for assessment and adopts the Consumer Assessment Tool (CAT) to be used for assessment of need by reference to 7 AAC 160.900. The CAT is used to identify level of need/level of care for the current PCS benefit, for the APDD waiver, and for the ALI waiver. Hours of personal care time allocated to a participant are based on the Personal Care Assistance Service Level Computation worksheet, which is also adopted by reference at 7 AAC 160.900. The computation worksheet does not account for time necessary for supervision or cueing, which are covered under 1915(k) and the budget methodology would need to be revised to account for this time as well. However, neither administrative code guiding the PCS benefit (7 AAC 125) nor 1915(c) waivers (7 AAC 130) align with the specific requirements of the federal rule.

The CMS regulation (42 CFR §441.535) requires face-to-face assessments of functional need, unless the state meets certain conditions when using telemedicine or other information technology in lieu of an in-person assessment. The conditions include meeting state-defined provider qualifications for professionals performing assessments, on-site support for the individual during the assessment as needed, and the opportunity for an individual to choose an in-person assessment over a remote assessment conducted using technology. Addressing these requirements in the regulations, along with the requirement that assessments must occur at least once every 12 months or more often if needed or requested by the participant receiving services, would ensure that State rules are consistent with federal requirements.

Recommendation: HMA recommends the State amend its administrative rules and address the functional needs assessment in the development of the new administrative rules for the implementation of the 1915(k) State Plan option.

Federal requirements §441.720: Independent assessment

State statute: See section on assessment of functional need at § 441.535 (above in the discussion of 1915(k)).

Federal requirements §441.735: Definition of individual's representative

State statute: Under current 1915(c) waiver administrative code (7 AAC 130), a participant's representative may play an active role in the acquisition of services on behalf of a participant. 7 AAC 130.319 refers to the definition of the "recipient's representative" provided at 7 AAC 160.990(b)(70) – "'recipient's representative' means a parent, guardian, or other individual with legal authority to act on the recipient's behalf." Under the administrative code guiding the PCS benefit (7 AAC 125), a participant's representative is referred to as the "legal representative" and defined at 7 AAC 125.199(8) as a/an "(A) agent under a power of attorney authorizing the person to make health care decisions; (B) parent, if the recipient is a minor; or (C) legal guardian." These definitions align with the intention of the federal regulation in sub-section (b). 7 AAC 100.006 details the process by which a participant may appoint an authorized representative; however, this administrative code guides only who is authorized to apply for Medicaid on behalf of the applicant. Neither 7 AAC 125 nor 7 AAC 130 provide detail on how a participant's representative or legal representative are formally identified. However, Section §441.735(c) of the federal regulation notes that the State must have policies describing the process for

authorization of the legal representative/participant representative who will participate in the service planning process with the participant.

Recommendation: HMA recommends the State change its administrative code to specify how the participant's representatives are identified. HMA suggest that new policies be developed describing the process in accordance with federal regulations.

Some of the federal requirements overlap both the 1915(i) and (k) regulations, and are noted here.

HCBS Settings Rule
Federal requirements §441.530(a)(1), §441.710(a)(1): Home and Community-Based Setting
State statute: HMA recommends a number of changes to State statutes regarding compliance with federal HCBS Setting rules.

The State should consider modifying the *Conditions of Participation for Providers*[16] (Section III.C) to read: "The Provider must support recipient control of personal resources [to the extent recommended by the planning team and the needs and preferences of the individual]." In addition, recommendations have been made to revise the *Care Coordination Conditions of Participation*[17] (Section IV.B.2) to read: "The care coordinator must identify, and consult with each member of a planning team for the purposes of [developing a plan] to address control of personal resources as an action to be considered by planning team."

With regard to "including non-disability specific settings and an option for a private unit in a residential setting," previous analysis of State statute, administrative code, and related documents resulted in recommendations to revise the *Care Coordination Conditions of Participation* (Section IV.B.1.b) to read: "provide information about options, including those available in non-disability specific settings, for medical, social, educational, and other services; and for residential services, if such services are of interest to or appropriate for the recipient; residential options must take into consideration the recipient's resources for room and board, and whether those resources would cover the cost of a private unit in the recipient's chosen residential setting, or another residential setting."

Similarly, regarding language in the federal regulations requiring that "options are identified and documented in the person-centered service plan," prior analysis resulted in a recommended revision to the administrative code 7 AAC 130.217(a)(3)(B) to read "identifies the settings … that were considered and the providers that were selected, to render services to the recipient in particular setting(s)."

Based on the federal language requiring that settings options are identified, documented, and based on participant's needs, preferences, and, for residential settings, resources for room and board, prior analysis suggested a revision to the *Care Coordination Conditions of Participation* (Section IV.B.1.b) to read: "provide information about options, including those available in non-disability specific settings, for medical, social, educational, and other services; and for residential services, if such services are of interest to or appropriate for the recipient; residential options must take into consideration the recipient's resources for room and board, and whether those resources would cover the cost of a private unit in the recipient's chosen residential setting."

For Section (C) of the federal rules, in review of State administrative code and other guidance, HMA found no specific reference to ensuring residents have access to safe storage and heating of food.

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[16] http://dhss.alaska.gov/dsds/Documents/docs/ProviderCOPs.pdf
[17] http://dhss.alaska.gov/dsds/Documents/docs/CareCoordinatorCOPs.pdf

Recommendation: HMA recommends that this be reviewed to ensure it is codified in regulations or in the *Conditions of Participation* for providers.

With regard to the requirement in Section (E) that the setting is physically accessible to the participant, prior analysis suggested an addition to the *Conditions of Participation for Care Coordination* (Section IV.C) to read: "confirm that settings where services are to be provided are physically accessible for the recipient." HMA also recommends that this requirement be included in State regulation in addition to its inclusion in the *Conditions of Participation*. An appropriate location for regulatory language may be in 7 AAC 130.220, or the analogue to this section for the regulations that will be associated with 1915(i), to ensure that provider-owned or provider-controlled residential settings, adult day services facilities, or other physical locations designated for HCBS be physically accessible to the participant. Further, 7 AAC 130.300(b)(1)(B) allows for environmental modification services if the services "result in physical adaptations to rental property that is the recipient's residence, if the owner of the property consents to the physical adaptations."

Recommendation: The State may want to consider ensuring that there is a requirement that new residences under consideration by a participant already have basic and necessary physical accessibility. For example, in Section (F) of the federal regulations, a suggestion was made to revise the existing *Care Coordination Conditions of Participation* (Section IV.B.) to add language that requires the plan of care to identify the place of residence chosen by the participant and that the participant has a legally enforceable agreement, that the residential setting meets requirements, and that any modification from the requirements is noted.

Waiver services may be provided only in locations that have the qualities of a home and community based setting. Some locations, defined in the regulation, are presumed to lack such qualities because they isolate recipients from the community. The review conducted by SDS as part of the development of its transition plan (a requirement of 42 CFR §441.301(c)(6)) determined that there are no institutional settings and no service settings located in a building on the grounds of, or immediately adjacent to, a public institution in Alaska.

Recommendation: As a general recommendation, HMA suggests revising State regulations found at 7 AAC 130.220(f), guiding provider certification, to include an additional reason for denial of certification, denial of certification renewal, or suspension of certification if the provider is found to be out of compliance with the Settings Rule.

Person-Centered Service Planning

Federal requirements §441.540 and §441.725: Person-Centered Service Planning

State statute: 7 AAC 130.217 guides the plan of care development for participants accessing a 1915(c) waiver. There is clear guidance in the regulations regarding inclusion of individuals identified by the participant who may participate in the planning process (7 AAC 130.217(a)(2)(B)). There now is no reference in the regulations to ensure that the recipient "directs the process to the maximum extent possible," but a specific reference to this provision of person-centered service planning could be included in the regulations in 7 AAC 130.217. Per 7 AAC 130.217(a)(2), the care coordinator is to consult with each member of the planning team, including the participant, in person or by electronic mail, telephone, or videoconference.

Recommendation: This language should be revised to reflect that the mode of communication is determined based on the preferences of the participant and the same section should be revised to indicate that the process reflects cultural considerations of the participant and information is presented

in plain language that is accessible. This same language then could be included in the *Care Coordination Conditions of Participation* and addressed in training curricula. As noted above in the section on the HCBS Settings Rule, recommendations have already been made to require that the service plan document all settings that were considered by the participant.

Additionally, the State should consider developing assessment tools that guide discussion of needs and preferences in a person-centered way.[18] The State also should be mindful of how the functional assessment tool that drives service planning is structured, how training on that tool is structured, and how the person-centered service planning process is structured. Process requirements also may be codified in the *Care Coordination Conditions of Participation,* but will require some review and input from providers to articulate the changes necessary. Finally, while there is no requirement in the regulations to provide the participant or other people involved in the plan a copy of the service plan (sub-section 10 in this section of the regulation), when SDS approves the complete plan of care (7 AAC 130.217(c) and 7 AAC 130.217(e)), it should consider adding notification to the recipient by sending him/her a copy of the service plan.

Conflict of Interest

Federal requirements §441.555(c), §441.730(b): Conflict of Interest

State statute: The State has been deeply involved in a number of activities to directly address issues around Conflict of Interest and has been in regular contact with CMS to resolve specific issues. SDS released final regulations in July of 2016 reflecting changes to the State regulations governing 1915(c). These regulations apply specifically to 7 AAC 130, but the State will need to determine whether and how they would translate to benefits provided under 1915(k) and the Targeted Case Management for TABI, assuming new regulatory chapters will be developed governing these programs when they are established, as the conflict of interest provisions in the federal requirements are aligned across authorities.

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[18] Task 6 of this same project addresses functional assessment tools.

4. Planning and Operations Infrastructure

HMA has recommended that Alaska move forward to implement a 1915(k) option to include Personal Care Services (PCS) and Participant-Directed Personal Care Services (PDPCS); as well as Personal Emergency Response Systems (PERS). However, HMA also recommended that the State <u>not</u> pursue 1915(i) for any target groups, but instead explore a limited Supports 1915(c) waiver program that would be capped in number of participants and amount of money to serve individuals with a lower level of need than is required for the existing 1915(c) I/DD waiver, as well as a Targeted Case Management (TCM) State Plan benefit for individuals with Traumatic and Acquired Brain Injury (TABI). These new programs will require changes to the current operating infrastructure. These recommendations are covered more in the above Section 2, Cost Impact Analysis. Below HMA has outlined some of the primary changes necessary and recommendations for planning the implementation of those changes.

Recommendations for Rate Setting

HMA does not recommend incorporating any new services into the 1915(k) program at this time beyond the PERS, and as such the recommendation is to utilize current Medicaid rate setting methodologies for PCS/CDPCS services being transitioned into the 1915(k) option. Current rate structures are detailed in a separate project document.[19]

Policies and Procedures Development

SDS will want to review all State policies and procedures to ensure that they incorporate the appropriate references and requirements for the Community First Choice 1915(k) State Plan option, a limited Supports 1915(c) waiver for persons with I/DD, and a Targeted Case Management (TCM) State Plan benefit for persons with TABI they choose to implement. Without a thorough review of the existing policies and procedures, HMA cannot recommend actual changes; however, important considerations for updates and clarifications should include:

- Program rules reviews and updates to identify specific language in State statutes that needs to be modified to support each new program (supported by the review and recommendations in the above Section 3 of this report, Approvals and Rules). This will need to include planning adequate time to go through established processes and reviews for rules changes, including legal reviews and public notice/comment periods.
- Ensuring that each new program has complete policies and procedures covering all new requirements and that all new program requirements are added to existing policies and procedures to ensure their new requirements are adequately and appropriately covered. This will require a thorough review of existing policies and procedures and development of new policies and procedures based on each new program SDS implements. If there is not already one in place that SDS uses for periodic reviews of its existing policies and procedures, HMA recommends development of a specific process for doing so. This should include: staff designated to both oversee and conduct policy and procedure reviews, a timeline for when reviews should be conducted (e.g., every two years or upon any program changes, etc.), structured reviews of all policies and procedures to identify what may need to be updated or revised, additions of new information and deletion of old/outdated information (as appropriate), review and approval of all changes, and steps to disseminate updated policies and procedures to all appropriate staff and train them on changes.

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[19] This information can be found in the combined Project Deliverable for Tasks 5, 7 and 10.

- Stakeholder involvement in the review and development of any new Alaska Administrative Code and internal procedure development and will assist the State to ensure that all current codes have been discussed and that any necessary coverage changes are clearly communicated to the field. HMA recommends using the existing Inclusive Community Choice (ICC) Council or a subgroup chartered by this forum. This would also include the development of any communication materials for internal and external distribution. The ICC Council can assist with written materials and this can be disseminated on known websites and through normal means, including AAC revisions and requests for public comment as new codes are promulgated.
- Training for department staff internally and tailored trainings depending on the audience developed.
- Training sessions planned at existing public forums to train providers, participants and interested stakeholders on administrative changes.

New Assessment Tools

Having a sound assessment tool and assessment process in place will be critical for SDS moving forward with 1915(k), as well as any new limited Supports 1915(c) waiver and TMC programs, plus the existing 1915(c) waivers and PCS/CDPCS programs for applicants and participants who do not meet LOC. Having a statistically valid tool with high inter-rater reliability will give SDS a consistent approach to eligibility and needs assessments while allowing it to put necessary controls around the programs based on assessment results.

Pilot Testing a New Assessment Tool

Prior to implementing a new assessment tool, however, SDS should allow a testing period to ensure accuracy and appropriate outcomes of the assessments. This should be done while running the current assessments in a parallel process which will allow SDS to analyze side-by-side results. SDS should do this for a period of no less than six months and up to the first full year of the new assessment tool. HMA recommends that SDS establish clear methodologies, policies, and procedures related to the utilization and interpretation of assessment results to ensure that it can effectively evaluate how well any new tool tested achieves the desired and expected results. Once SDS is satisfied that a new assessment tool will meet its needs, it can phase out use of the old tools. Testing and implementing a new assessment tool also will require SDS to work closely with its information technology (IT) team supporting the Automated Service Plan (ASP) so they have adequate time to build a new tool into the Harmony system (or other system that SDS may use to support it).

Conversations with IT should begin as early in the process as possible and should include developing a detailed implementation plan and timeline with key milestones. To the extent that Harmony interfaces, or will interface, with the State's Medicaid Management Information System (MMIS – Enterprise), SDS also should ensure that the IT team responsible for supporting Enterprise is engaged early enough in the process to ensure adequate time to plan and prepare for any changes that may be necessary to that system. HMA understands that SDS has contracted with HCBS Strategies to assist with the implementation of a new assessment tool, including developing a detailed implementation timeline. As such, HMA did not include that level of detail in this report.

Recommended Tool(s)

For 1915(c) waivers and PCS/CDPCS services, which includes 1915(k), the new assessment tool should be used for program eligibility, as well as be directly linked to service allocation based on assessed need. HMA recommended SDS move forward with implementing the interRAI tool, specifically the **interRAI**

Home Care and interRAI DD tools.[20] This recommendation was brought forward for a number of reasons, primarily the fact that the interRAI suite of assessments has the capacity to evaluate needs across diverse populations, with a set of assessment items common across the tools. Additionally, Alaska's current Mediware IT vendor is a licensed vendor for the interRAI suite and has some, albeit limited, experience building the IT solution to implement the assessments. SDS has already decided to move forward based upon the HMAHMA's recommendation and the vote of the ICC Council in support of the adopting the interRAI tool.

Preliminary Intake Protocol Recommendations

Current process for Personal Care Services

The following describes the administrative processes by which a participant obtains needed Personal Care Services (PCS). Currently, Alaska offers PCS to all Medicaid-eligible individuals who need this type of assistance. This service is part of Alaska's Medicaid State Plan. Within the Alaska Department of Health and Social Services (DHSS), SDS manages the PCS Program that now serves approximately 5,300 Alaskans statewide. PCS are provided through two different models, Agency-based PCS (ABPCS) and Consumer Directed PCS (CDPCS).

ABPCS serves people through an agency that supervises a participant's care, which includes:

- Hiring and scheduling PCS staff, as well as RN oversight of all PCS staff.
- Developing a backup plan to provide PCS if the regularly scheduled personal care attendant (PCA) is unavailable.
- Developing a contingency plan to ensure a participant's health and welfare if PCS services cannot be provided.
- Deploying PCAs to a participant's home.

