CONFLICT-FREE CASE MANAGEMENT SYSTEM DESIGN

Prepared for Alaska Association for Developmental Disabilities
By Agnew::Beck Consulting and HCBS Strategies
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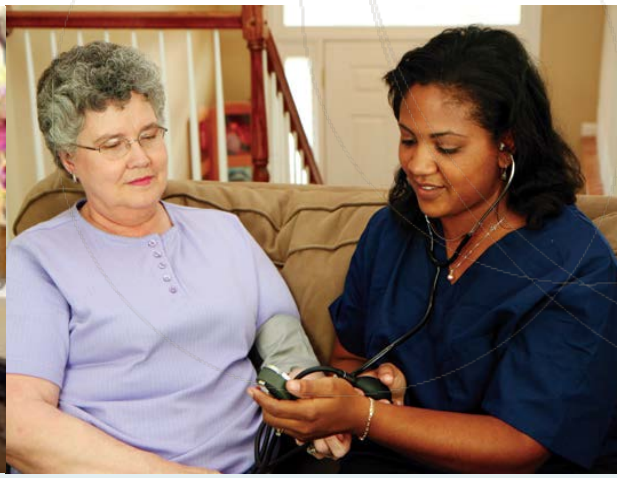

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1. INTRODUCTION

PURPOSE AND STRUCTURE OF THE REPORT

PURPOSE

Alaska currently funds its Medicaid-funded Home and Community Based Services (HCBS) Waivers under the 1915(c) waiver authority. US Centers for Medicare & Medicaid Services (CMS) published final rules that were effective on March 17, 2014 that affect these waivers. These rules have major implications for how case management, called 'care coordination' in Alaska, is provided under Alaska's waivers because they require that providers of HCBS direct services cannot also provide case management, except in very limited circumstances. While person-centered planning has long been standard practice for many of Alaska's providers, separating case management from service provision will require additional focus on person-centered planning and a restructuring of case management activities.

It is important to note that other major initiatives in Alaska are also seeking to restructure case management. The State has engaged in a number of systems change efforts aimed at integrating case management and making it more comprehensive. In developing a plan for complying with the conflict-of-interest requirement, it will be important to understand these other plans to help ensure the conflict-of-interest compliance plan does not undermine or complicate other plans.

This project is an opportunity to build upon person-centered planning and values, to improve quality of case management and to increase accountability in Alaska's HCBS system. It is also an opportunity to design a streamlined and comprehensive case management system that is effective for recipients and providers across all Department of Health and Social Services (DHSS) structures and that has the potential capacity to meet needs across the spectrum of Medicaid recipients. In a comprehensive case management system, participants would not have multiple case managers and the model would be scalable to serve other individuals, potentially including those not covered by Medicaid. For example, private insurers are increasingly using case management to monitor quality, reduce cost and improve health outcomes. Ideally, this will result in a more effective model that improves health and functioning for the individual and reduces costs for the system.

In this effort, we took a two-pronged approach. One, we sought to develop a plan for complying with the conflict-free requirements of the CMS rule that must be addressed as soon as feasible. We have developed a draft plan for compliance, and we note areas that may be problematic. Two, we tried to determine if there was a consensus regarding a longer-range vision for how case management for individuals with disabilities and older adults should be structured. We found that there was strong consensus regarding a vision for building comprehensive, integrated case management infrastructure.

TIMELINE

The timeline for this project was from December 2014 to February 2015. The consultant team performed a series of key informant interviews to learn about case management in Alaska currently and to identify pertinent lessons from other states also transitioning to conflict-free case management. This was followed by a stakeholder work session in January 2015 where the group reviewed the decisions required to comply with the CMS rules and worked in small groups to identify key elements of the conflict-free case management system design for Alaska. The work session also addressed the timeline for reforms.

Building from the results of the first work session, the consultant team and the steering committee for this project developed a draft set of recommendations and an implementation plan that was reviewed by the stakeholders at a second work session in February 2015. This report compiles the results of the work completed by stakeholders and State representatives and provides key directions for developing the conflict-free case management system for Alaska.

STRUCTURE OF REPORT

This report includes five main sections:

- This first section introduces the report.
- The second section describes the CMS rules that require conflict-free case management, current case management practices in Alaska, lessons learned from other states, the reforms needed to comply with the CMS rules and the case management activities that will be altered as Alaska responds to the CMS mandates.
- The third section provides a draft plan for complying with the CMS conflict-free requirements and includes four possible options for developing infrastructure to support conflict-free case managers. This section also includes an implementation plan for the period from March 2015 to June 30, 2016.
- The fourth section describes a longer-term vision for a major restructuring of case management in Alaska supported by the stakeholders convened for this process. This section includes an implementation plan for the period from July 2016 to July 2017 during which additional reforms may be undertaken to achieve a comprehensive approach to case management for additional Medicaid.
- The final section describes the level of stakeholder support for the key issues and identifies areas of concern where agreement was not reached.

2. CMS RULES DRIVING THE NEED FOR CHANGE

FEDERAL CHANGES THAT REQUIRE CHANGES IN CASE MANAGEMENT IN ALASKA

There have been several major changes at the federal level that are driving the need to modify how Alaska structures case management for older adults and individuals with disabilities. Complicating the process is the difference in language between CMS and Alaska used to describe the same services. CMS uses the term 'case management' for the service that in Alaska is called 'care coordination'. In Alaska, some service provider agencies use the term 'case management' to describe the oversight of services provided to an individual participant. In this document, we will use 'service management' to describe the oversight by providers that is not funded as part of care coordination.

The Centers for Medicare & Medicaid Services (CMS) and the Administration for Community Living (ACL) (then the Administration on Aging (AoA)) started encouraging states and Area Agencies on Aging (AAAs) to transform how they provide home and community based services (HCBS) more than ten years ago. A major milestone in this effort was the creation of the Aging and Disability Resource Center (ADRC) initiative for which CMS and AoA offered a joint solicitation in 2002. The primary goal of the ADRC effort was to allow individuals to make informed choices about their long-term service and support options and prevent institutions from being the default LTSS choice. This movement continues with the 2010 Affordable Care Act (ACA), which included a provision in Section 2402(a) that is transforming the delivery of long-term service and supports (LTSS). This section has been translated into rules and guidance that are at the heart of why Alaska Senior and Disabilities Services (SDS) must take immediate action.

Section 2402(a) requires that the U.S. Department of Health and Human Services (HHS) create regulations that:

- Respond to beneficiary needs and choices;
- Provide strategies to maximize independence, including client-employed providers; and,
- Provide support and coordination necessary for "individualized, self-directed, community-supported life".

These rules mark a fundamental shift in the federal requirements for HCBS. Previously, federal agencies only had regulatory authority to enforce health and welfare requirements. Now, under 2402(a), states will likely be required to implement programs that offer participant-direction, person-centered planning and greater opportunities for community integration. Participant-direction means offering services in which individuals have greater control over services, including the ability to hire

and fire workers and, in some cases, determine how much workers will be paid. The sections later in this document discuss the federal definition of a person-centered planning process.

HHS issued guidance to all of its agencies, including ACL and CMS, about how to implement these requirements. This guidance provides strategies for changing HCBS delivery, such as the provision of support coordination, which is often known by other names, such as 'care coordination' and 'case management', to assist individuals in living in the community. This guidance also requires that entities receiving federal funds achieve consistent and coordinated policies and procedures across HCBS programs and providers.

CMS has published rules to apply the 2402(a) mandate to the largest portion of Medicaid funded HCBS, 1915(c) HCBS Waivers. ACL has also issued guidance and other HHS agencies are presumably determining how to act upon these requirements. So far, rules and guidance have only mandated a person-centered planning process, including requirements to limit financial conflicts of interest. None of the rules or guidance has mandated that states or AAAs offer participant-directed services.

UNDERSTANDING THE CONFLICT-FREE REQUIREMENTS AND PERSON-CENTERED PLANNING INCLUDED IN CMS'S HCBS RULES

CMS published final rules for HCBS that became effective on March 17, 2014. The rules apply to 1915(c) HCBS Waivers, such as those operated by SDS and 1915(i) State Plan HCBS. There are similar rules that are in place for 1915(k), also known as the Community First Choice (CFC) Option.