The ABPCS agency provides administrative support to both the participant and the PCA, including payroll, Medicaid billing, ensuring that PCAs have met training requirements, and background check requirements. PCAs working in this program must successfully complete an approved PCA training program, have current CPR/FA, be enrolled with Alaska Medicaid as a rendering provider, and pass the criminal history background check. Participants further must obtain a completed Verification of Diagnosis forms and any prescriptions needed directly from their licensed medical providers. Participants who choose the ABPCS option are required to notify the provider agency within 15 days of any changes to important and necessary information such as place of residence or living arrangement, personal contact information, legal representative information, medical provider and service needs, improvements or declines to mental, physical, or medical condition, and age or marital status that would alter eligibility for PCS. Participants must work with their chosen provider agency to submit annual application documentation that is complete and timely, so they do not lose eligibility.

The major difference with CDPCS is that this program requires a participant to manage his/her own care, as well as select, hire, fire, and supervise PCA, with some administrative support from the Consumer Directed agency who is the employer of record, sets the wages and ensures that the PCA meets the state qualifications. The participant takes responsibility for specifying training requirements for his/her PCA and assuring that they have received the training. As in ABPCS, participants in CDPCS participate in the functional assessment, take responsibility for developing a backup plan about how PCS are provided

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[20] This information can be found In the Project Deliverable for *Task 6 - Environmental Scan of Functional Assessment Tools*.

if the regularly-scheduled PCA is unavailable, and developing a contingency plan to ensure their health and welfare if PCS cannot be provided. Also, as in ABPCS, participants must work with their providers to get a Verification of Diagnosis and any prescriptions, and have 15 days to notify their CDPCS agency of any important changes in their circumstances. Enrollment in CDPCS also requires annual renewals, which must be completed prior to losing eligibility.

If a participant is not capable of managing his/her own care, there must be a legal representative who is involved in their day-to-day care to manage and evaluate the PCS as it occurs in the home. As with ABPCS, PCAs working in this program must pass the criminal history background check, have current CPR/FA, and be enrolled with Alaska Medicaid as a rendering provider. The CDPCS agency supplies administrative support including payroll and Medicaid billing and support for the PCAs, participant or legal representative, and training in managing the PCS.

Intake Requirements

The formal intake process is specified in administrative code rule 7 AAC 125.012. "Initial application for personal care services; reauthorization for personal care services." Rule language is excerpted below.

a. A recipient may apply for personal care services under 7 AAC 125.010 - 7 AAC 125.199 if the recipient:
1. Is a current Medicaid recipient working in cooperation with a personal care services provider chosen by the recipient; and
2. Submits to the department
   A. A request for services; the request for services must include, on a form provided by the department, a medical diagnosis verification that is completed by a physician, physician assistant, or advanced nurse practitioner who is
      i. Licensed under AS 08; or
      ii. A federal employee described in 7 AAC 105.200(c) ; and
   B. If the recipient intends to use consumer-directed personal care services, a document that identifies the recipient's legal representative and the representative's authority and responsibility in accordance with 7 AAC 125.140.
b. A recipient of personal care services under 7 AAC 125.010 - 7 AAC 125.199 who wishes to have personal care services reauthorized must submit to the department a request for reauthorization and the items required under (a) of this section at least 60 days before the expiration of the recipient's current authorization.
c. Upon receipt of the information required in (a) or (b) of this section, the department will schedule an assessment under 7 AAC 125.020.

The steps individuals typically follow to obtain services are specified below and were pulled from current DHSS/SDS publications used for individuals enrolled in or eligible for Medicaid. This is a highly manual process and requires significant participant engagement and understanding.

Current Intake Processes

The four major activities or components of the PCS intake process include: Screening, Assessment, Eligibility Determination, and Service Authorization. The following describes the current PCS intake process.

I. Screening
1. A participant seeking PCS contacts the Agency Based PCS agency (ABPCS) or Consumer Directed PCS agency (CDPCS) of their choice from a list of agencies available from SDS.

2. The ABPCS/CDPCS agency completes the required application forms with the participant and submits them to SDS.
3. An SDS assessor schedules and completes a functional assessment.
4. If, through the functional assessment and information from the participant's medical provider, the participant is determined eligible for PCS, SDS will develop a PCS "Service Level Authorization." As specified in 7 AAC 125.024, SDS notifies the participant, or legal representative if applicable, and the ABPCS/CDPCS agency of the results of the functional assessment.
5. Once notified of the approval of services, the ABPCS/CDPCS agency will begin the process to hire and place PCAs to support that participant's specific needs. For participants who choose the ABPCS, this will be done entirely by the ABPCS agency; for those who chose to self-direct care, the CDPCS agency will coordinate with the participant on all PCA selection, hiring and training.

II. Eligibility

To be eligible for personal care services, a participant must meet financial eligibility criteria and be found to need physical assistance with at least one ADL or IADL through a standard functional assessment.

III. Assessment

Determinations are based on service plans developed as a result of a functional assessment conducted and approved by SDS. To be considered complete, assessments also require a Medical Diagnosis Verification to be filled out by a physician, physician assistant, or advanced nurse practitioner on the specified SDS form.

IV. Service Authorization

PCS must be prescribed in accordance with a participant's plan of treatment and provided by a qualified person, or if in the ABPCS, under the supervision of a registered nurse. Details are spelled out in the *Personal Care Assistance Service Level Computation*, revised in March 2012. The Personal Care Authorized Treatment (PCAT) services plan is now called the Service Level Authorization. Time allowed for various services is set by the Consumer Assessment Tool (CAT) and the Service Level Computation Chart.

Recommended Changes for PCS Intake Process

For participants eligible under 1915(k), HMA recommends that Alaska transition the current PCS program and related services under the general provisions of the Medicaid State Plan, to an approved State Plan Amendment for home and community based services (HCBS) using the Community First Choice option under 1915(k) authority, while retaining the existing PCS program for individuals who do not meet the institutional level of care. The majority of existing procedures can still be used under this transition, with the addition of the care coordinator engaging the 1915(k) participants in a person-centered planning process and the need to develop a conflict-free enrollment process. The 1915(k) Option would only be for participants who meet institutional level of care requirements, and the State would continue to cover PCS under the State Plan for participants who do not meet the level of care criteria.

In regard to the major components of the Intake process, HMA recommends the following changes.

1. Overall Intake Process: Use same administrative code with appropriate necessary revisions to include 1915(k) references and changes to processes.

2. Screening: Use the process outlined below to make needed changes. Consider developing capacity of ADRCs or other conflict-free entities to assist with application process instead of SDS agencies.
3. Eligibility Determination: Continue to use the same eligibility criteria.
4. Assessment: The CAT is still appropriate and should continue to be used until implementation of any new assessment tool SDS decides to adopt.
5. Service Authorization: Use the same process with the addition of providing time for the task/service for supervision and cueing, and incorporating a person-centered planning process consistent with 1915(c).

Recommended Intake Process to Address 1915(k) Requirements
1. Utilize ADRCs and/or other conflict-free enrollment entities for the initial application and eligibility process for individuals seeking PCS who are not currently enrolled in Medicaid, including individuals referred by PCS agencies.
2. For current Medicaid recipients seeking PCS, as well as individuals who meet initial Medicaid eligibility screening requirements, refer individuals to SDS for functional assessment.
3. An SDS assessor completes an assessment using the CAT, consistent with the 1915(k) assessment requirements. The assessor also verifies health and safety of the setting and evaluate for Nursing Facility Level of Care (NFLOC). If found to meet NFLOC, the participant will be referred to a care coordinator for waiver services and PCS under the 1915(k).
4. If the individual does not meet level of care for 1915(k), but **is** eligible for PCS under State Plan:
   a. SDS will develop a PCS Service Level Authorization and notify the participant, or legal representative if applicable, of the results of the functional assessment, and provide information on PCS agencies.
   b. Participant selects PCS agency and notifies SDS and agency of selection. SDS provides assessment and authorization information to agency.
   c. Agency begins the process to hire and place PCAs to support that participant's specific needs.
5. If the individual **is** eligible for 1915(k):
   a. Individual selects a care coordinator, consistent with current 1915(c) procedures, to develop a person-centered plan, incorporating the PCS authorized and selected providers.
   b. Care coordinator should notify the chosen agency of the service authorization for services and hours based on the participant's assessment and person-centered plan, consistent with the service level authorization.
   c. The agency may schedule an initial service delivery visit based on the service authorization and give the prior authorization number specified on the service authorization.
   d. Agency begins the process to hire and place PCAs to support that participant's specific needs.
6. If the individual is **not** eligible for PCS:
   a. SDS should notify the participant of the determination and include information about hearing rights for an appeal.

      b. SDS should refer and link the participant to other Medicaid or State services as appropriate, such as a limited Supports 1915(c) waiver for persons with I/DD, TCM for persons with TABI, or State-funded Grant services to address a participant's assessed need.

Additional Operational Recommendations

SDS Staffing Adjustments

Although there are minimal changes to the current intake and eligibility processes currently in place for the PCS program and the 1915(c) HCBS waiver programs, staffing adjustments will be necessary with the implementation of the 1915(k), TCM, and additional limited Supports 1915(c) waiver program. When the State adds PCS under the 1915(k) authority, there may not be a need for <u>new</u> staff initially to implement this additional Medicaid benefit. However, existing staff may have to re-direct their attention or the State may wish to explore adding additional staff to manage the benefit more closely by developing rule changes, procedural changes, oversight protocols, and stakeholder involvement.

Further, HMA recommends the State plan for additional staff to assist in submission of the required State Plan Amendments for the 1915(k) and for the TCM programs, as well as submission of a new limited Supports 1915(c) application and the review of all the future HCBS programs that will require compliance with the federal HCBS regulations. SDS also likely will need additional new staff to support reassessments and transition of participants now receiving PCS as they move to 1915(k) and have access to other services, as well as to help track new quality assurance and improvement measures. The State could consider temporary staff to help manage the implementation and participant transitions. Current staff will need to be retrained as procedures are revised and aligned with each other, and rule changes are reviewed and revised and providers are trained and monitored (*see* the Alaska SB 74 fiscal note recommendations regarding staffing[21]).

HMA acknowledges the fiscal note for Senate Bill 74 analysis, which called for the State to hire one new full time position beginning in 2016 (FY2017) and two more staff beginning in FY2018. The fiscal note analysis indicated the need for four non-permanent positions in the following areas:

- *Research and Analysis Unit* for ensuring continued data integrity as changes to the new Automated Service Plan are implemented for 1915(k), building management reports necessary for Division operations and federal and State reporting requirements, and building subject matter expertise in a variety of data systems.
- *Provider Certification and Compliance Unit* for certifying providers as qualified to provide services to vulnerable Alaskans, and monitoring each provider's compliance with current and upcoming federal regulatory requirements.
- *Quality Assurance Unit* for the quality assurance work, including fraud investigations, related to the system-wide changes required to implement new 1915(i) and (k), as well as limited Supports 1915(c) programs, and mandates for conflict free care coordination and settings compliance.
- *Policy and Program Development Unit* for regular communication with the Centers for Medicare and Medicaid Services (CMS) on Alaska's Medicaid reform goals, maintaining SDS's desire for transparency through provider and participant education, outreach, the formal public comment

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[21] All Senate Bill 74 fiscal note information can be found at this link: http://www.akleg.gov/basis/Bill/Detail/29?Root=SB%20%2074#tab2_4

process, and the research for and development of State Plan Amendments and related amendments to Alaska's four 1915(c) waivers as HCBS transition from General Fund programs to Medicaid.

Role of Care Coordinators

Since care coordination is an essential part of implementing a 1915(k) State Plan option, HMA recommends training for all care coordination staff in the development of the service plan and the coordination of the mandatory PCS, back-up systems and voluntary training in staff management.

The State should explore the development of tailored training on 1915(k) for care coordinators, who will need to be trained on how to explain the service options available to participants. Under the 1915(k) option the participant's care coordinator remains the waiver service coordinator and their waiver service plan is adjusted for the 1915(k) PCS. The State does not anticipate any participants that meet the institutional level of care criteria and require PCS who are not also enrolled on a 1915(c) waiver.

While PCS agencies will not provide care coordination services, they will need to understand the impact of the implementation of the 1915(k) option on care coordination. PCS agencies will need to receive outreach/training on the two different funding mechanisms, billing procedures, and need for annual assessment for PCS, depending on a participant's level of care (LOC).

Other Staffing Needs

SDS will need to make staffing adjustments to manage the implementation of 1915(k) and any limited supports 1915(c) waiver or TCM programs it decides to implement, as well. HMA recommends the State consider further review of the need for additional staff for policy development and implementation. Current policy was developed in a past environment in which a 1915(k) option did not exist. Legacy programs and assessments existed and minimal State Plan options were available. Now staff will need to focus on transition processes, as well as quality assurance and provider monitoring. Additional staff may be needed for ongoing monitoring and program improvements, as well as future endeavors once initial programs are up and running.

Staff Training Infrastructure

HMA recommends SDS conduct an analysis of its current staff training. SDS can complete this task by identifying each of the SDS personnel used for the various processes and procedures such as intake, authorization, service plan development, care coordination, quality monitoring, policy development and training, enrolling providers, and any other task currently completed by SDS staff and identify the corresponding training specifications for each position description. For example, if SDS now uses registered nurses to conduct participant assessments and the position description says that the nurse must be trained in crisis intervention, then SDS would want to crosswalk to the established crisis intervention training. If SDS had a position description that indicates a specific training that is not offered, then the SDS would need to decide if it wanted to develop a training curriculum for such topic or purchase the training for its staff. Additional staff position descriptions and corresponding skill sets may need to be developed for those positions that SDS may not employ currently or may not have existing training programs.

This process could be undertaken by designated State staff, or outsourced through a contractor. If conducted by State staff, HMA recommends that this be the primary focus of, at minimum, one full-time staff person for the duration of the work effort, estimated to be between three and six months, depending on the number of positions and existing position information, and the magnitude of gaps identified in training needs. This will help to ensure a thorough review and assessment, as well as allow

SDS to complete the assessment as quickly as possible so it can begin to hire and train new staff as deemed necessary. If outsourced to a contractor, HMA recommends that SDS plan and budget for an intensive, focused effort by at least two contractor staff, as well as ensuring that the contractor staff have access to designated SDS staff who can help them gather necessary information and get decisions made quickly.

HMA also recommends that SDS leverage existing training opportunities wherever they exist rather than develop specific training for the implementation of the 1915(k) option, as well as for a limited Supports 1915(c) and TCM. For example, a State funded Grant program may currently use a reputable staff training program on interviewing participants and their family members that is used now for non-Medicaid programs and would be beneficial for this State Plan option implementation. Or the TABI advocacy network may have existing trainings for how to assess persons with traumatic or acquired brain injury that may be beneficial to the State staff who review person-centered service plans for participants receiving 1915(k) PCS.

IT Infrastructure Support

SDS will need to engage its current case management IT vendor, Mediware, to develop and implement the new assessment tool within the Automated Service Plan system, Harmony. There also will be other changes required within the EIS (legacy) and ARIES (new) eligibility systems, the Enterprise system (MMIS), and any data analytics and reporting systems or software used by SDS and DHSS. There is more detail on HMA's recommended IT systems changes below *in Section 5 – Recommendations for Information Technology and Systems Changes*.

Participant Infrastructure Support

SDS should leverage the existing infrastructure as it relates to 1915(k) implementation. Currently the State's partnerships developed with participants, providers, associations, family, and supportive stakeholders though the ICC Council has fostered a state-of-the-art plan for Alaskans to move toward an integrated person-centered and participant-directed service delivery system for participants who need home and community long term services and supports. The knowledge gained and the momentum accomplished thus far to find cost-effective ways to provide needed services to seniors and persons with disabilities is commendable. Implementation of the 1915(k), a new limited Supports 1915(c) waiver, and TCM will require continued involvement by and support from this forum, including training and monitoring to ensure participants' safety and welfare through the transition periods. HMA recommends leveraging as much as possible and appropriate these existing stakeholder supports as part of the implementation of the 1915(k).

Quality Management Infrastructure

HMA recommends SDS leverage the existing quality management infrastructure for 1915(k) incorporating elements outlined in the Project Deliverable for *Task 8 – Quality Assurance and Improvement*. A thorough review of the 1915(k) components added to the existing procedures for quality assurances of the 1915(c) waivers will allow the State to implement the 1915(k) with the minimal federal expectations of assurances for health and safety. As soon as possible, the State should elicit the assistance of the ICC Council to develop additional quality assurance measures for the 1915(k) and to support the addition of the TCM benefit for persons with TABI. One suggestion for an additional quality assurance measure would be to review the utilization of back up plans to ensure continuity of care and review incident reports for circumstances in which participants were not able to use their planned back up and subsequently were at risk for health and safety. These incidents should then be compared to the

individual service plan to determine if such incidents could have been avoided and/or planned for differently in the future.

Community Outreach

The nature of the kinds of changes that HMA recommends SDS make to its HCBS will require the Division to continue to focus heavily on community and stakeholder engagement. Community outreach plans should build on work from the Project Deliverables for *Task 2 - Stakeholder Input Process*, and include a plan for outreach efforts tailored to address issues and concerns identified in that process. For example, SDS should continue to engage various stakeholders through informational events (e.g., town hall meetings, webinars), the ICC Council through an informational website with the ability to ask questions and receive timely responses, and through a "hotline" for participants and other interested parties to get information and support in an appropriate post-implementation time period. This section should be integrated with this report's *Section 7 – Plan and Timeline for Communications with Participants and Providers*. For example, HMA recommends that SDS create a single, comprehensive Communications and Education Plan that includes:

1. Communications and Education for Participants
2. Communications and Education for Providers
3. Communications and Education for Other Stakeholders

Most of the messages and information SDS develops related to program changes can be used across all three of these audiences; however, there are important differences and nuances that must be addressed. A comprehensive plan that identifies these three groups and the subgroups within each that will need information about program changes will help to ensure that SDS is providing timely, accurate information to everyone who needs it. This, in turn, will help SDS more effectively manage expectations and issues that inevitably arise during any major program change or implementation.

Community Outreach Activities

Key Milestone 1: State Leadership Meetings with Providers/Community Members.

State leaders from relevant divisions including, but not limited to SDS, should conduct a statewide tour, similar to the tour conducted in late 2015/early 2016 comprising provider and community forums. Forums would address issues of interest raised in the first tour and allow SDS and DHSS to specifically cover why they are moving in a different direction that previously thought. For example, directly discussing how, after conducting a more formal analysis, SDS found that the costs of implementing a 1915(i) would simply be too much to support; but that there are other alternatives that SDS believes it can implement now.

HMA recommends the same venues and cities be considered for the tour: Anchorage, Barrow, Bethel, Fairbanks, Juneau, Kenai, Ketchikan, Nome, and Wasilla. We recommend these meetings be scheduled no less than four weeks in advance to ensure ample time for advertising. Advertising will include statewide press releases, state e-mail blasts, local provider advertising, promotion through existing State field representatives, and direct service providers.

Key Tasks: Identify sponsors/hosts for community meetings; identify time, dates, locations; develop presentation and leave-behind materials (*see* notes below on recommended materials); develop promotional materials; and promote the event.

Timeline: These meetings can be planned and conducted over the course of 3-4 months.

Resources: Time of state leaders to conduct the meetings, time of staff to handle logistics, travel expenses.

Key Milestone 2: Statewide Webinar/s
For communities not part of the in-person forums and meetings, SDS should conduct at least one or a series of broadly advertised webinars available to anyone in the State with Internet access or ability to come to a local provider organization with Internet access that agrees to create an opportunity for community members to view. Advertising should include statewide press releases, SDS e-mail blasts, local provider advertising, promotion through existing State field representatives, and direct service providers.

Key Tasks: Development of slide deck for webinar/s (*see* notes below on recommended materials), advertising for webinar/s through multiple channels.

Timeline: Webinar slide deck/s can be developed and approved relatively quickly. Advertising should be spread out over the course of about a month.

Resources: State leadership time for development and conducting webinar/s; staff time for handling logistics; and advertising.

Key Milestone 3: Outreach to Existing Participants
Written communication to all existing SDS participants with clear, simple messaging about what the HCBS changes mean for them and what they need to do differently, if anything, to access and use services. Consistent messaging of SDS and DHSS field representatives and provider organizations, including direct service providers, is critical, so providing talking points and training for these staff to help ensure clear, accurate, and consistent messaging and a standard set of reference materials is important. Field representatives and direct service providers should be instructed to use a variety of outreach/communication venues as appropriate to reach participants -- face to face, telephonic, written communications.

Key Tasks: Prepare informational materials and talking points (*see* notes below on recommended materials); develop and provide training to staff; staff to develop and implement a plan for systematic coverage of all existing participants with consistent messaging; and offer ongoing opportunities to address participant questions.

Timeline: Intensive preparation and outreach can be done in 3-4 months with reinforcement and continued engagement over the course of the implementation period.

Resources: Staff time to develop informational materials, talking points, training; time for staff training; additional contact time with clients to provide messages, engage them in discussion of transition planning, and answer questions.

Key Milestone 4: Outreach to Prospective Participants
There will be new target populations eligible for HCBS and innovative methods of outreach to those populations will be required, particularly, for example, to identify potential TABI participants for TCM.

Key Tasks: Identify methods for reaching new target populations using provider organization newsletters, associations, advocacy groups, general media, etc.

Timeline: Identifying venues for sharing information with these target populations can be done quickly – in 1-2 months. Messaging should continue throughout the implementation period and continue through general outreach and enrollment efforts.

Resources: Staff time for development of informational materials on HCBS changes including new target populations, information on eligibility, and enrollment.

Key Milestone 4: AK LTSS Website
Maintain an interactive website with Frequently Asked Questions (FAQs) that are updated as new information becomes available, slide decks from presentations, and bi-directional communication to enable participants and others to ask questions and have them answered quickly.

Key Tasks: Maintain the existing website including timely response to questions; update FAQs as new information becomes available; post new slide decks and informational materials.

Timeline: Ongoing throughout implementation.

Resources: Time of webmaster to maintain website and post new documents; time of staff to respond to questions, update FAQs, request postings.

Key Milestone 5: Development and Implementation of the ICC Council
Maintain the Council, which is required for implementation of 1915(k), but which also can be the designated community voice in State-level decision-making, and through which HCBS information can be disseminated to other providers, stakeholders, and advocates.

Key Tasks: Maintain ongoing meeting schedule; create agendas; conduct meetings; document and disseminate minutes.

Timeline: Ongoing throughout implementation.

Resources: State leadership time to craft agendas, conduct meetings, maintain membership. Staff time to arrange meeting logistics, document and disseminate minutes.

Suggestions for Presentations and Informational Materials
The themes and issues from community and provider forums related to HCBS Medicaid State Plan Options 1915(k) and 1915(i), conducted in the Fall 2015 and Winter 2016 are presented below in *Section 9 – Summary of Input from Focus Groups and Community Forums*. Over the course of this project, progress has been made in researching, developing, and decision-making around several of the themes and issues. An outreach plan for implementation should provide communication and stakeholder engagement around as many of these issues as are ready to be discussed. HMA recommends that the content of the communication and outreach include the following:

High-Level Overview of Implementation Plans. Discuss and justify implementation decisions related to 1915(k), a limited Supports 1915(c) waiver, and TCM, including timeline of roll-out. Address effect on service offerings, projection of number of persons eligible, and State budget implications.

Target Populations. Identify and justify populations selected for 1915(k), a limited Supports 1915(c) waiver, and TCM. Discuss what this means for other priority populations, as well as the future of the current 1915(c) waiver and current PCS/CDPCS program.

Eligibility/Enrollment. Clarify the process for eligibility and enrollment to the extent possible with discussion of transition from the existing PCS/CDPCS or other programs to the 1915(k).

Conflict-Free Case Management. Discuss resolution and CMS approval for conflict-free case management waiver in frontier areas and what that means practically for providers and participants.

Workforce Issues, Staff Recruitment and Training. Identify any plans for workforce capacity expansion and discuss any changes made to recruitment and training processes of care coordinators/direct service

providers. Conduct training in person-centered assessment and planning and for workers to support skill-building of participants.

Share Person-Centered Assessment Tool and Processes. Once SDS has made a final decision, identify the tool that is ultimately selected/developed and the justification for choosing that specific tool or suite of tools. Describe attributes of the tool related to person-centeredness. For example, does it have drop down options that allow for more participant flexibility than the previous tool? Does it address co-occurring diagnoses? Will assessments be conducted in the home setting?

Streamlining Administrative Requirements for Providers. Update on any changes made or planned for annual certification requirements, regulations, annual re-assessments for persons with life-long disabilities, reporting requirements, on-site licensing reviews, audits, technology systems/new technology.

Services. Update on any changes made or planned for services that target previously uncovered priorities such as: supportive housing and supported employment, low-level supports for target groups, technology supports, which relate to both 1915(c) and 1915(k).

5. Recommendations for Information Technology and Systems Changes
Management Information Systems and Technology that Support Alaska's LTSS Programs

Under Senate Bill 74, passed by the Alaska State Legislature during its 2016 session, Alaska's Department of Health and Social Services (DHSS), Division of Senior and Disabilities Services (SDS) was directed to explore changes to several current Medicaid and State-funded Home and Community Based Services (HCBS) programs. SDS had already contracted with Health Management Associates (HMA) to conduct a study on the financial and operational feasibility of implementing new 1915(i) and 1915(k) options for certain populations receiving long-term supports and services (LTSS). HMA's recommendations based on this analysis are presented in the *Executive Summary and Section 2* of this report, *Cost Impact Analysis*. This section of the Implementation Plan summarizes information that HMA gathered regarding current state management information systems (MIS) and information technology (IT) systems, and recommendations for what MIS and IT systems changes SDS Alaska needs to make to successfully implement HCBS program changes HMA has recommended.[22]

This Section summarizes business process and IT systems work HMA recommends SDS should do to most effectively support any new HCBS program decisions and requirements. These recommendations also reflect a suggestion that SDS look more broadly at its business process and IT systems than only these program changes, and use this as an opportunity to build greater overall efficiencies in its participant eligibility, enrollment, and management processes. HMA believes this is particularly relevant given the implications of a number of recent CMS rules related to existing and new HCBS programs; specifically, the provisions for person-centered care, conflict of interest requirements for care coordination/case management, and the HCBS settings rules. These rules have substantial implications for how SDS structures virtually all of its programs and services going forward, most immediately with any new HCBS programs.

HMA conducted an environmental scan to assess existing information about Alaska's Medicaid IT enterprise as it relates to the administration and operation of the current HCBS programs, as well as IT infrastructure readiness to implement a 1915(i) and/or 1915(k) State Plan options. This scan included documents such as, but not limited to:

- *State of Alaska, Department of Health and Social Services, Enterprise Roadmap Phase I and Phase II Enterprise Technology Roadmap* documents, from project work prepared by Cognosante for DHSS between 2012 and 2013.
- *Alaska, Department of Health and Social Services, Division of Health Care Services, State Medicaid HIT Plan Update (SMHP-U)*, prepared by Cognosante, May 2012.
- *Impacts of the Health Enterprise MMIS Conversion on the Home & Community Based Service Providers*, prepared by Information Insights for the Alaska Association on Developmental Disabilities & the Alaska Mental Health Trust Authority, September 204.
- *Alaska Medicaid Management Information System (MMIS) Corrective Action Plan*, prepared by Xerox, October 2014 and revised January 2015.

HMA interviewed, via telephone, several individuals from DHSS, including individuals from SDS, the Division of Public Assistance (DPA), and Information Technology Services (ITS). Additionally, HMA talked

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[22] This information can be found in Project Deliverable Task 4.d, *Review of Management Information and Technology Systems.*

to representatives from Mediware Information Systems, Inc., which built and currently supports the State's Automated Service Plan system, Harmony.

DHSS MIS and Technology

Within DHSS, the Division of Health Care Services (DHCS) serves as the State's Medicaid Agency (SMA). The Division of Public Assistance (DPA) is responsible for determining Medicaid and CHIP eligibility of individuals and families (except foster children), and SDS administers Medicaid Long Term Supports and Services and Waiver programs, as well as the Medicaid Personal Care Services (PCS) Program and several State-funded grant programs. SDS also will be responsible for any new HCBS programs, such as those under 1915(k), other 1915(c) waivers or Targeted Case Management (TCM) options. The DHSS Information Technology (IT) enterprise is managed by Information Technology Services (ITS).

Implementation of recommended program changes (a limited Supports 1915(c) waiver, a 1915(k) State plan option, and TCM for individuals with TABI) would require a range of activities which will significantly impact DHSS' existing business process and IT infrastructure. Key elements of required changes include: establishing new eligibility groups, defining new benefit packages, building new claims processing criteria, reimbursing providers appropriately, managing new participant notices and communications, and gathering and reporting data for federal, State, Legislative, and DHSS/SDS performance and quality measurement purposes. These same process and IT impacts would apply were the State to decide at some point in the future to implement a 1915(i) plan option (currently not recommended). Systems that will be most heavily impacted include the State's legacy Eligibility Information System and its new eligibility system, ARIES; Enterprise, the Medicaid Management Information Systems (MMIS), and the Automated Service Plan (ASP) care management system, Harmony.

Eligibility and Enrollment Systems

Medicaid eligibility determination is supported by Alaska's Resource for Integrated Eligibility Services (ARIES). This relatively new, rules-based modern eligibility platform was designed, developed, and implemented by Deloitte Consulting, LLC (Deloitte). ARIES went live in 2013, but currently only supports Modified Adjusted Gross Income (MAGI) eligibility determinations for Medicaid and the Children's Health Insurance Program (CHIP). Deloitte also serves as the systems integrator for ARIES, and is now working on Release 2 for ARIES, which is supposed to incorporate additional federal and State assistance programs including LTSS medical programs, the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), Senior Benefits, Child Care Assistance, General Relief Assistance, and Women, Infants, and Children (WIC) Program. Until Release 2 is live, eligibility determination for these programs, and for Medicaid and State-funded long-term supports and services (LTSS) programs, will continue to be done via the legacy EIS. However, the State's expectation is that eligibility for all programs eventually will be in one system – ARIES.

ARIES consists of a Worker Portal and a Self-Service Client Portal (SSP), the latter of which can be accessed through Alaska's single sign-on portal, My.Alaska.gov. The ARIES SSP allows individuals to apply for Medicaid and CHIP, as well as check their benefits and access notices and other program information. The SSP contains disability related questions that then populate screens within the Worker Portal when the application is submitted. When determining eligibility, this information is fed thru ARIES' eligibility determination tables that will identify if the individual is potentially eligible for HCBS services. If eligible, ARIES will generate a notice, along with supporting documentation, that is sent to the applicant directing them to contact the Aging and Disability Resource Center (ADRC) serving their area http://dhss.alaska.gov/dsds/Pages/adrc/default.aspx. Medicaid waivers, State Plan options, and

State-funded grant programs require applicants to meet additional eligibility criteria to qualify for services. This is done through a separate application step, or steps, depending on the program. SDS is responsible for the final eligibility determinations for individuals receiving LTSS.

Recently, SDS has begun piloting a more efficient application process for individuals seeking HCBS services through the Adults Living Independently (ALI) and Adults with Physical and Developmental Disabilities (APDD) waivers. This includes plans to more fully use the network of Aging and Disability Resource Centers (ADRCs) to provide pre-screening of applicants to triage them to the appropriate next steps. Individuals who appear eligible for services work with SDS-certified Care Coordinators, who help them to complete applications, which are faxed or e-mailed to SDS. In addition to the applications, Nursing Facility Level of Care (NFLOC) assessments are conducted by an SDS assessor using the Consumer Assessment Tool (CAT) to determine if an individual meets all the criteria for ALI and APDD. The Children with Complex Medical Conditions (CCMC) waiver also requires applicants go through a similar process and meet a NFLOC criteria. However, a separate tool, designed specifically for children, is used for the assessment.