The CMS rule requires a separation of the provision of HCBS direct services, such as assistance with personal care, from the provision of case management (called 'care coordination' in Alaska) and the service plan development. The rule states, "Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual, must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. In these cases, the State must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS." In reviewing this language, it is important to understand the major components within this language:

- The rules do not appear to explicitly prohibit agencies or individuals who provide HCBS from also providing case management and service planning. However, the rules clearly do not allow an agency or individual to provide both to the same person.

- If a state is proposing to allow exceptions to the rule, it must have a mechanism for demonstrating that in a particular geographic area, there is no independent case management and service planning option.

- If a state allows exceptions, they will need to have clear requirements for how providers will mitigate conflicts of interest.

- The rule prohibits "providers of HCBS" from providing case management and service planning. It is important to note that the rule talks about service planning and case management broadly and does not only apply to service planning and case management paid for as a waiver service. Therefore, paying for service planning and case management through another source, such as Medicaid administrative funds or State-only dollars, would likely not be acceptable.

- It is also important to note that the prohibition is limited to providers of HCBS. In Alaska, that includes services provided through any of the waivers or Personal Care Assistant (PCA) or Consumer-Directed Personal Care Assistance (CDPCA) programs. The rule does not appear to create a prohibition against providers of other services.

Alaska's current case management structure for its 1915(c) waivers, which allows service providers to also provide service planning and case management, **clearly violates these requirements**. Alaska will need to make major changes to its infrastructure, and this report provides recommendations for doing so. The prohibition does not appear to apply to the activities that providers may call 'case management' that we refer to as 'service management' performed by direct service providers. However, it is impossible to rule out a conflict entirely because it is not entirely clear what 'service management' includes and it is likely that these practices differ across providers. This highlights the need to not only address what is being reimbursed as 'care coordination,' but to also clarify when 'service management' crosses over into 'care coordination' and should, therefore, be supplied by an independent entity.

Alaska already uses a person-centered approach to service planning; however, the rules include very specific requirements. SDS will need to build infrastructure so that it can assure that this planning meets the following requirements:

- Be directed by the participant to the maximum extent possible

- Provide necessary information and support the participant in making decisions and leading the process

- Include a participatory role for the participant's representative(s)

- Include people chosen by the participant in the planning process

- Include participant-identified goals and desired outcomes

- Identify participant strengths, preferences, and clinical and support needs

- Include services and supports and their providers

- Identify risk factors and measures in place to minimize them
- Prevent provision of unnecessary/inappropriate services and supports
- Be written in a plain/accessible manner
- Be distributed to the participant and other people involved in the plan

The State will need to make changes to service planning, currently performed in Alaska by care coordinators, to comply with these requirements. The State may consider developing tools and templates to ensure these requirements are met. The State will also need to change the requirements for case management to ensure that service planning complies with the new rule. The new requirements will likely substantially change the amount of time it takes to develop a service plan. Therefore, the State will need to evaluate whether the reimbursement structure for case management is adequate to support these additional activities.

Lastly, the HCBS rule also sets requirements for what can be considered a HCBS setting. The rule allows the State to grant exceptions to these requirements, such as limiting access to food, if this restriction is justified in the individual's person-centered plan. Case managers will need to assume much of the responsibility for operationalizing this requirement. This will likely require closer oversight of residential and adult day settings by the case manager to ensure that any exceptions to the settings requirements are justified and that they are being implemented in a manner that is consistent with the individual's person-centered plan.

Our proposed plan does not include tasks that address the person-centered planning or settings requirements in the rules because 1) this was beyond the scope of our project and 2) SDS likely has other planning efforts to address these requirements and we did not wish to create potentially conflicting plans.

ALASKA'S CURRENT DELIVERY OF CASE MANAGEMENT

PROGRAMS AFFECTED BY CHANGE IN CMS RULES

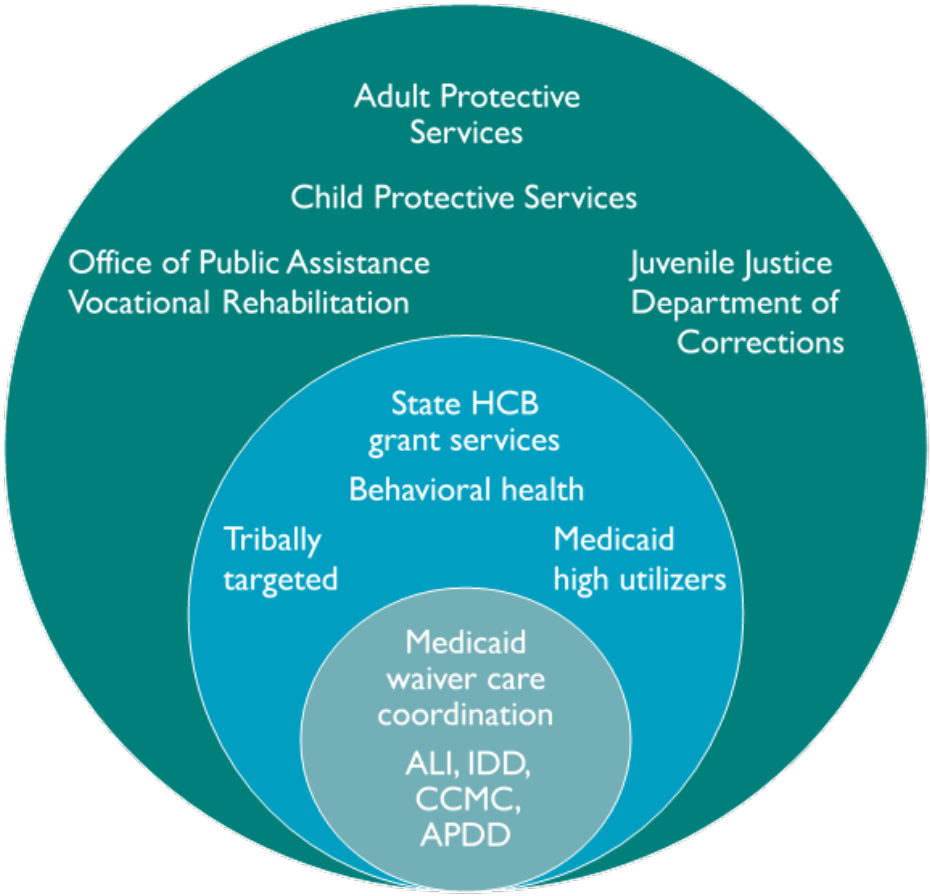
Many departments and divisions at the State of Alaska provide case management services. However, the HCBS rule currently only affects the Medicaid waiver program under the Department of Health and Social Services, Division of Senior and Disabilities Services. The waiver program reimburses "care coordinators" to manage the process of planning for services, developing a plan of care, providing ongoing monitoring of services, and renewing the plan of care annually. The care coordinator must make two contacts per month with the participant, one of which is in-person. If the participant is living in a remote community, the care coordinator must seek approval to make one quarterly in-person visit. SDS pays a flat rate of $240.77 per month per participant served for care coordination. This rate is adjusted by geographic differentials. In addition, the care coordinator

can bill for a one-time fee of $90.33 for the initial screening and an annual fee of $384.81 for Plan of Care development and renewal.

SDS staff conduct assessment and eligibility determinations for the waiver. The care coordinator works with the participant to develop the plan of care, which is used to authorize services. The State currently requires that a waiver participant work with a care coordinator to develop the plan of care in order to receive waiver services.

Though not directly affected by the change in CMS rules, case management delivered as part of the State's Medicaid-funded behavioral health services, Medicaid high utilizers and targeted case management may also require modifications once CMS provides guidance regarding how the 2402(a) requirements described earlier will be applied to these funding streams. In addition, because the federal guidance for implementing 2402(a) also requires that states achieve consistent and coordinated policies and procedures across HCBS programs and providers, theoretically, these requirements could be applied to Alaska's HCBS grant services. Additional case management programs, including those provided by Adult and Child Protective Services, Public Assistance, Juvenile Justice, Department of Labor, Vocational Rehabilitation, and the Department of Corrections, also might require future modification and discussion to best meet the needs of individual and the requirements of federal rules. For a more complete comparison of case management services, including grant services, tribally targeted case management, behavioral health case management and Medicaid high utilizers' case and care management, see the matrix included in the Appendices.