Individuals applying for the Developmental Disabilities Waiver (I/DD) must first be found to meet the State's definition of a person with a developmental disability. Most individuals applying for I/DD waivers seek assistance through the Short-Term Assistance and Referral Program (STAR), because the process can be confusing. STAR helps with navigating the eligibility process and understanding what non-waiver services may be available. Once determined I/DD, applicants must complete the on-line I/DD Registration and Review (DDRR), which SDS then evaluates to determine a service score for placing applicants on the Registry. Based on the Waiver SDS had recently approved by CMS (July 2016), up to 50 individuals a year from the Registry can be moved into the waiver once they have been assessed for eligibility using the Inventory for Client and Agency Planning (ICAP). Individuals chosen for waiver slots must choose whether to participate in the waiver, and if yes, must choose a care coordination agency. Applicants notify SDS of the care coordination agency and individual care coordinator they have chosen, who then works to develop their initial Level of Care (LOC) packet. If SDS approves the LOC packet, the individual works with their care coordinator on a plan of care (POC), which also is submitted to SDS for approval. LOC and POC processes are manual and SDS notifies applicants of eligibility via US Mail.

To be eligible for Personal Care Services (PCS), an individual must meet financial eligibility criteria as well as require physical assistance with at least one Activity of Daily Living (ADL) or Instrumental Activity of Daily Living (IADL). Individuals apply through a state-approved PCA Agency, which will assist with the application. Once the application is completed, an SDS assessor conducts an assessment in the individual's home and determines eligibility for services. This assessment is used to create a Service Plan and Service Level Authorization (SLA). Individuals seeking PCS can choose to receive services through either an Agency Based PCS (ABPCS) model, or a Consumer-Directed PCS (CDPCS) model. Both models use the same Service Plan and SLA; however, individuals in the CDPCS model will work with a CDPCS agency, which will advise them on how to begin the process to hire their PCS provider and get scheduled services set up, while for individuals in the ABPCS model, the ABPCS agency hires providers and set up a service schedule.

Medicaid Management Information Systems (MMIS)

In 2007, Xerox (which purchased the original contractor, Affiliated Computer Systems, or ACS) began working with DHSS on the design, development, and implementation of a new MMIS to replace the legacy system used by the state since 1987. The Xerox Health Enterprise System (Enterprise), is a web-based suite of technologies centered on a set of applications and data analytics used to support Alaska's

Medicaid program, including: provider enrollment; processing and payment of claims; service authorization for transportation, dental and other specified services; first-level appeals; provider inquiry and problem resolution; provider education, communication, and outreach; the Care Management program for individuals who inappropriately use services; and surveillance and utilization review.

HCBS and PCS service providers must be certified by SDS before they are enrolled as providers in Enterprise; providers not enrolled in Enterprise cannot submit claims for payment. The basis for MMIS adjudication of provider claims for waiver participants is an approved Plan of Care (POC – for waivers) or Service Level Authorization (SLA – for PCS). SDS must approve the individual's POC or SLA then create a Service Authorization (SA) that includes the number of units, date range, and service codes that are approved for the individual to access. Today, this process is manual, because there is not a provider interface between Enterprise and the Automated Service Plan system, Harmony.

When the SA has been approved, the care coordinator notifies the appropriate providers that services can begin. The MMIS matches Medicaid claims with the SA and adjudicates appropriately. If approved, a Remittance Authorization (RA) or 835 file is generated and the claim is paid. Providers look for the RA in the MMIS via the Provider Portal. Enterprise also includes web-based reporting functions that use Cognos, a reporting tool platform from which specific users can generate program reports, limited custom analytics, and system queries.

DHSS experienced significant difficulties with the Enterprise implementation, including issues that delayed implementation from 2009 until 2013. One of the major changes with Enterprise implementation was the way HCBS providers access Service Authorizations (SA). The changes caused payment problems that had some financial consequences for many smaller HCBS providers. Most of the major issues with Enterprise have been resolved, and Xerox and DHSS continue to work on additional improvements. Currently, Xerox is in the midst of an MMIS certification reviews with CMS, a critical system step that was significantly delayed due to the implementation issues noted above.

SDS's Automated Service Plan
DHSS began working with Mediware Information Systems, Inc. (Mediware) in 2013 to implement the State's Automated Service Plan (ASP) project for seniors and people with disabilities. Alaska uses Mediware's case management platform – Harmony – a cloud-based long-term care software product that provides an integrated case management tool for planning, tracking, managing, and payment for services, as well as licensing and certification approval processes for service providers. Harmony supports Alaska's HCBS waivers, PCS, State-funded grant program services, services offered through the Older Americans Act programs, and Adult Protective Services case management services. Currently, Harmony's functionality includes online applications for waivers, PCS, long term care and State-funded programs that can be accessed by ADRCs, service agencies, and care coordinators. It also includes the online CAT assessment tool used for the PCS, ALI, APDD, and CCMC waivers. The ICAP for I/DD assessments is completed in a separate process and staff input the assessment result into Harmony. For all programs the planned services then are processed online in Harmony.

Harmony does not yet interface with the MMIS (Enterprise), with the new eligibility system, ARIES, or with the legacy eligibility system, EIS. Delays and issues with the Enterprise go-live that were noted above impacted the original Harmony implementation schedule. DHSS now is in the final stages of its Phase 2 ASP implementation, expected to go live in the near future. This implementation will include most of the functions needed for SDS to more efficiently support LTSS programs, including assessment tools, the electronic Waiver POC, the suggested PCS Plan. In the current processes, care coordinators

and providers submit their reports to the CAT Review Team for processing. With ASP Phase 2, providers and care coordinators will be able to enter a POC online and have it approved online for all waivers and PCS services. This implementation will also include the LTC institutional authorizations and other grant and state funded programs. ASP Phase 2 originally was supposed to include interfaces with ARIES, but those have been delayed. SDS is considering whether it would be worth connecting to the EIS via 270/271 files to share eligibility information between EIS and Harmony, an option that is less than ideal because of costs associated with interfacing with a legacy system. Additional Phase 2 ASP implementation will include functionality for:

- SAs for POCs, care coordinators, and PCS agencies
- Role-based access to Service Plans
- Creating and tracking care plan goals, objectives, and outcomes
- Aggregating participant information, including demographics, assessments, activities, care plans, service plans, and service orders and deliveries
- Ensuring required preauthorization has been granted for billable services
- Automated dashboards for reviewing selected key program information by approved entities
- Recording and archiving Service Plan information, as well as building custom reports[23]
- Store claims data

In addition to these updates to ASP functionality in Harmony, SDS is considering whether to move to a single assessment tool/suite that could support all of its LTSS programs. Such a change would require a significant effort from both State IT and Mediware staff.

Recommendations for IT Changes to Support Program Changes

HMA offers the following recommendations for SDS consideration as it works through final program design, operational planning and stakeholder engagement, and ultimately, implementation of program changes.

Overall Business Process and IT Approach

SDS should continue to follow the DHSS Enterprise Roadmap, developed in 2013 by Cognosante. This roadmap outlines recommendations for a department-wide approach to building an information systems infrastructure necessary to support DHSS' current programs.[24] The Roadmap suggests a gradual approach toward building a Shared Services model, established using enterprise-level service-oriented architecture (SOA). This approach also requires corresponding business process and cultural changes, including how technology is procured and implemented, alignment of business processes across divisions, and improved testing and change management. There are several important guiding principles and strategies for DHSS in the Roadmap which are applicable to the changes SDS wants and needs to make in LTSS programs, including:

- Alignment of business needs and business processes.
- Moving to a DHSS-enterprise, consumer-centric focus and away from siloed, program-specific systems.

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[23] https://www.mediware.com/news/ltss/harmony-wins-competitive-bid-for-alaska-provider-portal-and-automated-service-plan-system/

[24] State of Alaska, Department of Health and Social Services, Enterprise Roadmap Phase II, Version 1.4. Prepared by Cognosante, May 17, 2013.
http://dhss.alaska.gov/HIT/Documents/AK%20DHSS%20Enterprise%20Roadmap%20Phase%20II_V1.4.pdf

- Maximizing the use of Department HIT expenditures through reuse of shared technology and business services.

The Roadmap strategies also align with the recent CMS regulations established to enhance the quality of individuals receiving HCBS. Core to these new requirements are a focus on person-centered planning, structures to ensure conflict free case management, and ways to ensure that individuals receive HCBS in the most appropriate care setting of their choice. These new rules will bring significant changes to business processes for SDS that in turn will drive changes in the technology needed to support them.

Additionally, DHSS has undertaken two very large new IT systems implementations in a very short time period – the ARIES eligibility system and the Enterprise MMIS system. This has put considerable pressure on DHSS ITS staff, and significant issues with both systems have required program staff to create manual work-arounds for many processes that could, and should, be automated. At the same time, DHSS has been working on the Automated Service Plan (ASP) implementation built around the Mediware product, Harmony. Problems with Enterprise and ARIES have impacted the ASP implementations, causing delays in deployment of important functionality. Again, this has resulted in program staff having to create manual work-arounds for many processes. Beyond the staff impacts, these systems issues have had, in some cases, impacted both providers and program participants.

Within this much larger context of systems changes, SDS must understand and evaluate the business process and systems changes necessary to ensure successful implementation of new policies and programs related to its HCBS programs. Further, SDS must be mindful of the new rules regarding person-centered care, conflict free case management, and ensuring care is delivered in the most appropriate settings that meet individual participants' desires and needs. These requirements provide Alaska the opportunity to rethink and redesign policies, programs, operational processes, and infrastructure supports to both be more person-centered for participants, but also more efficient and effective for staff, for providers, and for other stakeholders. Confusing processes and complex systems create barriers to individuals and families who need services; they also create inefficient and expensive operational environments for staff.

Through the work currently underway as part of the Testing Experience and Functional Tools (TEFT) grant, SDS could benefit from the experiences of program grantees. TEFT is a CMS grant testing quality measurement tools and demonstrating e-health specifically for Medicaid community-based LTSS (CB-LTSS). The grant program continues through March 2018, and is:

- Field testing a cross-disability experience of care survey and set of functional assessment items.
- Demonstrating Personal Health Records.
- Creating an electronic LTSS service plan standard.

Following the status of the project could lend additional insights to SDS as it adjusts processes and implements system changes to support the State's HCBS programs. A link to the project website is provided here: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/grant-programs/teft-program.html

Systems Changes to Support New HCBS Programs
Implementing any new HCBS programs and services - including new 1915(c) or 1915(k) options or a TCM program - will require a variety of business process and IT activities, including establishing new eligibility groups, defining new benefit packages, building new claims processing criteria, paying providers appropriately, managing new participant notices and communications, and gathering and reporting

program data. Although HMA has recommended against it at this time, the same kinds of process and IT activities would be required if the State chose to implement a 1915(i) plan option at some point in the future.

The biggest IT impacts for these program changes will be in the State's legacy Eligibility Information System (EIS) and the new eligibility system, ARIES; in Enterprise, the MMIS; and in the Automated Service Plan (ASP) system for care management, Harmony. More importantly, these program changes will require significant policy, procedure, and business process revisions. As noted above, although there is a considerable amount of work that would have to be done to implement the recommended program changes, it is also an opportunity for SDS, and more broadly the Department, to identify process and systems improvements that can build efficiencies that support more than just this small subset of programs and can move the Division toward a more person-centered approach to care for all programs and participants.

Business Process Changes

A core assumption is that once SDS determines whether or not to adopt each of the recommendations from HMA, some subset of them, or some other options, it will have a process for thoroughly and comprehensively defining the final program design elements: eligible population, services available and any service limitations, appropriate providers, rate structures, etc. This program design and definition process is critical to having the information necessary to build the business process changes and IT systems changes to support the new programs. Once SDS has finalized program design, it can begin to make operational changes.

- SDS should establish standardized definitions, terms, language used to describe the new programs, the eligible populations, the services, etc. Once this is done, then there should be a comprehensive review all the places that information is/will be used to ensure that it is consistent with the standards. For example (but not limited to):
  - o General program descriptions and information
  - o Policies and procedures
  - o Training materials, desk guides, "cheat sheets" and other reference materials
  - o Systems and systems manuals
  - o Communications materials/mechanisms (website, newsletters, brochures, presentations, correspondence to providers and clients, etc.)
  Ideally, SDS would do this for all HCBS programs, new and existing.
- SDS should continue to revise the intake and application processes to make it easier for individuals who need these new services to access them. Again, this is an opportunity to identify process improvement opportunities for all HCBS programs.
  - o Keep building on "No wrong door" eligibility options - make it as easy as possible for individuals to apply, recognizing there still are additional steps to qualifying for these programs, beyond just the financial eligibility determination.
    - Online, on paper, over the phone, in person (for example, build out financial eligibility determination in ARIES, make it possible/easier for clients to apply via Self-Service Portal for LTSS)
    - On their own, with assistance from their supports, with assistance from other available resources (for example, continue to expand ADRC screening/navigation role)
  - o Don't make the applicant have to do more than necessary

- Create mechanisms to identify and outreach those who are potentially eligible
- Gather as much of the required eligibility information as possible from electronic sources or make it easy for them to submit information electronically
  - o Streamline the assessment processes as much as possible
    - Develop a single assessment tool/tool suite that can support all the HCBS programs with as little variation as possible (there will have to be some)
    - Evaluate who is conducting assessments for each program and whether there are opportunities for improvement in this step that can support process efficiencies across programs, as well as conflict free case management requirements
  - o Create Plan of Care/Service Plan development processes that follow a person-centered approach
    - Again, this should be done across all existing and new programs to support more efficient operations, as well as better person-centered planning
- SDS should develop comprehensive business requirements and business logic based on the program design. This is critical for any IT systems changes that will need to be made.
  - o Bring both business analysts and IT analysts in to this process at the beginning
  - o Include other staff from other programs that these programs touch in any way (e.g., behavioral health, inpatient LTC and IMFR, etc.) to identify common business requirements across programs
  - o Include teams from all key systems: Enterprise, ARIES, Harmony (at minimum)
- SDS should identify the key program data/information that is needed to ensure SDS can meet all reporting requirements, as well as desired reporting needs.
  - o Determine the programs' goals and objectives, quality metrics, financial targets, etc., and identify the data/information that is needed to support those things. Don't collect data just to collect data
  - o Define the data so it is clear exactly what is meant or needed
  - o Identify how the data will be collected and from what sources. For example, if data must be collected from providers, do they have the capability/capacity to collect and report it? If it cannot be easily collected, consider using different data

IT Systems Changes

IT systems built on inefficient business processes will be inefficient IT systems. This is why it is so important for SDS to invest the time and effort into reviewing business processes and developing comprehensive business requirements and business logic based on the design of any new HCBS programs. Some business process and IT work can be done in parallel, but generally the business requirements and business logic must be defined first, then reviewed and validated by both program and IT staff, before any IT changes can be made. As noted above, ideally, SDS should involve both business analysts and IT analysts in its program planning and design efforts from the beginning. Bringing IT staff into the process early gives them the opportunity to better understand program needs, but also to offer important insights and guidance on what may or may not work in the IT systems, or where process steps could be automated or completed by systems rather than manually.