Figure 1: Alaska Case Management Programs + Conflict-free Requirements



May require modifications for consistency

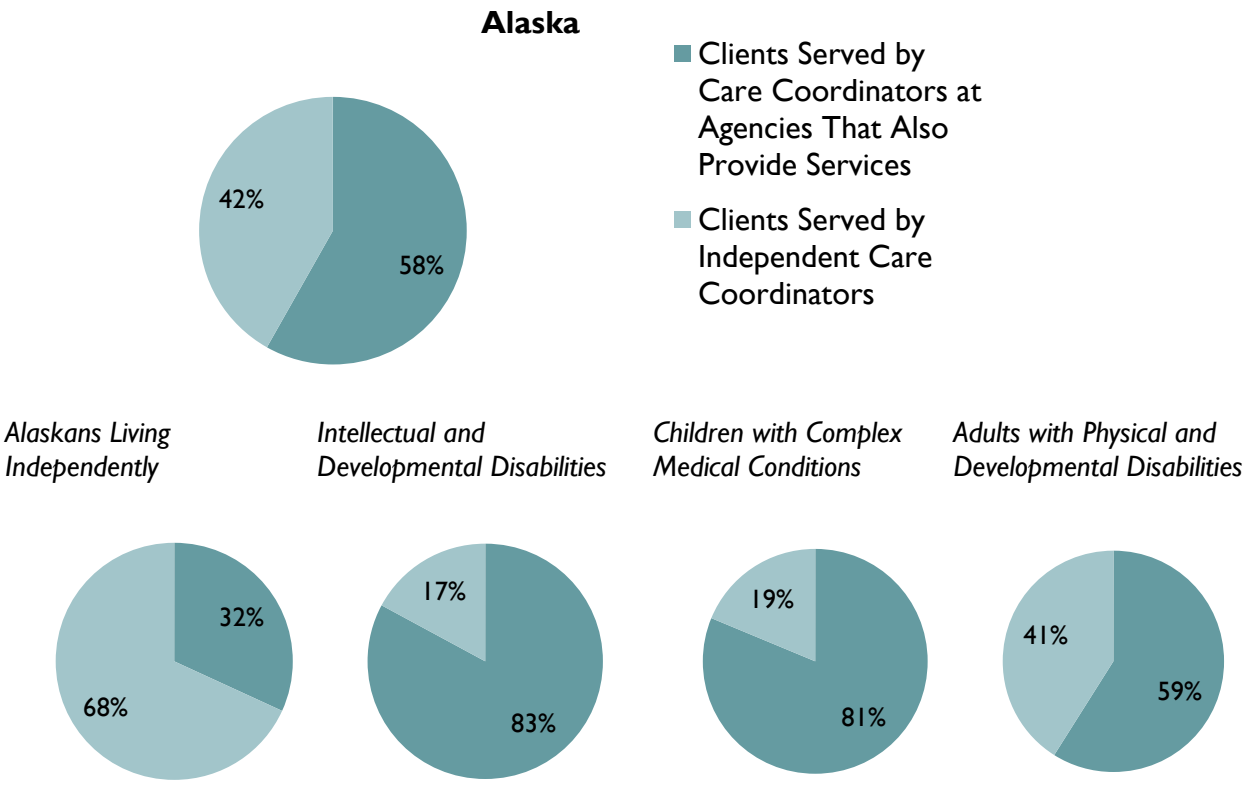
May require modifications for consistency

Directly affected by Conflict-free Case Management requirements

ANALYSIS OF WAIVER PARTICIPANTS CURRENTLY SERVED BY AN INDEPENDENT CARE COORDINATOR

Currently, the State offers four waiver programs. The Adults Living Independently (ALI) waiver primarily serves seniors; sixty-eight percent of the 2,059 ALI waiver clients are currently served by a care coordinator who does not work for an agency that provides waiver-funded services. The Intellectual and Development Disabilities (IDD) waiver serves 1,963 clients; of these, only 17 percent are served by a care coordinator who does not work for an agency that provides waiver-funded services.

Figure 2: Percent Independent Care Coordinators by Waiver Type



Source: Alaska Department of Health and Social Services Data Transmittal 12.18.14

CARE COORDINATORS BY REGION AND BY WAIVER TYPE

In Alaska, there are 592 care coordinators and 359 agencies offering care coordination serving 4,343 clients. Approximately 42 percent of clients are served by an independent care coordinator. 2,518 individuals are served by care coordinators who work within service provider agencies and are therefore not conflict-free, as defined by the HCBS rule. In more rural areas, it is less common for a participant to work with an independent care coordinator. For example, fifty-one percent of

Anchorage's waiver clients are served by independent care coordinators compared with only four percent in Northwest Alaska.

Figure 3: Clients Served by Independent Care Coordinators, by Region and Waiver Type[1]

Region	Number of Care Coordinators	Number of Agencies Providing Care Coordination	Number of Clients	Number of Clients Served by Independent Care Coordinator	Percent of Clients Served by Independent Care Coordinator
Anchorage			**2,197**	**1,114**	**51%**
IDD	83	38	925	195	21%
ALI	87	62	1,144	882	77%
APDD	26	17	36	18	50%
CCMC	38	18	99	21	21%
Southcentral			**1,360**	**586**	**43%**
IDD	72	37	538	89	17%
ALI	76	54	716	471	66%
APDD	25	18	31	9	29%
CCMC	33	15	76	17	22%
Southeast			**320**	**64**	**20%**
IDD	31	16	192	34	18%
ALI	21	16	98	18	18%
APDD	4	3	6	4	67%
CCMC	13	9	24	8	33%
Interior			**326**	**47**	**14%**
IDD	24	14	206	16	8%
ALI	12	11	95	29	31%
APDD	5	3	5	1	20%
CCMC	10	4	20	1	5%
Northwest			**45**	**2**	**4%**
IDD	5	4	31	0	0%
ALI	2	2	2	2	100%
APDD	0	0	0	0	n/a
CCMC	4	2	12	0	0%
Southwest			**95**	**3**	**3%**
IDD	12	8	71	2	3%
ALI	3	3	4	1	25%
APDD	0	0	0	0	n/a
CCMC	6	5	20	0	0%
Alaska Total			**4,343**	**1,816**	**42%**
IDD			1,963	336	**17%**
ALI			2,059	1,403	**68%**
APDD			78	32	**41%**
CCMC			251	47	**19%**

[1]Source: Alaska Department of Health and Social Services Data Transmittal 12.18.14. Note: Total number of clients is unduplicated. Regional totals for care coordinators and agencies providing care coordination are not available as unduplicated counts.

LESSONS FROM OTHER STATES

The consultant team conducted interviews with four states that are transitioning, or have recently transitioned, to conflict-free case management in order to learn lessons from their experiences that will inform Alaska's reforms. We selected the following states:

- Colorado: We selected Colorado because the State is actively engaged in a planning effort to determine how to comply with the CMS conflict-free requirements.
- Wyoming: Wyoming engaged in a strategic planning effort to establish a conflict-free system and is currently implementing its plan.
- Hawaii: Hawaii transitioned from a conflicted system in the late 90s. Hawaii, like Alaska, serves diverse cultural populations, many of whom live in remote, difficult to access locations.
- Minnesota: Minnesota has a conflict-free system in which they are separating the roles of assessment and support planning from ongoing case management and service provision. They are engaged in a number of efforts to try to facilitate seamless handoffs among all of the players involved. These efforts may serve as models for how Alaska can minimize disruptions caused by the separation of case management from service provision.

In this section, we summarize the major lessons learned from interviews with state representatives. A summary of the interviews with each of the states is included in the Appendices.

The first lesson from other states is that it is very hard to achieve a consensus plan for how to comply with the CFCM requirements. In Colorado, the State and its stakeholders are struggling to reach a consensus regarding how to comply with the conflict-free requirements. After extensive discussions, it appears that a consensus plan will not be possible and the State will need to make a decision that will displease some stakeholders. Wyoming chose to move forward with its plans despite objections from stakeholders, notably providers. The representative from Hawaii recalled how the switch to conflict-free case management was very acrimonious and included a temporary return to conflicted case management.

A second major lesson is that reforming conflict-free case management should be done in conjunction with other reforms to case management, including the following:

- **Refinement of CM requirements, qualifications, and training:** Simply separating the case manager from the direct service provider may create problems if the State does not clearly define the role and performance expectations for the case managers. If performance measures are not explicit, participants may be harmed by delays in having service plans developed, authorizing services, and renewing and changing service plans. Wyoming instituted a major refinement to the requirements and reimbursement for case

management in conjunction with the conflict-free requirements. Wyoming also emphasized the need for extensive training to ensure that case managers understood the new requirements. Because Hawaii chose to replace provider case management with case management done by State employees, it addressed this issue by creating clear job descriptions and training for the State case managers.

- **Increasing monitoring and enforcement capabilities:** In a system in which case management is provider-based, providers have a strong incentive to ensure that service plans and authorizations are completed in a timely manner in order to be able to bill for direct services. A participant with an independent case manager who is delinquent in updating plans and authorizations may be pressured by providers to switch to the provider-based case manager to prevent gaps in services. When only independent case management is an option, much of this pressure may go away. Wyoming recognized and responded to this by building increased monitoring and enforcement capabilities as part of its restructuring. Hawaii addresses this by having timeliness of service authorizations as part of its performance expectations for its State case managers.

- **Reimbursement strategies:** The four states interviewed recognized that how case management is reimbursed influences the amount of case management that is provided. Therefore, they have moved away from per day or per month rates that incentivize providing the least amount of case management to fill the basic case management requirements. Instead, they are moving to billing on 15-minute increments with the total amount of billing subjected to service caps.

- **Clear roles and processes for sharing information across providers, case managers, and assessors:** As more individuals are involved in managing the supports for individuals with disabilities, it is more important to clarify roles and information-sharing processes. When provider-based case management is allowed, the case manager may directly perform many of the functions necessary to actually implement supports (e.g., identifying and scheduling staff, etc.) or work closely with the staff who perform these functions. Clarifying the role of the case manager was a major component of Wyoming's plans. Minnesota has done the most work in this area, including developing IT solutions to facilitate the sharing of information across entities.

Finally, we obtained from each of the states their perception of the pros and cons of allowing service providers to continue to supply case management as long as they did not provide both direct services and case management to the same person. None of the states interviewed supported this arrangement. They acknowledged that the separation could create coordination challenges, however, they supported a complete separation of case management and service planning from service provision for the following reasons:

- **Concerns about quid pro quo arrangements and collusion:** All of the states were concerned that providers in their case management role might be hesitant to aggressively

monitor or challenge plans being developed by another provider because of concerns about retaliation when the roles were reversed. One state provided an example in which several providers had acknowledged that they planned to collude to minimize any changes and maximize revenues.

- **De-emphasis of case management:** State staff interviewed were concerned that staff who conduct both case management and provide direct services may give a higher priority to the direct service role rather than the case management role. This is especially a concern among very small provider agencies where the case manager may also be providing the direct support.

- **Ability to establish a professional workforce:** The states emphasized that they were trying to develop a workforce of professional case managers who had greater training and skills and were more carefully monitored. In states in which smaller provider agencies performed multiple functions, it was more burdensome for part-time case managers to participate in trainings. In addition, it was more burdensome for the State to oversee a larger number of case managers.

OVERVIEW OF REFORMS NEEDED TO COMPLY WITH CMS RULES

To comply with the CMS rules, SDS will need to make the following decisions:

- **Establish a definition for conflict-free case management:** Alaska will need to clarify what will and will not be approved as case management. As discussed earlier, the rules do not explicitly rule out the provision of case management by provider agencies, only the provision of both by the same entity to the same participant. However, the other states interviewed encouraged a complete separation of case management from service provision. SDS has made an initial decision that a complete separation will be required in Alaska.

  A key component of this definition will be to establish the criteria for whether service providers can own and/or serve on the boards of directors of case management agencies. Other sections of the CMS rules appear to prohibit ownership of the case management agency by an individual or entity that also owns an agency that provides HCBS. SDS may want to explicitly include this in its rules and include a disclosure form as part of the application.

  Sharing board members may be a more complicated issue especially in the smaller communities. In many cases, there may be only a limited number of people with knowledge about HCBS delivery and forbidding any crossover in board membership may be extremely challenging and exclude individuals who could make a valuable contribution. As an alternative, SDS could require that if an agency has a board of directors, the board must include representation by participants, family members and/or

advocates. Recent federal guidance in the form of grant solicitations and rules (e.g., the CFC Development and Implementation Council) have set a goal or requirement of having a least 50% of advisory bodies consisting of participants, family members and/or advocates.

- **Establish a process to identify areas where provider-based case management will be allowed:** The rules allow for provider-based case management in areas where the state has demonstrated that there is no other "willing and qualified entity to provide case management." A state could consider trying to meet this criterion by establishing thresholds based on factors such as population density. However, this approach has two primary drawbacks. One, there are many factors that could limit the number of providers such as population density, accessibility to other population centers, cultural and language diversity of the population, other competing employers, etc. If a state goes this route, it will likely need to develop a process for addressing these exceptions. Two, how will a state address instances in which a conflict-free case management option is available in an area deemed excepted? Does the criteria need to be adjusted? Is it invalidated? Will the state need to make exceptions to the exception? If so, what will be the process for doing so?

  A second option would be to systematically detail the areas for which conflict-free case management is provided and deem that exceptions will be allowed in areas where no option exists. If this route is taken, a state will want to be able to demonstrate to CMS that it made a good faith effort to enroll conflict-free case management entities. This effort will likely include two components. One, a state will need to demonstrate that it made the desire widely known to have conflict-free case management entities enroll. This could be accomplished through outreach efforts including a solicitation and/or advertising about the availability of the opportunities. Two, a state will need to demonstrate that there are no structural barriers, such as overly burdensome administrative requirements and/or insufficient reimbursement, to attract case managers who are not also providers.

- **Establish mitigation strategies for where a conflict is allowed:** States will need to establish requirements and policies for mitigating potential conflicts of interest. Descriptions of potential mitigation strategies can be found in the CMS-sponsored Balancing Incentives Program (BIP) Implementation Manual, which can be found at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Balancing/Downloads/BIP-Manual.pdf. Potential mitigation strategies include:

  - Internal firewalls which dictate if and when staff conducting case management interact with staff responsible for direct service provision.

- Complaints and grievance processes that allow participants to easily identify when they believe a provider is not acting in their best interests.

- State monitoring of conflicted providers to identify any potential conflicts.

SDS will need to describe clearly how it will address each of these design questions in the waiver applications they file to renew the existing waivers.

CLARIFYING CASE MANAGEMENT ACTIVITIES THAT MAY BE ALTERED AS ALASKA RESPONDS TO THE CMS MANDATES

Earlier, we discussed the conflict-free requirements included within CMS's HCBS rule. This rule explicitly discussed service planning and case management. Alaska now faces the challenge of translating that definition into specific policies and rules that guide program operations. In doing so, we believe that a necessary first step is to break out the specific activities that may be considered case management so that the State and its stakeholders can have an informed discussion about each component.

This effort's review of the different types of case management in Alaska revealed substantial differences about what is and is not considered case management. This highlights that there are a number of business processes that may be included under the case management rubric.

Figure 24 provides a summary of the different business processes that may be considered case management. Case management services, such as the case management offered under the HCBS Waivers, consists of all or a subset of these services. We have broken these functions into four major categories:

- **Gate keeping:** This includes the processes for determining eligibility and assigning budgets, hours, or other units of services.