- Eligibility systems (EIS, ARIES): SDS should establish the specific eligibility categories and codes necessary to define populations who will be eligible for new programs and services.
  - o Define aid categories and codes
  - o Define populations associated with those aid categories

- o Define services and benefits associated with those aid categories
- o Define financial impacts associated with those aid categories (e.g., different FMAP)
- o Define whether or not an individual can be in any of these aid categories as well as another aid category at the same time; if yes, define order of precedence for services and payments (e.g., 1915(k) + PCS)
- o All HCBS waiver participant eligibility information should ideally "live" in single system of record – ARIES; while EIS is still eligibility system of record for HCBS participants and there is no definite date for implementing HCBS in ARIES, SDS should consider whether it would be worth building the interface between Harmony and EIS
- MMIS (Enterprise): SDS should establish the specific services, providers and rates for each program.
  - o Define services
  - o Define service limitations and authorization requirements
  - o Define rates/rate structures for each service
  - o Define providers eligible to deliver services
  - o Ensure all HCBS providers are correctly enrolled as Medicaid providers; verify they can access necessary information via the Provider Portal; verify they can be searched for in the public-facing Provider Directory
  - o Build interface between Harmony and Enterprise
- ASP (Harmony): SDS should automate as much as possible applications, assessments, plan of care/service plan.
  - o Applications for all new programs should be accessible online by participants, providers, service agencies, others who might be providing assistance to applicants (similar to current programs today)
  - o Application information should auto-populate appropriate information for online assessment tool(s) and any other forms related to an individual's case/record through the eligibility determination process
  - o Assessment tool(s) should include the appropriate modules or suite of sub-tools to meet each program's unique eligibility criteria requirements and should not be harder to use online than on paper
  - o Online assessment information should auto-populate other forms and tools as much as possible with appropriate data (e.g., POC, SP)
  - o POC and SP should be online and accessible by participants, providers, care coordinators, or others with appropriate role-based access privileges
  - o Online POC and SP should support person-centered planning, per the HCBS regulations that provides necessary information and support to the individual to ensure that the individual directs the process to the maximum extent possible
  - o Participant correspondence and notices should be generated automatically and participants should be able to elect to receive paper or electronic notices and correspondence
  - o Ensure all HCBS providers are certified and enrolled
  - o Build interface between Harmony and Enterprise

Asset Verification System (AVS)

Alaska currently does not have an Asset Verification System (AVS). However, per 42 U.S. Code § 1396w, states are required to have processes and systems for electronic asset verification through access to

information held by financial institutions. Alaska was scheduled to implement a system in 2012, but has not implemented one, in part because of the significant expense for such a small population. Recently Congress has pressured CMS to push states to implement AVS, and because CMS has not made AVS a Federal Data Service Hub priority, states must pursue solutions themselves. Although only a handful of states have fully implemented AVS, a number of states are currently in the process of procuring solutions. There are a limited number of vendors currently doing this work, so Alaska could likely do a relatively quick procurement, depending on the State procurement rules. HMA recommends that Alaska:

- Request examples of RFPs from some other states to modify for its own procurement (AVS could be procured as a service, which should make the cost much more reasonable); or
- Consider exploring options to share a system or service with another state.

6. Plan and Timeline for Transitioning Services

Transitioning Waiver and Personal Care Services to the Home and Community Based Services and Community First Choice 1915(k) Programs (also includes where appropriate TCM)

HMA reviewed the current Personal Care Services (PCS) intake process and Consumer Assessment Tool (CAT). HMA found that the current operational procedures and processes used in existing 1915(c) waiver programs and the existing PCS are sufficient, with minimal adaption, to effectively implement the new Home and Community Based Services (HCBS) State Plan options. Proactive preliminary analysis of the current assessment information is recommended in order to transition participants efficiently and minimize disruption in services. It is extremely important to identify which participants will be the easiest to transition, and which will present challenges for a smooth transition to a different service model design. HMA recommends the following approach to prepare for transitioning participants from PCS to the 1915(k) options:

1. Conduct a desk review and analysis of the CAT information to determine the appropriate HCBS and whether or not participants meet the State's criteria for institutional level of care. To the extent possible, conduct this process also for participants who are currently receiving Grant-funded services who are Medicaid eligible or have potential to be Medicaid eligible.

2. Conduct a desk review and analysis of participants receiving services via Grant funds to determine if they qualify for Medicaid and also if they qualify for 1915(k) and/or Targeted Case Management (TCM) (for persons with Traumatic or Acquired Brain Injury -TABI) or one of the 1915(c) waivers.

3. Compile the list of participants who qualify for Medicaid (financially) but do not qualify to receive PCS under 1915(k), 1915(c) or TCM, based on their most recent CAT and/or their Grant program plan.) Refer this group of participants for screening for other Medicaid services or State-funded services they may be able to receive.

    a. Re-evaluate (conduct new CAT or similar assessment) for most appropriate service regime.

4. Prioritize the groups of participants to move to the new options and develop a communication plan for State staff to begin arranging: The 1915(k) option is scheduled to go live first with TCM potentially following however, SDS could decide on a different timeline for TCM based on other needs and budget considerations, such as Maintenance of Effort (MOE) requirements for the 1915(k) option. SDS will determine the best time for implementing any new limited Supports 1915(c) waiver if it decides to move forward with that program.

    a. As appropriate, State staff or Care Coordinators meet with participants and update service their individual service plans.

    b. Identify and arrange for additional providers, as appropriate.

    c. Assist participants in understanding any new and different information they need to know.

    d. Track participants to new the program option.

The following table indicates participants will transition to the new 1915(k) or TCM State Plan options depending upon their need for assistance with activities of daily living (ADLs), their level of care need (LOC), as well as their individual diagnosis for any of the target groups.

Table 1-Section 6

Population	Service	Option	Date
Non-target DX	Personal care	1915(k)	7/1/17
TABI	Care coordination	TCM	1/1/18

Critical administrative activities with established timelines must occur in order to transition participants from current State Plan PCS to receiving assistance with ADLs under the new State Plan option. Times reflect the estimated amount of time it will take to accomplish each of the tasks. These administrative activities may occur at the same time and include, but are not limited to:

1. Development and submission of a White Paper to CMS (30 days).
2. Moving updated regulations for the new 1915(k) eligibility group through the process (90-120 days).
3. Submission of State Plan Amendment (SPA) Application for 1915(k) to CMS (180 days), once regulations have been approved by the Department of Labor (DOL) Regulations Unit (i.e., no more changes).
4. Revisions and drafting of new State Administrative Rules (120 days).
5. Stakeholder communication and public noticing (90 days).
6. Revisions to forms, procedures, and systems (90 days).
7. Training of staff, providers, and other key stakeholders (90 days).
8. Communications to participants, their families, and caregivers (90 days).
9. Ongoing monitoring and troubleshooting to mitigate initial implementation issues (180 days).

Additional Considerations

- SDS should begin conversations with CMS now so that it has an understanding of where the State is looking to move and why, and that it coincides with the Statewide Transition Plan and other efforts and initiatives that the State may have before CMS, such as other SPAs. It will be important for CMS to know the overall plan and timeline so that they understand the interdependencies. It is also important that CMS understand the extent of planning and communication undertaken by SDS to redesign the HCBS model. HMA recommends that SDS develop a White Paper and request to begin dialogue with CMS as a good way to start.
- SDS must develop and submit a 1915(k) application for the Community First Choice option. This is a cross between a SPA and an HCBS waiver application. The appendixes that are submitted with the 1915(k) SPA application should be consistent with the White Paper and previous submissions of other waivers, as well as the Statewide Transition Plan and any waiver renewals.
- SDS should develop a communication plan specific to the implementation timeline so that all stakeholders, staff, providers, participants, and their families have clear and consistent messages about when significant milestone activities will occur.
- As part of its communication plan, SDS should ensure that all participants receive notification in writing via many different means (mailed letters, website information, informational materials through providers, etc.) with clear message of who they may contact for questions.
- SDS must ensure that all local community supports, providers, care coordinators, and family supports have adequate information and clear understanding of who to contact with questions about program changes.
- SDS must ensure that all State Administrative Rules and internal policies and procedures are updated and all changes are supported in State law and policy.

- SDS must work closely with DHSS IT staff and vendors supporting the Enterprise Medicaid Management Information System (MMIS) system, as well as the Automated Payment System (ASP) to ensure that any and all changes to the payment system are clearly identified and that claims are suspended and reviewed, as opposed to denied, during an established transition period.
- SDS should consider establishing a temporary prior authorization process to resolve emergent issues and to inform SDS if the system is not working correctly and allow it to determine common themes for claims payment/denial and for policies and procedures.
- SDS must develop and conduct comprehensive Provider Education Training for appropriately billing and documenting services. New providers need to be enrolled in the Medicaid program and in the Enterprise system, and existing providers need to be reviewed for any provider type updates to ensure they can serve new/different populations, bill using new time or coverage limitations, and will be paid correctly and promptly.

The 1915(k) option requires care coordination, therefore once SDS has received all the appropriate authorities and approvals to implement the 1915(k) option, and has adapted the State Administrative Code as needed, staff can begin making appropriate adjustments to participant service plans to specify from which program the participant is receiving their services, in what amounts, and from whom. HMA recommends it be completed in the following order:

1. Participants eligible for 1915(k) – those receiving both waiver and PCS.

2. Participants eligible for TCM for persons with TABI.

Since PCS will remain a covered service on the State Plan, all participants who do not meet the level of care criteria will continue to receive services and not be without access.

Transitioning Participants Who Require Services of the New HCBS State Plan Options (1915(k), TCM, limited Supports 1915(c) waiver) from Grant Programs (e.g., TABI, IDD)

HMA reviewed the applicable Grant-funded benefits for participants with varying diagnoses, levels of functioning, and financial situations. Each of the current intake processes for the Grant programs are different and dependent on the type of service and the particular Grant proposal. Since HMA believes that the current operational procedures and processes for Medicaid-funded PCS are sufficient, with minor adaptations, to effectively implement the new HCBS State Plan options, we recommend that SDS use the State's existing PCS/waiver intake and assessment process for participants who are currently receiving State-funded Grant program services, and may qualify for these new HCBS programs.

Therefore, all participants receiving Grant services could be assessed for Medicaid eligibility (financial) and assessed using the CAT for functional abilities, as well as to make formal determinations of level of care for long-term supports and services (LTSS). Again, proactive preliminary analysis of the assessment information is recommended to help transition participants efficiently and minimize disruption in services. It is extremely important to identify which participants will be the easiest to transition, and which will present challenges for a smooth transition to a different service model design. HMA offers the following approach to prepare for transitioning participants from existing Grant-funded services to the 1915(k) option:

1. SDS should assess all participants currently receiving Grant services for financial Medicaid eligibility, and complete the analysis as soon as possible. The implementation plan is directed toward participants who are Medicaid eligible.

2. SDS should conduct a desk review and analysis of the CAT information (if available) or the appropriate Grant program's clinical/functional assessment information to identify participants who currently receive Grant services, are in need of PCS, and have appropriate diagnoses for the target population groups. As stated above, this should be started as soon as possible for all Medicaid and potential Medicaid eligible participants currently receiving Grant-funded services, including:
    a. IDD
    b. ADRD
    c. TABI
3. SDS should conduct a desk review and analysis of the information available to determine the appropriate HCBS State Plan option for participants in each target group and those that are not in a target group, and whether or not they meet the State's criteria for institutional level of care. As stated above, this step should be completed as soon as possible for participants receiving State-funded Grant services.
    a. 1915(k) participants who require assistance with ADLs <u>and</u> meet level of care but are not currently enrolled on a 1915(c) waiver.
    b. TCM if participant has TABI <u>and</u> <u>no</u> level of care
4. SDS should compile the list of participants who qualify for Medicaid (financially) but may not be able to receive PCS, (based on their most recent CAT and/or their Grant program assessment) under the new State Plan options 1915(k), TCM, or the limited Supports 1915(c) waiver.
    a. Re-evaluate (conduct either a new CAT or a functional assessment) to determine the most appropriate service regime for the participant.
5. SDS should prioritize the groups of participants to move to the new options and develop communication plan for staff to begin arranging. At this time, SDS is planning to implement the 1915(k) option first, on 7/1/17; it is exploring implementing TCM on 1/1/18, but may choose to modify this timeline based on assessment of other factors which may make it more financially and/or operationally feasible to implement at a different time.
6. In accordance with the requirements of the 1915(k) State Plan option, SDS should have the Care Coordinator, Case Manager, or whoever is assigned to work with the participant provide appropriate management to include:
    a. Meet with participant and update the service plan.
    b. Identify and arrange for additional providers, as appropriate.
    c. Assist the participant in understanding any new and different information they need to know.
    d. Track participants to new program option.

The following table indicates participants who would transition to the new State Plan options, depending upon their need for assistance with ADLs, their level of care need, and their individual diagnosis for any of the target groups.

Table 2-Section 6

Population	Service	Option	Date
Non-target DX	Personal care	1915(k)	7/1/17
TABI	Care coordination	TCM	1/1/18

SDS will need to make necessary revisions to applicable procedures for State-funded Grant programs so that Medicaid-eligible participants with LOC and those who meet the target groups without level of care

are referred to the new 1915(k) State Plan option for PCS. This includes, but is not limited to the following:

1. Referral and follow-up for participants by someone assigned to make sure proper determinations are made and a smooth transition to the Medicaid program occurs.
2. Amending Grant agreements, as appropriate. For example, if all participants in a particular Grant program are eligible for one of the new Medicaid HCBS options, then the contract with the provider(s) may need to be terminated and potentially a new agreement made as a Medicaid provider (if the provider determines to become a Medicaid provider).
3. Developing and training providers on changes to Grant-funded programs, as well as assisting them in becoming Medicaid providers (if they choose to do so).

7. Plan and Timeline for Communications to Participant and Providers

It will be critical to ensure timely, accurate and comprehensive communications to both members and providers, to ensure they understand not only the changes that SDS is making in the HSCB programs, but why it is making them, and how they will impact each group of members and providers. It should be noted that this section ties closely with *Section 4k - Community Outreach* above, and there is overlap in message and materials development and dissemination. A single formal communications and outreach plan should be developed as part of the final implementation plan. SDS will need to develop a communications plan timeline that tracks with its timing for when each recommended program change will occur.

At minimum, it will be important to continue *current* communications with key stakeholder groups (e.g., the Inclusive Community Choices Council and other advisory committees/boards) as SDS finalizes decisions on program changes. Optimally, SDS can begin working on key messages and basic program information now, as well as ensuring the appropriate communications channels/mechanisms are in place so it will be easy to update and disseminate new information as needed. For example, SDS already has a website which it currently uses to provide important program information. It will be important to ensure that staff who maintain this website are aware of timing and messages that will need to be updated in preparation to implement new programs so they can appropriately prepare for any changes in the web page or ensure there are steps in place to capture new site visit traffic data to be able to evaluate how many visitors there are as one measure of the website's effectiveness.

Major changes for populations served through HCBS and PCS programs can cause a lot of disruption for participants, their families, caregivers, and providers. Preparing messages and communications plans well in advance of "go live" is critical for implementation success. As soon as SDS has finalized program change decisions, it should start to communicate those changes with these key groups. However, SDS must take care to ensure that communications are accurate and easy to understand for each specific audience. Disseminating incorrect information, or information that is confusing or overly complex, can have very negative consequences and create significant barriers to a smooth implementation. Establishing a timely process for developing messages and materials, doing a thorough quality review of those messages and materials, and requiring approval from an appropriate-level staff person before they are disseminated, can help to ensure accurate, appropriate information gets to the right target audiences at the right times.

Participant Communications and Education

Participant Communications Plan Outline

Initial Communications

1. Identify target participants – individuals who will benefit from 1915(k), limited Supports 1915(c) waiver, and the new TABI TCM
    a. PCS enrollees
    b. Individuals with I/DD
    c. Individuals with ADRD
    d. Individuals with TABI
    e. Potentially new enrollees
2. Develop core messages
    a. General messages for all participants
        i. SDS is changing the HCBS and PCS programs – here's why and how
        ii. Overview of timeline for changes

        iii. What to expect over the next 12 to 18 months
        iv. What this means for participants
        v. What this means for family/natural supports caregivers
        vi. What this means for providers
        vii. Where to go/call for more information or questions (customer service, website, ADRCs, STAR, community organizations, etc.)

b. Messages specific to PCS participants
        i. SDS is changing the PCS program, you may be eligible for new 1915(k) services – here's why and how
        ii. Overview of timeline for changes and how PCS participants will be affected
        iii. What to expect over the next 12 to 18 months
        iv. What this means for participants, including any actions participants must take
        v. What this means for family/natural supports, caregivers
        vi. Where to go/call for more information or questions (case management/care coordination structure, customer service, website, community organizations, agencies, etc.)

c. Messages specific to individuals with I/DD
        i. SDS is implementing a new 1915(c) waiver for which you may be eligible, as well as State plan 1915(k) services – here's why and how
        ii. Overview of timeline for changes and how I/DD participants will be affected
        iii. What to expect over the next 12 to 18 months
        iv. What this means for participants, including any actions participants must take
        v. What this means for family/natural supports, caregivers
        vi. Where to go/call for more information or questions (case management/care coordination structure, customer service, website, community organizations, etc.)

d. Messages specific to individuals with ADRD
        i. SDS is not implementing any new programs for ADRD, but adding 1915(k) to State plan – here's why and what the impact may be
        ii. Overview of timeline for implementation of the 1915(k) and how ADRD participants will be affected
        iii. What to expect over the next 12 to 18 months
        iv. What this means for participants
        v. What this means for family/natural supports, caregivers
        vi. Where to go/call for more information or questions (case management/care coordination structure customer service, website, community organizations, etc.)

e. Messages specific to individuals with TABI
        i. SDS is implementing a Targeted Case Management (TCM) program for which you may be eligible – here's why and how
        ii. Overview of timeline for changes and how TABI participants will be affected
        iii. What to expect over the next 12 to 18 months
        iv. What this means for participants, including any actions participants must take
        v. What this means for family/natural supports, caregiver
        vi. Where to go/call for more information or questions (case management/care

coordination structure, customer service, website, community organizations, etc.)

f. Messages specific to individuals with SMI/dual diagnoses I/DD and SMI
   i. SDS should coordinate closely with the Division of Behavioral Health to develop joint messages and communications for these groups that explain both the work that both Divisions are doing to support them, such as efforts to develop an 1115 waiver and other options for individuals with dual diagnoses
   ii. SDS and DBH should develop communication to providers related to supporting individuals with dual diagnoses on plans for services and supports for this population

3. Create materials for general participant audiences and target groups using messages developed
   a. Fact sheets, program briefs, Q&As, mailers
   b. Website information
   c. Customer Service scripts
   d. Presentations
   e. Newsletters
   f. Press releases and news stories
   g. Materials for providers to share with participants

4. Create dissemination plan for each target group
   a. Timelines for releasing information (timed appropriately as part of overall implementation plan)
   b. Community presentations and opportunities for two-way dialogue related to information, questions, concerns
   c. Establish channels and modes for releasing information (online, mail, via providers, customer service scripts, etc.)
   d. Establish mechanisms to monitor information dissemination and evaluate effectiveness/impact (e.g., track mailings, monitor customer service calls, check with providers, etc.)