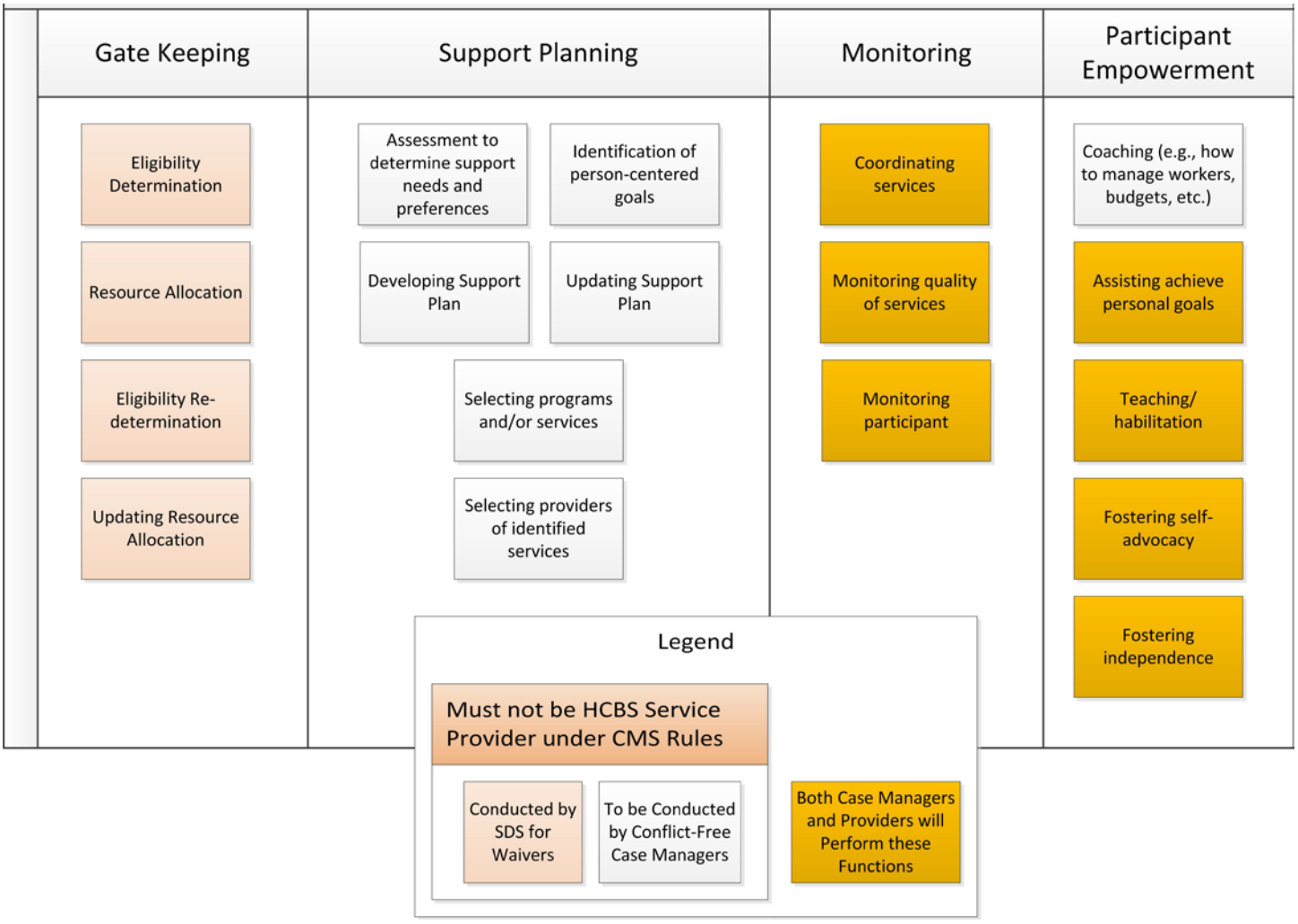
- **Support planning:** These are the processes that lead to a service or support plan. Under the CMS rules, these processes must be restricted to be consistent with the person-centered approach described in the rules including addressing potential conflicts of interest.

- **Monitoring:** These are the processes for ensuring that services are delivered according to guidance included in the support plan. Activities include coordinating services, monitoring the quality of the services (e.g., verifying staff showed up on time and performed the activities in the manner described in the support plan), and monitoring the participant (e.g., watching for changes in needs or preferences).

- **Participant empowerment:** Traditionally, this role was known as advocacy. Under the new rules that emphasize a person-centered approach and fostering participant independence and control, this role is shifting. The role now includes activities such as

habilitation and building the ability to self-advocate, which will allow participants to assume more choice and control.

Figure 4: Core Functions that could be Considered Case Management and Service Management



In this chart, we have color-coded the activities (as identified in the legend) to reflect the following:

- In Alaska, SDS conducts the gate keeping functions for the HCBS waivers.
- The CMS conflict-free requirements clearly require that the gate keeping and support planning activities must not be conducted by the HCBS service provider.
- Coaching, which can be considered a type of case management, is often used as a model for self-directed programs.[2] Coaching involves teaching individuals how to manage workers and other services and provides support to the participant as she or he assumes

[2] Alaska's Consumer-Directed Personal Care Assistance (CDPCA) program is an example of a self-directed program. At this time, Alaska does not have a case management or coaching option that is focused solely on CDPCA. However, CDPCA participants who are also enrolled in a waiver receive case management, but SDS does not require that case managers use a coaching approach.

these management tasks. This differs from traditional case management, in which a case manager will typically manage services and supports directly. Coaching is not an approach that is required, specifically endorsed, or independently financed by SDS. In reforming case management, SDS could consider offering coaching as an option to participants receiving self-directed services. If this service is offered, under the CMS rules, the function would need to be offered by a conflict-free entity.

- It is important to recognize that both case managers and service managers, employed by the service provider agency, perform all of the monitoring and most of the participant empowerment functions.

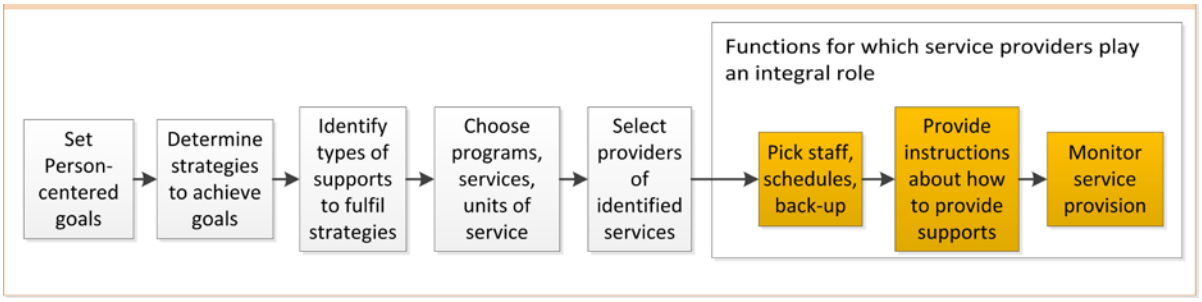
It will be important to recognize and address the overlap in monitoring and participant empowerment. Minnesota described the separation of these roles as being the development versus the implementation of the support plan. The provider is responsible for the implementation of the plan. Figure 3 helps clarify this separation by showing the core steps necessary to implement a person-centered plan. Once Alaska implements changes to comply with the conflict-free requirements, the conflict-free case manager will play a major role in all of the steps. However, the service provider will likely play a central role in the last three steps:

- While the case manager may help the individual identify preferences for which types of staff they want and when they want to receive supports, providers will likely retain primary responsibility for identifying the actual staff, setting schedules and ensuring that back-up supports are available.

- The support plan will likely include guidance about the participant's preferences about how supports are provided. However, it will be up to the provider to flesh out the details of these instructions and ensure that staff are trained and instructed to provide supports in a manner that is consistent with the person-centered support plan.

- The case manager will play a monitoring role through regular contact with the participant likely including observing the provision of services. However, the provider will be monitoring daily service provision and will be responsible for notifying the case manager of any issues or critical incidents.

Figure 5: Core Steps in Implementing a Person-centered Plan



The CMS rules do not recognize the necessary overlap in the monitoring and participant empowerment roles. This has created confusion in the states regarding how to implement the requirements. In restructuring case management, SDS and the stakeholders will need to carefully delineate the respective roles, responsibilities, information sharing, and hand-offs for each of these functions. Wyoming and Minnesota provide the best guidance for how to approach this delineation. To avoid unnecessary federal concern, the State should avoid using terms that could be considered as pseudonyms for case management if and when it labels these activities when they are performed by providers.

3. DRAFT PLAN TO COMPLY WITH THE CMS CONFLICT-FREE REQUIREMENTS

SDS has made a policy decision that case management will need to separate completely from service provision. Therefore, our plan does not include the option of allowing HCBS service providers to offer case management even when they do not provide other HCBS services for or with that participant. However, stakeholders raised the question of whether an agency that provides direct services to participants in one region of the state would be allowed to provide case management in a different region of the state. This will need to be determined during the design phase in 2015.

When SDS renews the state's waiver plan it will need to describe how care coordination will comply with the HCBS rules. Therefore, to avoid being subject to a Corrective Action Plan, the State must have a care coordination system that is compliant by July 1, 2016. Communications with participants, caregivers, service providers and policymakers will be ongoing during 2015 and 2016 in order to encourage transition over that period. By January 1, 2016, all **new** waiver participants will be served by a conflict-free case manager. By June 30, 2016, case management and service provision will be separated completely, except in areas where conflict will be allowed as defined by CMS for rural and frontier areas, where no conflict-free case manager exists.

This section provides an overview of the key issues addressed in the implementation plan below.

COMMUNICATION

The State must keep multiple stakeholders informed throughout this transition. The first steps of the Implementation Plan focus on communication between the State and participants, caregivers, current care coordinators, service providers, policy makers and legislators.

Because each region of the state has different factors that will determine the optimal way to provide conflict-free case management to participants, stakeholders strongly support regional and community-level forums to weigh options and identify local resources to provide conflict-free case management. These forums will also provide the opportunity to publicize the process for participants and families and to identify infrastructure needed in each region to support conflict-free case management, as well as available resources to provide it.

In addition, the stakeholders that have been engaged to date would like to continue to meet as an advisory body to provide feedback and guidance throughout this transition.

CLARIFYING THE CORE REQUIREMENTS FOR CONFLICT-FREE CASE MANAGEMENT AND SUPPORTING INFRASTRUCTURE IN THE SHORT TERM

This section identifies the short-term steps to comply with the conflict-free requirements of the HCBS rule. In the short term, SDS must address two objectives to implement a conflict-free case management system:

- One, SDS must establish a process for determining whether a conflict-free case management option exists in all areas of the state. This will allow SDS to determine where it will be necessary to grant exceptions that will allow service providers to continue to provide case management in rural and frontier areas. It appears that a solicitation will be the most efficient process for making this determination. This solicitation process should also address mitigation measures that must be in in place when conflicted case management is allowed.

- Two, SDS must determine whether it needs to take action to ensure there is adequate case management capacity once provider case management is removed as an option. It is unclear whether market forces alone will adequately increase the supply of conflict-free case management. In addition, some stakeholders and SDS has expressed concern about its ability to train and monitor a large number of independent conflict-free case managers.

To address the second concern, SDS should consider whether to facilitate the development of infrastructure to support high quality conflict-free case management. The goals for developing this local, regional or statewide infrastructure to support conflict-free case management include:

- Improve value for State resources and increase efficiency of State oversight.

- Improve and monitor performance of case management.

- Sustain capacity to provide case management during the transition to conflict-free case management, and beyond.

We discuss four options for addressing this issue in the next section. The Draft Implementation Plan to Comply with CMS Conflict-Free Requirements, included below, identifies the following steps to develop needed infrastructure, however, the State will work with stakeholders to determine the specifics of whether and which type of regional infrastructure to incent or require.

Between March and September 2015, the State must identify the requirements for conflict-free case managers and case management agencies. This includes the following steps:

- SDS will need to clarify specific requirements for conflict-free case management. This will include addressing issues such as the following:

- Will an agency that provides direct waiver services in one region be allowed to provide conflict-free case management in another region where it does not provide direct services?

- To what extent can non-profit agencies include members of their Boards of Directors who have an affiliation with a service provider agency?

- Can a conflict-free case management agency offer a service to an individual when no other direct service provider option is available?

- The State will work with tribal health organizations and other community agencies serving rural areas to determine mitigation strategies for establishing conflict-free case management in areas where no conflict-free agency exists, as allowed by CMS for rural and frontier areas. In these same areas, it will also be critical to identify where service providers are and are not able to provide HCBS services.

- Stakeholders will convene and facilitate regional and community-level dialogues to publicize the process and identify needed infrastructure to provide conflict-free case management to participants in area. The State will work with stakeholders to determine how to develop regional or statewide infrastructure to deliver high-quality case management. Based on the outcome of this process the State will identify requirements, if any, for affiliation between independent case managers and case management agencies.

- Based on this report and the subsequent work with stakeholders, the State will identify performance measures against which the quality of case management will be monitored.

- The State will expedite the rate-setting process in order to provide the necessary information to potential conflict-free case management providers to evaluate the business case. This may be especially important because SDS will likely need to change requirements for care coordinators to comply with the person-centered planning portion of the CMS rules. These changes will likely impact the amount of time that care coordinators need to spend on core activities. This potential combination of removing provider case management from the market while increasing care coordination requirements could dramatically impact the availability of case management if the current reimbursement structure remains unchanged. To address this, and to match CMS expectations, the State will need to investigate moving from a flat fee to a billing model that uses a 15-minute increment for case management. This structure is considered a best practice in order to address different participants' acuity levels and to monitor the performance of case managers.

    - The steps needed to research, propose, refine and develop regulations for a revised rate structure may not be possible in the timeframe identified in this plan. SDS will

need to identify the steps that will be possible in order for providers to determine the business case for conflict-free case management.

- The State will also determine changes to documentation and billing requirements and processes.

By September 2015, once requirements are determined, the State will draft and release a solicitation of interest to determine availability of conflict-free case management in all census areas, allowing 45 days for response. If possible, the State will release the solicitation earlier and allow the response to extend to 90 days to allow maximum time for providers to organize their responses.

The solicitation will, at minimum, identify rural and frontier areas where conflict-free case management does not exist and where mitigation measures will be needed to allow service providers to provide case management in these areas.

The State will evaluate responses to the solicitation against certification requirements and identify conflict-free case managers for each waiver and each census area. The State will also identify the areas of the state where no conflict-free case management exists for each waiver type. For these areas, the State will work with the tribal health organizations, Community Health Centers and other organizations in those regions to secure conflict-free case management for participants in these regions, using the mitigation measures identified above.

On January 1, 2016, the State will publish the list of conflict-free case managers for each census area and for each waiver. A conflict-free case manager will serve any new participants from this date forward. Current care coordinators will establish that they are conflict-free, or will be in the process of moving to a conflict-free employment setting. Participants will work with their current care coordinators to determine if transition is needed to receive conflict-free case management.

By June 30, 2016, all waiver participants will be served by a conflict-free case manager. Any entity that provides case management will no longer be allowed to provide waiver-funded direct services, unless exempted from the requirement by the process outlined above.

IDENTIFYING MECHANISMS TO ENSURE ADEQUATE CASE MANAGEMENT CAPACITY

Stakeholders were concerned that the pending changes were causing current care coordinators to seek other positions and that the knowledge and capacity of current care coordinators would be lost in the transition to conflict-free case management. Stakeholders believe that SDS needs to take action to ensure that there are a sufficient number of care coordinators after the transition occurs.

There was consensus that the State needed to develop infrastructure that would allow new approaches for organizing case management and providing the administrative support for case managers. Stakeholders vary in their views as to which type of local, regional or statewide

infrastructure would best achieve this goal. The State and The Trust may choose to help facilitate regional forums to gather additional input to determine whether regional or statewide infrastructure is needed to deliver high-quality case management.

The State and the stakeholders should together consider the four options described below and in

Figure 6, which notes the advantages and disadvantages of each option, as identified in the work sessions convened for this project.

Option 1 Market-Driven, State performs Quality Improvement / Quality Assurance: Set the Conditions of Participation to require professional-level case management and to set performance measures to monitor quality. SDS directs Quality Improvement and Assurance activities using new on-line platform and sanction processes when performance measures are not met. The solicitation would allow multiple case managers and agencies per census area and would leave it to the market to determine the volume for case managers and agencies. The State would also leave it to the market to determine how best to meet the quality standards and administrative requirements, for example, by a group of independent case managers forming a co-op to share billing and administrative functions.