5. Create mechanisms for participants to provide feedback, access additional information, get questions answered
   a. Utilize Ombudsman services or set up special unit in existing office
   b. Allow individuals to send email and questions via Website or dedicated email inbox
   c. Develop tracking/reporting in customer service to ID calls related to HCBS and PCS changes
   d. Public forums jointly planned with advocacy organizations and stakeholder groups (early in the process) to assist with participant engagement

<u>Sample Participant Communications/Education Topics (Table 1 –Section 7)</u>

Participant Education Topics and Content
New HCBS programs: Overview of the current HCBS and PCS programs; overview of the new program options; why the State is making these changes; what changes mean for participants (based on services they receive or are qualified for); where to call or go for more information
Eligibility: Who is eligible for the new programs and services; how and where to apply or get help to apply
Changes in Assessment Tools: Explanation of changes in the assessment processes and new tools that will be used to conduct assessments

Covered Services: Changes to existing benefits and services, who qualifies for them; description of new benefits and services, who qualifies for them; service limitations or prior authorization requirements; qualified providers; where to call or go for more information
Agency-Directed and Self-Directed Options: Explain the difference, pros/cons for each model, checklist of considerations as participants and their supports consider options.
Identifying Providers and Accessing Services: Provider responsibilities and requirements; where to get a list of qualified enrolled providers; how to choose the right providers; who to contact if there are problems with a provider
Conflict-Free Case Management: What is the role of the care coordinator, and why is it important that this function remain independent of providers or people providing supports to you? How can a care coordinator help participants make sure their supports and services meet their needs in a manner consistent with their preferences?
Person-Centered Service Plans: What a service plan is and why it is important; participating in development of service plans; including other providers in the development of service plans; including other family members or authorized representatives in the development of service plans; changes or updates to service plans, annually or as needed
Waiver Case Managers: What role case managers play; how to access a case manager; how case managers help coordinate with other care providers; who to contact if there are problems with a case manager
Role of Family Caregivers and Natural Supports: Role of family and natural supports in person-centered planning and service delivery
Other Medicaid Benefits and Services: What other services and benefits Medicaid covers; how to access other services and benefits; finding Medicaid providers; where to call or go for more information about other Medicaid services and benefits
Participant Rights and Responsibilities: Participant choice and control; abuse and neglect; complaints and grievance; Medicaid fair hearings; using advocates; confidentiality; fraud, waste and abuse

Provider Communications and Education

Provider Communications Plan Outline

Initial Communications

1. Identify target providers
   a. Current PCS and HCBS providers
   b. Current Grant Program providers
   c. Current Medicaid providers who could be PCS providers but are not currently
   d. Community non-Medicaid HCBS providers (AAAs, Independent Living Centers, other CBOs) not enrolled in Medicaid[25]
2. Develop core messages
   a. General messages for all HCBS
      i. SDS is changing the HCBS and PCS programs – here's why and how
      ii. Overview of timeline for changes and how providers and participants will be affected
      iii. What to expect over the next 12 to 18 months

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[25] Presuming that Alaska faces the same workforce challenges that most states do, it would make sense to expand the pool of providers available for both new waiver and 1915(k) benefit as SDS does outreach and education, to encourage community-based organizations such as AAAs or CILs who provide PCS under other funding mechanisms to become enrolled providers.

     iv. Training opportunities

     v. Where to go/call for more information or questions (provider relations, website, etc.)

   b. Messages specific to PCS agencies/providers – both Agency Based PCS and Consumer-Directed PCS agencies

     i. DHSS is changing the PCS program – here's why and how

     ii. Overview of timeline for changes and how providers and participants will be affected

     iii. What to expect over the next 12 to 18 months

     iv. Training opportunities

     v. Where to go/call for more information or questions (provider relations, website, etc.)

   c. Messages specific to other HCBS providers

     i. SDS is changing the Grant program – here's why and how

     ii. Overview of timeline for changes and how providers and participants will be affected

     iii. What to expect over the next 12 to 18 months

     iv. Training opportunities

     v. Where to go/call for more information or questions (provider relations, website, etc.)

3. Create materials for general provider audiences and target provider groups using messages developed

   a. Fact sheets, program briefs, Q&As, mailers

   b. Website information

   c. Provider relations scripts

   d. Presentations

   e. Newsletters

   f. Materials for providers to share with participants

4. Create dissemination plan for each provider target group

   a. Timelines for releasing information (timed appropriately as part of overall implementation plan)

   b. Establish channels and modes for releasing information (online, mail, community presentations, provider trainings, provider relations scripts, etc.)

   c. Establish mechanisms to monitor information dissemination and evaluate effectiveness/impact (e.g., track mailings, monitor provider relations calls, training evaluations, etc.)

5. Create mechanisms for providers to give feedback, access additional information, get questions answered quickly

Sample Provider Communications/Education Topics (Table 2- Section 7)

Provider Education Topics and Content
New HCBS programs: Overview of the current PCS and Grant programs; overview of the new 1915(k) programs; why the State is making these changes; what changes mean for providers (based on types of providers); where to call or go for more information
Eligibility: Who is eligible for the new 1915(k) services; how and where participants can apply for Medicaid and the new 1915(k) services

Changes in Assessment Tools (once a final decision is made on a new tool): Overview of the new tool and specific changes from the previous tool; when and how the new tool will be rolled out; what the new tool means for participant eligibility and services
Covered Services: Changes to existing benefits and services, who qualifies for them; description of new benefits and services, who qualifies for them; service limitations or prior authorization requirements; qualified providers; where to call or go for more information
Conflict-Free Case Management Requirements: What is the role of the care coordinator, and why it is important that this function remain independent of providers; how providers in rural areas can establish firewalls to offer CFCM
Person-Centered Service Plans: What a service plan is and why it is important; participating in development of service plans; including other providers in the development of plans; including other family members or authorized representatives in the development of plans; changes or updates to plans, annually or as needed
Engaging Family and Natural Supports: Role of family and natural supports in person-centered planning, decision-making and service delivery
Waiver Case Managers: What role case managers play; how to coordinate with case managers; who to contact if there are problems with a case manager
HCBS Settings Requirements: Qualities necessary to ensure a setting is eligible for HCBS funding under the 1915(k)
Other Medicaid Benefits and Services: What other services and benefits Medicaid covers; how to help participants access other services and benefits; finding Medicaid providers; where participants can call or go for more information about other Medicaid services and benefits
Billing and Submitting Claims: How to submit correct claims; where to submit claims; where to inquire about unpaid or denied claims; claims audits and reviews
Reporting Requirements and Payment Models: Quality assurance program(s); fee-for-service payments; other types of payments and payment models
Statutory and Regulatory Requirements: Federal program regulations; State program regulations
Provider Rights and Responsibilities: Enrolling as a provider with Medicaid; HCBS provider roles; complaints and grievance; confidentiality; fraud and abuse
Schedule/Location of Provider Trainings: List of scheduled provider trainings and locations (published early enough and broadly enough for providers to be able to plan to attend)
Provider recertification: New requirements and processes, documents, etc., that will be required

A Training Plan for Providers

As SDS moves forward on implementation of the 1915(k) option as well as development of the new limited Supports 1915(c) waiver and TCM for TBI populations, key constituencies will need to be supported through organized training efforts: providers, care coordination entities, staff, external stakeholders, and participants and their families with special attention paid to participants who choose the self-directed model.

Once SDS has made final decisions related to policy and program, it should work with the ICC Council to develop an outline, curricula topics, and timeline for voluntary and required trainings consistent with SDS policy related to provider qualifications and needs as defined by stakeholders. Utilizing the Alaska Training Cooperative and/or the State's Medicaid Learning Portal will offer efficiencies in online learning and provider participation tracking.

HMA presumes that current State training for HCBS providers will remain applicable, in areas such as background checks, abuse and neglect, critical incident reporting, basic safety in the home and the

community, licensing, provider enrollment, decision-making/guardianship, participant safeguards, confidentiality and privacy, fraud/waste/abuse, reporting requirements, etc. SDS should review existing training modules which may need to be updated as a result of the adoption of the 1915(k).

The specific elements of the various training needs are not unlike many of the topics addressed *Section 4k – Community Outreach* of this Implementation Plan, and all outreach and training efforts should be coordinated. Potential topics for training include:

Background and High Level Overview of Implementation. Discuss implementation decisions related to each new program (1915(k), limited Supports 1915(c), TCM) including goals of and rationale for the program. At a high level, address effect on eligibility, enrollment, service offerings, and overall impact on HCBS in Alaska.

Program Transition Plan and Process. Clarify the process for transition from the existing programs to the 1915(k), with specific decision processes for each program related to which services will continue to be provided through existing waiver authorities versus services moved to State Plan under 1915(k).

Conflict Free Case Management. Present detailed policy explanation and implementation process for conflict free case management (care coordination), with training targeted to providers, case managers, and participants/family members.

Person-Centered Assessment Tool and Processes. Describe the tool that was selected/developed, how it will be used and the rationale for changes. Offer training for case managers and providers related to development of person-centered service plans, roles, and responsibilities (including distinctions under 1915(k) for providers of agency-directed services and self-directed services). Include training on the appropriate inclusion of natural and unpaid supports in the person-centered plan.

Eligibility and Enrollment. Train providers and case managers on topics including which populations require annual recertification, monthly service requirements, and revised eligibility and enrollment processes.

Provider Qualifications. Present detailed information on changes to provider qualifications, especially If SDS implements any policy changes related to payment for family members, live-in caregivers, village-based counselors, transitional living specialists, and/or if SDS seeks to enroll other new providers.

Participant-Specific Provider Requirements. Present training for participants and providers related to the right of the participant to establish provider qualifications, to train Personal Care Attendants (PCAs) in the specific areas of attendant care needed by the participant, and to require that provider(s) perform the needed assistance in a manner that comports with the participant's personal, cultural, and/or religious preferences.

Provider Administrative Requirements. Update on any changes made or planned for annual certification requirements, regulations, annual re-assessments, reporting requirements, on-site licensing reviews, audits, technology systems/new technology and/or other administrative functions, including updated forms and/or data systems. Additionally, specific data collection and compliance requirements related to the first year maintenance-of-effort should be covered.

Billing and Rate Changes. Offer training related to any planned changes in billing, prior authorizations, or rate structures, requirements or processes.

Selecting, Managing and Dismissing Attendants. The State is required to offer voluntary training for all 1915(k) participants (and/or families, legal representatives as applicable) on how to choose, manage and release PCAs.

State Plan vs Waiver Services. For providers and staff, offer clear policy and program explanations of which services are allowable and will be provided under which program, distinctions in the service definitions, and any differences in authorizations, billing and claims processes for waiver vs. State Plan services.

Denials, appeals and reconsideration procedures. Ensure that all providers and participants understand participant protections and process.

Labor law requirements. Offer guidance and training related to federal and State labor law requirements for homecare and related workers.

Quality Assurance. Provide information and guidance on changes to quality monitoring and/or reporting, outcome measurement requirements, continuous quality improvement processes and related quality assurance activities.

Inclusive Community Choices Council. Ensure that all providers and participants are trained on and understand the role and responsibilities of the Council.

SDS will need to adopt Training Standards as part of the Quality Assurance System, as required by CFR § 441.585 (a)(4), and the topics above are intended to begin to define the areas SDS may want to consider for training, dependent upon current standards and expectations. State Training Standards under 1915(k) should be aligned with other quality assurance standards, existing training standards for PCS programs, stakeholder feedback, and final program design.

8. Experiences from Other States

The Project Deliverable for *Task 3 - Review of Regulations,* includes the detailed reviews of four states' 1915(i) and 1915(k) waivers, profiled for the Alaska HCBS study, as per the RFP: California, Maryland, Montana and Oregon. Below is a summary of the lessons learned from these states.

Lessons Learned from Other States

California 1915(i) and (k)

1915(i) Summary of Successes & Challenges

California was one of the first states to pursue the 1915(i) option, even before the Patient Protection and Affordable Care Act (ACA), which is what allowed them to have a single 1915(i) SPA. California's approved SPA provides services to individuals with developmental disabilities who do not meet institutional level of care criteria and have a need for habilitation services. California's HCBS delivery system was already designed to meet the person-centered approach to care, so met those requirements initially. They also drafted provider qualifications and service descriptions to meet the proposed HCBS settings requirements. This approach allowed the state to design the program so it would already comply with new rules, which staff noted was a big advantage, even though the state is still finalizing the implementation the transition plans for final CMS approval. Because the Department of Developmental Services staff see they will always have a hand in Quality Assurance monitoring and oversight, they did not believe that a conflict free case management was completely necessary or even practical. In many rural California areas, 1915(c) waiver service providers both develop plans and deliver services. To help ensure there are no issues with conflicts of interest, the DDS team reviews a larger sample of care plans and assessments for any anomalies or indications of conflict. After they were able to finalize the Early Periodic Screening Diagnosis and Testing (EPSDT) carve out and reimbursement methodology, California DDS staff said they did not experience any major challenges related to implementation of their 1915(i) program.

1915(k) Summary of Successes & Challenges

Again, California was the first state to submit a SPA to implement the Community First Choice 1915(k) Option under the new ACA rules. California was serving individuals in the community through the personal care services program, In-Home Supportive Services (IHSS), as well as 1915(c) waivers and State-funded programs. The state also had in place a robust county-based infrastructure to support administrative functions for personal care services, which made pursuing the 1915(k) authority and the additional 6 percent FMAP rate an easy decision. Using the 1915(k) authority, California successfully averted program reductions at a time when other states were making cuts to Medicaid. The state expanded opportunities for individuals with a Nursing Facility Level of Care to receive services that would allow them to safely remain in the community, as well as expand services to the ages 80+ population.

However, although the state received $300M in additional federal funding for 1915(k) program, staff noted that had they pursued a budget neutral proposal, the state would not have been able to implement the changes necessary to comply with the program. Because much of California's settings and processes were already in compliance with the HCBS rule, they did not have to make significant program changes other than updating some aspects of their plan to comply with the final rules.

Maryland 1915(i) and (k)

1915(i) Summary of Successes & Challenges

The 1915(i) was one component of the Maryland Department of Health and Mental Hygiene's (DHMH) health reform and behavioral health integration efforts to facilitate transformation of behavioral health services, in particular for services to children/youth with Serious Emotional Disturbance (SED) who met residential treatment center criteria but were able to be served in the communities. DHMH also pursued a health home SPA, moving behavioral health services into the Medicaid budget, and developed a targeted care management (TCM) service. DHMH staff invested significant time and energy in initial onsite and quality oversight processes during the first year of the TCM program, and noted that while taxing on staff and providers, it allowed the state to truly understand provider needs and how to best support providers and the program. An additional critical investment DHMH made was getting buy-in from local core service agencies, including monthly meetings that helped the state develop collaborations and champions who were key to making program implementation as smooth as possible.