- **Advantages:** Minimizes change from existing system; allows case managers and agencies to determine appropriate business size and volume; maintains participant choice in case managers.

- **Disadvantages:** Does not necessarily decrease the number of case managers or agencies for the State to oversee; does not provide organizational infrastructure for current care coordinators to move to; does not work towards the long-term goal of a comprehensive case management system.

Option 2 Regional CFCM Agencies, one per region: State solicits regional umbrella organizations to oversee delivery of conflict-free case management. Identify one per region and require all case managers in that region to affiliate with regional organization. The regional organization serves all waiver participants in the region.

- **Advantages:** Guarantees volume to case management agencies, which may improve feasibility of business; provides organizational infrastructure for current care coordinators to move to; decreases the number of case managers or agencies for the State to oversee; allows for expansion to all types of case management to different populations to meet the long-term goal of a fully coordinated case management system.

- **Disadvantages:** Significant change from existing system; does not allow case managers to remain independent and determine business size and volume; may limit participant choice and will require a 1915(b)(4) waiver.

Option 3 Statewide or regional administrative support: The State contracts with an entity or entities to provide support to case managers without itself providing case management. ADRCs, Centers for Independent Living, tribal health organizations, the Trust Training Cooperative or a Quality Improvement Organization (QIO) could provide these services. Functions include training, monitoring, administrative support, and other functions. SDS could likely receive Medicaid administrative match to support these contracts, but would have to receive approval from CMS before doing so.

- **Advantages:** Provides central source for quality improvement and assurance activities; provides administrative support for case management statewide; minimizes change from existing system; maintains participant choice in case managers; allows for expansion to all types of case management to different populations to meet the long-term goal of a fully coordinated case management system

- **Disadvantages:** Does not provide organizational infrastructure for current care coordinators to move to; does not necessarily decrease the number of case managers or agencies for the State to oversee.

Option 4 Regional organizations, multiple per region, provide CM and administrative support: Regional or local entities, which could be non-profit, for profit, or co-operative organizations, provide infrastructure and administrative oversight for each region or local area. These organizations could both employ case managers and/or provide support to independent case managers.

- **Advantages:** Provides organizational infrastructure for current care coordinators to move to; may improve quality of case management; maintains participant choice; minimizes change from existing system; allows case managers to remain independent and determine business size and volume;

- **Disadvantages:** Does not guarantee volume so may not improve feasibility of case management business; does not necessarily decrease the number of case managers or agencies for the State to oversee.

Figure 6: Criteria to Evaluate Options

Criteria to Evaluate Options	**Option 1** Market-driven, State performs QI/QA	**Option 2** Regional CFCM Agencies, one per region	**Option 3** Statewide or regional training, monitoring and administrative support	**Option 4** Regional organizations, multiple per region, provide CM and administrative support
Improve value for State resources and increase efficiency of State oversight.	Low	High	Medium	Medium
Improve and monitor performance of case management.	Low	High	Medium	Medium
Sustain capacity to provide case management during the transition to conflict-free case management, and beyond.	Medium	Medium	Medium	Medium
Level of change from existing to reformed system.	Minimal change	High change	Minimal change	Moderate change
Is participant choice maintained?	Yes	Not entirely, participants could choose case manager but would be limited to one regional agency	Yes	Yes
Allow case managers and agencies to determine appropriate business size and volume.	Yes	No	Yes	Yes
Could require additional approval from CMS (e.g., 1915(b)(4) waiver).	No	Yes	No *(SDS could seek Medicaid Administrative Match)*	Yes, if do not approve any willing provider

In addition to discussing the four options above, the following questions should be considered:

- Would regional case management agencies serve participants from all four waivers?
- What would be the optimal manner for reimbursing these entities? In doing so, SDS will need to consider the following:
  - If the option includes the provision of case management, SDS will want to consider both the rate and rate structure and the potential volume to ensure that these entities are financially viable. There may need to be a tradeoff between the rate structure and volume. For example, Option 2 should help ensure higher volume, which in turn should allow the regional case management entities to be more efficient. Alternatively, if the State would like to foster multiple regional entities, each entity

may have lower volume. To compensate for this, the State may wish to consider a reimbursement structure that allows for more of the administrative costs to be covered for entities with lower volume (i.e., a higher rate for entities with lower volume). In conducting these analyses, SDS may want to consider differences in travel time and costs for rural locations.

  - If the State chooses Option 3, which only pays for administrative and other support, but not actual case management, the State will likely want to do so using an administrative contract that is eligible for Medicaid administrative federal financial participation (FFP).

- Will short-term grant funding be available to facilitate transition to new model and incentivize start-up of regional entities?
- How will the infrastructure model selected ensure participant choice?
- What will be the best way to maximize the role of tribal providers?

SHORT TERM IMPLEMENTATION PLAN TO COMPLY WITH CMS CONFLICT-FREE REQUIREMENTS					
Action Step		**Who**	**Timeframe**	**Status**	**Notes**
Short Term Reforms: Participants Transition to a Conflict-free Case Manager, March 1, 2015 – June 30, 2016					
1	State communicates key dates in implementation plan to participants, care coordinators and service providers.	State of Alaska Senior and Disabilities Services	March 30, 2015		Convene a Conflict-free Case Management Advisory Group, using current stakeholders and participants, to advise the process.
2	State develops and implements communication plan for policymakers and legislators.	State of Alaska Senior and Disabilities Services	Ongoing 2015-2016		
3	Stakeholders facilitate regional and community-level dialogues to publicize the process and identify needed infrastructure to provide conflict-free case management to participants in area.	Stakeholders, The Trust	March – September 2015		
4	State works with stakeholders to determine how to develop regional or statewide infrastructure to deliver high-quality case management.	State of Alaska Senior and Disabilities Services, Participants and caregivers, conflict-free case managers and agencies	March – June 30, 2015		See narrative for four options to consider.
5	Depending on outcome of process, State determines criteria for regional or statewide infrastructure.		March – June 30, 2015		
6	State determines requirements for conflict-free case managers and case management agencies. This includes identifying performance measures against which the quality of case management will be monitored.	State of Alaska Senior and Disabilities Services	March – June 30, 2015		

SHORT TERM IMPLEMENTATION PLAN TO COMPLY WITH CMS CONFLICT-FREE REQUIREMENTS					
Action Step		**Who**	**Timeframe**	**Status**	**Notes**
7	State determines requirements, if any, for affiliation between independent case managers and case management agencies.	State of Alaska Senior and Disabilities Services	March – June 30, 2015		
8	State expedites the rate-setting process for basic conflict-free case management.	State of Alaska Senior and Disabilities Services	March – June 30, 2015		
9	State determines if one agency is allowed to provide waiver services in one region and conflict-free case management in another region.	State of Alaska Senior and Disabilities Services	March – June 30, 2015		
10	State determines mitigation strategies for establishing conflict-free case management in areas where no conflict-free agency exists, as allowed by CMS for rural and frontier areas.	State of Alaska Senior and Disabilities Services	March – June 30, 2015		Consult with tribal health organizations and Community Health Centers to determine mitigation measures. Internal firewalls and policies to substantiate conflict-free status may include: ▪ Cannot share supervisors ▪ Separate office space and records storage ▪ Review all plans of care for conflict and biases ▪ Allow shared board members to the extent that it is allowed under corporate law
11	State determines documentation and billing requirements and processes.	State of Alaska Senior and Disabilities Services	March – June 30, 2015		Determine frequency and type of communication between conflict free case management performed by care coordinators and service management conducted by provider agency staff.