The state's biggest challenges were during the planning phase, but through a deliberate and thoughtful implementation, they were able to mitigate many of the issues that arose. Another challenge was that some of the competitive procurement processes at the local level that were meant to eliminate conflicts in case management services resulted in incumbent providers losing contracts. Many of these providers tried to keep their case-loads by moving them into other programs. This required significant DHMH monitoring, oversight, and clear communications to all parties to limit the impact on members.

1915(k) Summary of Successes & Challenges

Maryland was the third state to implement the 1915(k) Option, at the direction of the State Legislature to garner the additional FMAP and expand access to HCBS services, not to save money. At the same time, the state merged two 1915(c) waivers that offered similar services to different populations, to create a new waiver that covered services that are not permissible under 1915(k). DHMH redesigned the State Plan personal care program (Medical Assistance Personal Care, or "MAPC"), available to individuals who need assistance with one ADL but do not meet Nursing Facility Level of Care, to align procedures with those in 1915(k) and better facilitate transitions between the two programs. The state's goal in implementing 1915(k) was not to save money, but rather to expand services, which it did successfully. However, because they were not backfilling their waiver slots, the increase in 1915(k) enrollment had been offset by a decrease in waiver enrollment. They now have begun to fill waiver slots again. DHMH uses 1915(b)(4) authority to limit providers through a competitive solicitation that also requires responders to disclose any conflicts; plus, they developed conflict of interest standards that are included in their policy guidance to the network.

Because 1915(k) was only one piece of a larger reform effort by DHMH, they encountered challenges particularly with engagement and training of their partners. Implementation of multiple programs resulted in a large amount of trainings and retraining, all of which impacted the 1915(k) implementation timeline. DHMH noted they did not expect how hard it would be to change the way the existing case managers functioned.

The state also continues to struggle to motivate case managers to provide quality service delivery when paid fee-for-service, so they are pursuing a pay-for-performance initiative that would reward quality.

DHMH also is developing a more prescribed process for person-centered care that will enable better and more consistent monitoring of providers. Finally, the state had originally received CMS approval to use their 1915(c) waiver quality assurance plan for 1915(k). Recently they received a request from GAO to

produce a quality plan for 1915(k), so now are creating a separate quality assurance plan for 1915(k) to meet federal requirements.

Montana 1915(i) and (k)

1915(i) Summary of Successes & Challenges

In 2007, Montana was awarded the Psychiatric Residential Treatment Facilities (PRTF) Demonstration Grant to serve children with SED who met PRTF criteria in the communities where they resided. As the demonstration period closed, the Department of Public Health and Human Services (DPHHS) opted to pursue a 1915(c) bridge waiver for children receiving demonstration services prior to the demonstration's termination and a 1915(i) State Plan option for new service recipients. Despite the success of the demonstration program, political issues have led to low enrollment in the 1915(i) program. The legislature consequently defunded the program and today only two children remain enrolled. While the state has considered converting the 1915(i) target population to include youth with developmental disabilities and autism, initiation of the work to make this change is pending CMS' approval of the state's Transition Plan. DPHHS identified unique program features that would be beneficial to the target population, such as wrap-around and team based planning, that could have led to greater engagement of the state's tribal populations and young people. Over time, DPHHS determined that some providers were duplicating services between the 1915(i) and State Plan services and implemented audits to review billing practices and remedy the issue. Rather than Targeted Case Management, the 1915(i) used the high-fidelity wraparound facilitation for care planning and care coordination from the original demonstration program. DPHHS staff believe that because providers opposed the high-fidelity wraparound facilitation, they created barriers to enrollment in the 1915(i) program, and that the program may have been more widely accepted without the high-fidelity wraparound.

1915(k) Summary of Successes & Challenges

Montana has provided access to home and community-based Medicaid services through a Personal Assistance Services (PAS) program since the late 1970's and a 1915(c) waiver since 1982. Under the PAS program, most recipients were self-directing their care, so the 1915(k) option was a natural fit. DPHHS considered whether the 1915(k) program would support Montana's rebalancing efforts to develop integrated HCBS system and allow the state to build on successes in the PAS and HCBS waiver programs. They also noted it was also important to demonstrate that the option would increase funding for improved service delivery. Montana was able to minimize the wood-work effect that other states have experienced under 1915(k) in part due to the work that the state did on the level of care and their long-standing PAS and waiver programs with good penetration already. Piloting processes and forms with a provider before implementing them statewide also enabled DPHHS to make adjustments that reduced questions from providers and improved the adherence to the new materials. DPHHS staff were surprised by how hard it is for waiver case managers to manage State Plan services and found that no one wants to own the State Plan service coordination on the waiver side. They believe this is in part because waiver case managers had only managed waiver services before. Consequently, DPHHS has had to retrain all waiver case managers on how to manage non-waiver services.

The Developmental Disability (DD) delivery system network is inclusive of DD providers that provide a "bundle" of services. However, CMS would not authorize bundled services to be moved wholesale to the 1915(k); thus those services remain in the waiver and as a result, there are members on the DD waiver who should be getting 1915(k) services but don't want to leave that provider network. The state still sees the 1915(k) has provided an opportunity for people on the DD waiver waitlist to access some

services if they meet the level of care, and the state can provide them a more robust State Plan service. Lastly, there have been some challenges with claims payment because DPHHS relies on eligibility files to allocate claims to the 1915(k) program. Staff think that it would have resulted in a smoother process had they set up the MMIS to tag these claims as 1915(k) on the front end.

Oregon 1915(i) and (k)

1915(i) Summary of Successes & Challenges

A gap in the service continuum prevented individuals in Oregon with SMI from being effectively served in the community, as they were limited to residential and state hospital services only. The state saw the 1915(i) State Plan optional benefit as an opportunity to increase access to services and supports that promote independent living and choice and decrease reliance on institutional and residential care for individuals with SMI who require assistance with at least two activities of daily living that take at least one hour per day to provide. Services are need-based and include Home-Based Habilitation, Behavioral Habilitation and Psychosocial Rehabilitation Services. The 1915(i) option is currently up for renewal and the state indicated it does intend to make amendments during the renewal process. Oregon was able to use 1915(i) to expand access to new services for individuals with behavioral health needs, while also effectively minimizing the administrative burden on providers through the use of daily, monthly, and case rates. Because the state has not removed the General Fund liabilities (a $3M biennium spend on non-licensed rehabilitative settings), they have not been able to take the anticipated savings from leveraging federal match to pay for services not previously covered. Oregon has been working with CMS to clarify the state's perspective of the value that was achieved through the integration of service delivery with assessment and service planning. Additionally, the state had not fully implemented conflict free assessment for 1915(i), although staff expected that it would be final in June 2016 and would be addressed through state-wide transition and the 1915(i) renewal process.

1915(k) Summary of Successes & Challenges

Oregon pursued the 1915(k) authority – which it calls the "K Plan," as a means of maximizing the additional 6 percent FMAP rate and reinvesting it into the system to expand services in the community. Prior to the implementation of 1915(k), Oregon provided HCBS through its State Plan personal assistance services (PAS) program and six 1915(c) waivers. The state chose to maintain existing level of care criteria and lift the waiver programs out of the 1915(c) and move them in the 1915(k), as well cover expenditures for transition costs and expenditures that substitute for human assistance, such as environmental modifications, assistive devices, and community transportation. However, the state has seen expenditure growth in LTSS that has considerably outpaced projections due to more services allocated, higher payment rates, and reduced cost-share requirements associated with the in-home allowance. Being able to use the 1915(k) enhanced FMAP for transitions was important to enable Oregon to keep community service utilization primary, and permissive services have been very valuable to beneficiaries. To comply with the person-centered planning requirements, Oregon had to implement a single assessment tool, to which IDD stakeholders did not respond favorably. 1915(k) also created conflict of interest issues for individuals on the APD and IDD waivers who had family/guardians who were making decisions for them and being paid under the 1915(c) waiver as providers. Significant negative feedback from the advocate community led to the state and CMS developing a policy that allows a guardian to delegate the authority for directing services to a Designated Representative who is not paid. Another challenge in Oregon relates to a perception that any need identified in the assessment had to be met through services as opposed to natural supports, due to the statutory prohibition in 1915(k) on supplanting services with natural supports, which increases service utilization substantially.

The state has since received clarification from CMS on how to implement this provision, and is addressing the issue with case managers and within the assessment/plan development process. The most significant challenge, however, has been the growth of the program because the state expanded services to the MAGI population and children creating a financial burden that the state is challenged to sustain even with the additional FMAP. Based on current funding under the ACA, the MAGI services are being matched by the expanded FMAP rates, so CMS is paying for those services; but eventually the state will become fully responsible for these expenditures. Additionally, as a State Plan option, this set of services has been opened up to a larger population of children than before. The shift to the K Plan has created an entitlement to long term care.

Best Practices in Other States

To date, 17 states have adopted one or more 1915(i) State Plan optional benefits for children or adults,[26] while eight states have been approved for 1915(k).[27] Only four states currently offer both 1915(i) and 1915(k) State Plan optional benefits: California, Maryland, Montana, and Oregon. HMA conducted a focused review of the programs in each of these four states.[28] Similar to the *Lessons Learned*, below we have outlined several best practices for implementation of HCBS services through 1915(i) and (k) that were gleaned from the research conducted with these four states, as well as knowledge gathered from HMA's work in other states.

Key Recommendations and Best Practices from States

State Medicaid programs, while they must operate within the parameters of federal rules and regulations, differ greatly; and those differences are driven largely by each state's current and past political and financial environment, as well as historical Medicaid program design. It is, therefore, critical to understand state context when reviewing experiences states have had with various components of their Medicaid programs, such as those available through the 1915(i) and (k) waivers. Because these are entitlements, and have the potential to grow and create financial strain on Medicaid and state budgets, states' overall Medicaid program goals, how they have approached providing similar services in the past, and the influence of their various advocacy and stakeholder groups are among the factors that contribute to the level of risk states are willing to accept in the design and implementation of their 1915(i) and 1915(k) options. Through the state research HMA conducted, we identified the experiences and goals that drove states' implementation of these programs and have compiled the recommendations and best practices that we believe are most applicable to Alaska. Many of the recommendations noted are applicable regardless of whether designing or implementing a 1915(i) or 1915(k) SPA.

Planning

Eligibility. As entitlement programs, there are few levers to controlling the growth of both the 1915(i) and 1915(k) State Plan options once implemented. For this reason, states expressed how important it is to really understand eligibility criteria, both financial and functional/diagnostic. For example, this has particularly impacted Oregon, where they have been experiencing unanticipated growth in their 1915(k) program because they expanded eligibility to the MAGI population and a subset of children.

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[26] See: http://kff.org/medicaid/state-indicator/section-1915i-home-and-community-based-services-state-plan-option/

[27] See: http://kff.org/medicaid/state-indicator/section-1915k-community-first-choice-state-plan-option/

[28] This information can be found in Project Deliverable for *Task 3e – Summary of 1915(i) and (k) Rate Structures in Other States.*

Oregon state staff said CMS has made it clear that even if the program expands beyond what the state estimated, it cannot be rolled back because of the sufficiency requirements. In California they used clear cut functional or diagnostic criteria to target their 1915(i) population. As Alaska designs its program(s), the State needs to be very deliberate in how it defines the populations who will be eligible and how it uses data to project program impacts so it does not end up in a situation similar to that of Oregon.

Services. States essentially took two different approaches to developing the service arrays for their 1915(k) programs. California, Maryland and Oregon used as much of their existing programs as CMS would permit and moved them into the 1915(k) to maximize the additional federal match. Montana sought approval only for services required under 1915(k) and chose not to create permissible services they did not already have. In hindsight, California, Oregon and Montana all strongly recommended that any state considering the 1915(k) start with a minimalist approach. They noted and agreed that it would have been better to start with less and limit the initial program to just the required services, and wait to implement any permissive services until they had experience with the program and more data to understand the population and utilization better.

Fiscal Impact. While the incentive is for states to use 1915(k) as a mechanism to leverage the additional FMAP for existing services (6%), California and Maryland both noted that had they pursued budget neutral proposals, they would not have been able to implement the changes necessary to comply with the federal requirements. As Alaska continues to study the fiscal impact for 1915(i) and 1915(k), it should consider not only the service costs but also address the administrative costs that are associated with such changes (e.g., assessments, IT systems, staffing, training, etc.), which can be significant.

Development and Implementation Councils. States engaged Development and Implementation Councils required for 1915(k) to varying degrees, based largely on their existing structures, processes and histories with engaging stakeholders. Montana worked closely enough and early enough with its Council to develop the program and definitions and together they were able to challenge CMS and maintain the joint vision they created. But Montana also cautioned that states must set reasonable expectations with Councils because members can get excited about expanding services and lose sight of the long term impacts. It is in Alaska's best interest to cultivate a strong and ongoing relationship with its Council and provide members with a clear understanding of the State's goals for the system so they can help the State create both short-term and long-term strategies that benefit individuals who need services, while not having a negative impact on the State budget.

CMS Approval

Engagement with CMS. Every state reiterated the importance of engaging CMS early and often in the process for both 1915(i) and (k) programs. One key recommendation is to create a framework for the State Plan option that addresses the core elements of the program and dialogue with CMS informally to get their guidance as the state develops the SPA. States that worked closely with CMS from a very early point in the process received approval more quickly and avoided wasting time on things CMS would not approve. States also noted that large scale transformations with multiple SPAs are very complex, so it was an advantage to have the informal communications with CMS so they could raise questions and voice concerns about how programs were interrelated and potential duplication, outside of the formal RAI process. Alaska will need to assess its readiness for engaging with CMS during the planning process and make a strategic decision about how and when to begin the dialogue with CMS.

Negotiation with CMS. Negotiations do not need to wait until the SPA is ready for submission; in fact, as noted above states agreed that engaging with CMS early to bring them along in the development

process facilitated CMS buy-in to the state's goals and vision for the program. Early CMS engagement and the state's ability to clearly articulate how its vision fit within the federal program goals and requirements help to form a critical foundation for the negotiation process. States deliberately and carefully used language and terminology from the federal rules to describe their programs, which also helped to ensure that services were clearly defined within CMS' covered benefits. For the 1915(k) program, states agreed that their Councils were a significant point of leverage for them. When the state could show the full support of its Council, they were more likely to be successful in reaching agreement with CMS and getting approvals of their programs.

Compliance with Federal Rules. States cautioned that CMS is holding firm on the HCBS final rule, including not only the settings rule, but also person-centered planning and conflict free requirements. This means it is vital for Alaska to design new 1915(i) and/or 1915(k) SPA in alignment with the State's existing transition plan and conflict of interest activities. Some states have sufficiently addressed the conflict free requirements through competitive contracts; however, rural states like Montana and Alaska have significant provider access and workforce issues, so must develop policies that clearly address how they will monitor and mitigate any conflict, while still ensuring adequate access to qualified providers and services. Montana was able to negotiation with CMS a definition of person-centered planning and approach to the process that met the intent of the rule, while also accommodating the state's unique challenges. Alaska should address these requirements early in the planning process and discuss potential mitigation strategies with CMS informally so these issues do not impact the timeline of the State's SPA approval.

Implementation

Take a Measured Approach. Every state recommended building in ample time to implement new 1915(i) and (k) programs, including time to allow for unexpected issues outside of state or program staff control. They also recommended taking an incremental approach, starting small and growing. This allows the state to better manage unexpected issues that inevitably arise during any kind of new program implementation. Several of the states noted that they had planned for relatively short implementation timelines, but that this actually caused some delays and other negative outcomes. For example, Maryland and Montana had longer than expected implantations because it took additional time to train and prepare providers and case managers than they had planned. Montana also identified post-implementation billing errors that required substantial back-end audits due to what they felt was inadequate preparation up front. Assessing provider and case manager readiness on a regular basis requires staff resources on the front end, but can alleviate challenges from having to rework or fix processes, systems, or materials. Finally, most states recommended implementing only one program at a time. The volume and magnitude of change associated with implementing 1915(i) or 1915(k) options as part of a system transformation created significantly more challenges for staff and providers to manage when compared to a single program implementation.

9. Summary of Input from Focus Groups & Community Forums

Themes from Community/Provider Forums Related to Home and Community-Based Services Medicaid State Plan Options 1915(k) and 1915(i)

Health Management Associates (HMA) and the State of Alaska's Department of Health and Social Services' (DHSS) Division of Senior and Disabilities Services (SDS), along with the Division of Behavioral Health, conducted forums in nine communities throughout the State to provide information on the opportunity of the Home and Community-Based Services (HCBS) Medicaid State Plan options and to obtain input from community members and service providers in the design and implementation of these programs should the State choose to pursue them. Below is a list of the communities in which forums were held and the dates of these activities. HMA and SDS also conducted a State-wide webinar for individuals who were unable to participate in the in-person forums. The forums were held in:

Anchorage:	October 29 and 30, 2015
Barrow:	November 12, 2015
Bethel:	December 18, 2015
Fairbanks:	November 10 and 11, 2015
Juneau:	January 7, 2016
Kenai:	December 15, 2015
Ketchikan:	January 6, 2016
Nome:	December 16 and 17, 2015
Wasilla:	January 8, 2016
Statewide Webinar:	January 13, 2016

At each location, there was a community forum, and depending on the number of providers in the area, between one and four provider forums, as well as individual meetings with selected provider organizations. While the provider forums were open to all providers, particular emphasis in recruitment was placed on providers of service for seniors, individuals with developmental disabilities, individuals with Serious Mental Illness, and individuals with Traumatic Brain Injury. All sessions were open to the public.

The forums were typically two hours in length, and began with a presentation[29] on the HCBS State Plan Options followed by testimony and open discussion. Kenai Reporters transcribed each of the forums word for word. HMA reviewed the transcripts, and identified themes and issues for each forum in each community and the State-wide webinar. Once all forums and the webinar were completed, HMA reviewed themes and issues documented from across the State, coded, and categorized them into several topic areas. The most salient themes from across the State are described and presented below. There were other important issues and ideas noted by participants in the various forums and community meetings which HMA did not include in this summary report, as they were not relevant to the scope of this particular project. However, as the meetings were transcribed word-for-word, SDS has documented the information and will be able to use it to support both this project effort, as well as other reforms in the Division and across the Department.

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[29] The presentation can be accessed on the Senior and Disabilities Services website at http://dhss.alaska.gov/dsds/Pages/MRICC/MRICC.aspx

Person-Centered Planning and Coordinating Care

This section describes the issues, ideas, and concerns raised by forum participants related to person-centered planning.

Person-Centered Assessment

The State Plan Options require "person-centered planning", which is a process where the needs, goals, and preferences of the participant, as described by the participant along with family, friends, and care team members, are foremost in the planning. Several providers indicated the need to assure the use of a person-centered assessment tool that primarily serves to determine individual needs and desires, "not just right-sizes services."

Providers indicated that some of the current survey tool response options are "black and white" and that this needs to be changed to be able to capture a better understanding of the individual. For example, for a person with a behavioral health issue, the answer to an assessment question may be "yes" one day and "no" the next. An additional point was made by providers and community members that the assessment tools are only as good as the person administering them, and that we need to assure person-centered training for assessment staff.

Coordinating Care

Another theme that emerged from providers was the need to coordinate services for individuals that have a complexity of issues that don't neatly fit into one category, such as individuals with Intellectual and Developmental Disabilities (I/DD), as well as Serious Mental Illness (SMI). Providers raised concerns about how the assessment will accommodate individuals with co-occurring diagnoses and the need to minimize the assessment burden for such individuals. Providers also requested to continue the requirement of face-to-face assessments in the home; "assessments done in a clinical setting do not reveal the needs that become apparent when the assessor observes the home environment and the caregiver situations." Providers indicated that there is "enormous energy and capacity in the existing provider network, if silos are pulled down and regulatory restrictions changed, we can innovate."

Individualized Budget for Services

Providers also advocated for individuals to be able to control an "individualized budget" and purchase services in line with their own goals. Consumers advocated for local control and its importance in identifying problems and solutions to those problems. While SDS acknowledged that the idea of individualized budgets is important to consider for the future, it noted that at this time it would not be implementing this type of change in Alaska's 1915(k) State Plan option.

Service Hours Based on Individual Need

Community members gave testimony about the need to provide hours of Personal Care Services (PCS) based on the individual in the context of their existing support network. One example provided by a participant included the State cutting back on overnight support hours even though it has become too difficult for the aging caregiver to provide this support. The participant indicated that she strongly preferred to remain at home but "this action may ultimately lead me to having to be supported by the State at a much greater cost in an institutional setting." Again, SDS acknowledged this as an important consideration, but noted that it will not be considered for inclusion at this time in Alaska's 1915(k) State Plan option.

Target Populations

Individuals with Alzheimer's Disease and Related Dementias (ADRD)

Providers discussed the great need for services for the large population of individuals with ADRD that do not meet nursing facility level of care. Services for these individuals, such as cuing and other supports, are in great demand. They also described a sizable group of seniors with behavioral issues admitted to the Alaska Psychiatric Institute that don't meet nursing facility level of care; these individuals are not accepted to senior homes because these homes are not prepared to address the behavioral issues.

Individuals with Behavioral Health Diagnoses

Providers and consumers gave testimony to the importance of assisting individuals with SMI and/or Substance Use Disorder (SUD); indicating concern about individuals that fall through the cracks of services offered by Senior and Disabilities Services, and the Division of Behavioral Health.

Both community members and providers expressed a great need for expanding or making more robust the system for behavioral health services. Consumers noted increases in suicides in the State and the need to prevent these. Providers discussed lack of behavior supports available, and also emphasized unmet needs of the "General Relief Population" and the need for more services for this population and that a majority had SMI.

Individuals with Traumatic Brain Injury

Individuals with TBI and their advocates indicated that this population is under-diagnosed and under-treated [further described in the *Workforce* section on Page 4.]

HMA and SDS also noted that community members raised the question of supports and services for individuals in the justice/correctional system, as well as for those with Fetal Alcohol Spectrum Disorder. While important populations that deserve attention, both of these groups were outside of the scope of this project effort, so no analysis related to them was conducted.

Service Needs

Supportive Housing and Supported Employment

One of the strongest themes related to service needs that emerged is the need to "focus on things that stabilize individuals such as supportive housing and supported employment." Community members and providers discussed the difficulty that individuals with SMI, SUD, and/or criminal backgrounds have in being able to find housing, treatment options, and supported employment if needed.

Low-Level Supports

Providers advocated for more "low-level supports" (personal care attendant-like) for individuals with SMI appropriate to their needs, and agreed that "even low-level supports can prevent emergency department visits."

Transportation

Many community members and providers emphasized the need for transportation, as well as a medical escort to ensure individuals get to their medical and behavioral health appointments and have an advocate with them. "[These enabling services] will prevent more costly emergency department visits and hospitalizations." Participants indicated that transportation is also "needed for other activities required for individuals to stay at home such as grocery shopping."

Technology Supports

Providers and community members advocated for coverage of Personal Emergency Response Systems and other technologies that can support individuals in living at home and/or living more safely at home.

Workforce Issues

State Workforce

Providers expressed concern about the efficiency of the existing state infrastructure to manage the new State Plan optional benefits; "currently it takes months or years to access benefits." Community members also expressed concern about the impact new programs would have on an already limited workforce at the State level, citing lack of staff to return phone calls and address questions related to current State and Federal programs.

Capacity of Provider Workforce

Pediatric providers talked about children being sent out of state because services do not exist in Alaska to keep them home. Consumers and providers alike gave examples where individuals living in rural areas need to travel great distances to receive care and where Medicaid beneficiaries were denied coverage for a personal care attendant (PCA) to travel with them to obtain medical services, which creates a barrier to getting needed care.

Community members indicated that current workforce challenges result in long waits for service and expressed concern that this would become worse as they anticipate a greater demand for services under the State Plan Options.

Individuals with Traumatic Brain Injury (TBI) and their providers advocated for workforce development specific to this population. They identified a need for provider education on TBI and case management particular to brain injury to address unique needs, as well as an array of services for which there are current workforce shortages such as: cognitive rehabilitation, physical therapy, occupational therapy, vision therapy, speech and language therapy.

Community members, as well as some providers, indicated that providers do not always have the appropriate training to manage behaviors of individuals with SMI and will admit them to the Alaska Psychiatric Institute instead of treating in the community.

Quality of the Provider Workforce

Community members discussed their experience with direct support providers and indicated that "maintaining stable, experienced staffing is a challenge." Participants provided testimony on "unprofessional and unskilled workers" conducting assessments and providing in-home assistance. They emphasized the importance of background checks on personal service attendants to ensure client safety.

Proposed Solutions

Many community members and some providers advocated for payment for live-in/family caregivers; for many populations needing home and community-based services, it is the family members who are caring for them.

Providers discussed other types of workers to help address some of the workforce issues such as "village-based counselors" in rural communities and "transitional living specialists" for individuals with Traumatic Brain Injury – individuals who have recovered from brain injury themselves and assist others with TBI in becoming more independent.

Providers expressed the need for training dollars for Direct Service Providers to "support skill-building of clients."

Providers also discussed the need for health profession education to expand the workforce, and cited such efforts as a health academy in Anchorage and establishments of a registered apprenticeship training cooperative.

Alaska's Unique Features and Implications

Providers discussed the unique features of Alaska – lack of road systems, frontier regions, unique regional political/economic systems – and indicated that looking to the Lower 48 for implementation models may not be appropriate. Other providers addressed some of the same features of Alaska that make determining eligibility different than in many other states. For example, an individual may have the ability to mop their floor but they don't have running water and they need wood for their wood stoves; these individuals may need assistance with hauling water and chopping wood to be able to stay at home.

Community members and providers expressed interest in ensuring that the great differences in the cost of living across the State are taken into account when determining financial eligibility for the State Plan Options.

Workforce capacity is limited, especially in rural and frontier areas in the State. Providers indicated that "streamlining processes will be important to maximize the limited provider time available for direct service."

Opportunity to Improve Operational Efficiencies

Eligibility/Enrollment

Community members provided testimony on the bureaucracy and burden of Medicaid recertification and appealed to the State to streamline this process.

Hospital providers discussed the lengthy process to obtain General Relief (GR); sometimes it will take up to a month for an individual to qualify for GR, which is necessary for discharge to an Assisted Living Home. "For 30 days they sit in the hospital; hospitals in Alaska are full of people that don't belong there."

Providers expressed concern about young people with disabilities going from school straight into day habilitation instead of working so they don't lose their SSI benefits. "This is done to avoid the possibility of parents having to reapply for their family member's SSI because it is such an onerous process."

Assessments and Assessment Tools

Providers advocated for streamlining annual re-assessment for individuals with lifelong disabilities where level of disability does not change from year to year. Providers expressed strong interest in participating in the selection or development of a functional assessment tool; and encouraged the State to consider tools that take into account the different types of functional impairments across populations.

Provider Burden

Providers expressed concern about the burden the introduction of the State Plan optional benefits might put on providers -- certification requirements, assessments, paperwork, regulations, reporting requirements, on-site licensing reviews, audits. Providers appealed to the State to streamline these processes as the system is currently burdensome.

Providers emphasized the need to ensure adequate care coordinator capacity prior to rolling out the State Plan Options. They expressed the need to clarify care coordinators' roles, and strongly advocated for certifying care coordinators across programs.

Technology

The use of technology in current programs is very limited, and some of the current information systems were described by some providers as "dysfunctional." Providers expressed the need to reduce paper and manual processes; "everything that can be done electronically should be considered." Providers appealed to reduce the volume of documentation required and reduce the complexity of audits.

Providers identified opportunities to streamline processes using technology. For example, they suggested the development of a consistent care plan approach with integration where appropriate – across 1915(c) and (k) programs -- and an investment in interfacing systems to enable care plan access across agencies. Another example is to have care coordinators conduct both face-to-face visits and virtual visits which would allow them to carry a larger caseload.

Conflict-Free Case Management

Community First Choice – 1915(k) – requires "conflict free case management" which is the provision of case management (known as care coordination in Alaska) services by an independent entity, one that does not have a conflict of interest in either the assessment or development of the care plan. Providers expressed concern about the ability to be "conflict free" in rural and frontier areas where there may only be one organization -- the only game in town -- for direct service provision and case management/care coordination.

Continuing Communications with Stakeholders

Community members and providers appreciated the opportunity to participate in the forums and to share their concerns, as well as offer ideas and suggestions for improvements. They asked that SDS continue to make information available to stakeholders through a variety of mechanisms and channels, including additional public forums across the State as decisions are made and programs implemented.

Participants specifically noted they would like to continue to be informed about:

- How their input and feedback from these initial forums will be incorporated by SDS into ongoing planning and implementation work.
- When there would be other opportunities for the public to be involved in implementation planning, and what those opportunities would be.
- SDS' timeline for decision-making and implementation of the various program options.

10.   Questions Posed to CMS and Their Responses

While no questions were raised to CMS during the development of this report, HMA suggests that SDS engage early and often with CMS in the development of the new state plan and waiver services.

SDS may want to ask CMS questions about/discuss a variety of topics, such as:

1. Any anticipated technologies or devices in lieu of human assistance that the state may want to consider including especially for individuals in frontier, rural, tribal, or undeveloped regions of the state.
2. The timing requirements related to the Maintenance of Effort (MOE) provision under the 1915(k), in order to ensure implementation aligns with state budgeting as discussed above.
3. How the implementation of the new assessment tool may interact with Maintenance of Effort requirement under 1915(k).
4. Ensuring SDS plans for assessments via electronic means for 1915(k) participants are consistent with §441.535 Assessment of functional need requirements.
5. Development of conflict free case management consistent with federal requirements in frontier, rural, tribal, or undeveloped regions of the state.
6. Changes required in current State Plan for Personal Care Services for individuals who do not meet level of care criteria.
7. Establishment of final rate methodology for the new programs.

This list is intended to be exemplary and it is not inclusive of all subjects.

States that have implemented new waivers and substantial changes in recent years have found that working collaboratively with CMS in the development of the application/renewal, and utilizing the HCBS technical assistance program, can result in more effective programs and efficient approvals. Given the scope of proposed changes in Alaska, asking questions and receiving clarifications from CMS will be important.

11.   Conclusion

HMA supports and commends the State of Alaska in its pursuit to improve quality, implement program efficiencies and contain costs by reducing reliance on high cost, institutional settings and providing Alaskans personal care services (PCS) in their homes through programs such as the Community First Choice 1915(k) State Plan option, as well as considering other options to improve and expand access to HCBS.

After an extensive multifaceted review of the existing HCBS program environment in Alaska, including a cost analysis of current service and operational expenditures, HMA recommends that SDS pursue the 1915(k) State Plan option. HMA believes that implementing the 1915(k) will allow Alaska to transition individuals that meet the State's established institutional level of care criteria to a State Plan option for PCS that is aligned with the principles of HCBS programs. Today, these individuals are receiving PCS through the State Plan coverage but not getting care coordination, person-centered planning or the other mandatory services required of the 1915(k) such as back-up plans to ensure continuity of care and voluntary training to assist participants in self-direction. In addition to proving a high quality benefit and gaining program efficiencies, receiving federal approval to implement the 1915(k) will give Alaska a six percent increase in its Federal Medical Assistance Percentage (FMAP) for these participants, expected to produce an overall savings for the State within the first two years of program implementation.

HMA also recommends that Alaska seek federal approval to amend its Medicaid State Plan to include Targeted Case Management services for individuals with traumatic and acquired brain injuries (TABI). The cost analysis indicated this would allow SDS to provide assistance to individuals with TABI without creating a significant budget impact. HMA further recommends that Alaska seek federal approval for a new, limited Supports 1915(c) waiver for persons with Intellectual and Developmental Disabilities (I/DD). This limited Supports 1915(c) waiver would be capped at a maximum number of individuals participating, as well as a maximum cost for each participant's plan. It would cover individuals who require services that are supportive in nature such as day and employment services, as opposed to residential care.

This Implementation Plan provides SDS with both general guidelines and more detailed information to make informed decisions as it thoughtfully proceeds to operationalize these changes in its current HCBS programs.