SHORT TERM IMPLEMENTATION PLAN TO COMPLY WITH CMS CONFLICT-FREE REQUIREMENTS					
Action Step		**Who**	**Timeframe**	**Status**	**Notes**
12	State drafts and releases a solicitation of interest to determine availability of conflict-free case management in all census areas.	State of Alaska Senior and Disabilities Services	July 2015		Provide 90-days for response.
13	In responding to solicitation, conflict-free case managers and agencies will identify census areas of the state they will serve and which waiver participants they will serve.	Case managers and agencies	August 1 – October 15, 2015		
14	State evaluates responses to solicitation against certification requirements and identifies conflict-free case managers for each waiver type and each census area.	State of Alaska Senior and Disabilities Services	October 15 -November 15, 2015		Determine if multiple case managers per census area will be allowed, or if a regional model will be developed that limits the number of case managers per region.
15	State identifies areas of the state where no conflict-free case management exists for each waiver type. ▪ State works with the tribal health organizations, Community Health Centers and other organizations in those regions to secure conflict-free case management for participants in these regions, using mitigation measures identified above.	State of Alaska Senior and Disabilities Services	November 15 – December 15, 2015		
16	State publishes list of conflict-free case managers for each census area and for each waiver type.	State of Alaska Senior and Disabilities Services	January 1, 2016		

SHORT TERM IMPLEMENTATION PLAN TO COMPLY WITH CMS CONFLICT-FREE REQUIREMENTS					
Action Step		**Who**	**Timeframe**	**Status**	**Notes**
17	Participants work with current care coordinators to determine if transition is needed to a conflict-free case manager and to facilitate transition, if needed.	Current participants and care coordinators	January – June 30, 2016		
18	All new participants are served by a conflict-free case manager.		January 1, 2016		
19	State develops and implements second round of communication plan for participants and caregivers.	State of Alaska Senior and Disabilities Services	Spring 2016		
20	All waiver participants are served by a conflict-free case manager. Any entity that provides case management is not allowed to provide waiver-funded direct services.		June 30, 2016		

4. VISION FOR CASE MANAGEMENT SYSTEM IN ALASKA

In our work sessions with the stakeholders and State representatives, in addition to discussing how to comply with the CMS rules, we spent time trying to determine whether there was a consensus vision for how case management should be delivered in Alaska.

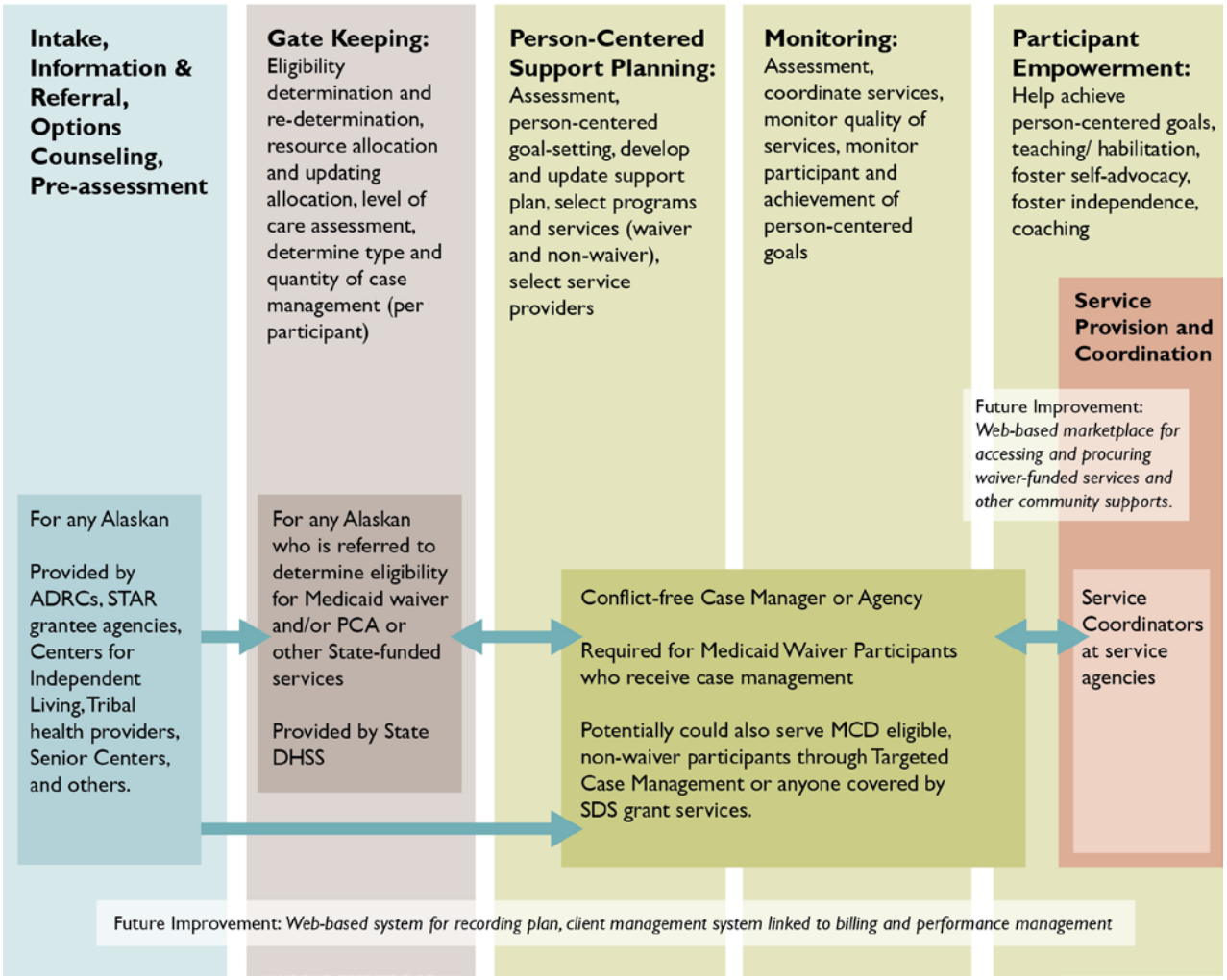
We found that there was a strong consensus among State staff and stakeholders for an approach that included the following components:

A fully coordinated case management system that is integrated and seamless from the participant's point of view. The system should be easy to access and clearly identify the role of ADRCs, the Short-term Assistance and Referral (STAR) grantee agencies and other referral sources. Define the core functions of the participant, family, case manager, service manager, service provider, and the State and the processes through which they interact. The case management model developed to serve participants in Medicaid Waiver programs should be flexible enough to be able to add on new participants, such as behavioral health clients, in order to move to a comprehensive case management approach, over time. Done well, this model could serve additional payers including private insurers. See Figure 7.

The systems should operationalize the following values:

- Be person-centered.
- Build participant empowerment, emphasizing choice and goal setting; respecting participant choice, including the refusal of services.
- Case managers must avoid personal bias and judgment of participants.
- Case managers must act with compassion, humility, self-awareness and respectfulness.
- The case management workforce must be competent to serve participants across diverse cultures, ages, diagnoses, and functional abilities.
- Case managers must incorporate person-centered interviewing skills into their practice to help participants determine goals and make informed choices.
- Case management must include family caregivers and build upon natural supports.

Figure 7: Conflict-free Case Management Within Coordinated Person-centered System



The needs and preferences of the participant should drive the level, type and frequency of case management. The State would develop an assessment and approval process that identifies which type and how much case management to allocate for each participant, as part of a person-centered plan. The process should include the following options: 1) minimal or no case management; 2) a coaching model of case management; 3) basic case management; and, 4) specialized comprehensive (including medical) case management. The State is currently working to develop an acuity-based system for long-term services and supports in Alaska. These acuity levels may inform the level and type of case management required by a participant. However, additional factors should also be considered including the strength and competency of the participant's natural supports.

The State may also determine the frequency of contact between the case manager and the participant as part of the assessment. The current requirement of two contacts per month, one of which is face to face, is high compared to other states; quarterly requirements are more typical. It may also be beneficial to allow telemedicine for some contacts with participants in remote communities. This

practice is increasingly accepted in rural areas in order to increase access to specialized consultation that is not available in the community or region. This will require a DHSS regulation change.

To meet the needs for basic and specialized case management, the State should develop tiers of case management with various levels of qualifications that can be matched with participant needs, associated with tiered reimbursement rates. Specific certifications such as the Qualified Developmental Disabilities Professional or Qualified Intellectual Disabilities Professional (QDDP/QIDP), the Care Management Certificate (CMC), degrees in nursing or other medical field, and the Certified Brain Injury Specialist may be required for a person to provide specialized case management to specific populations of participants. Depending on the availability of case managers with specialized certifications, it may be beneficial to develop a consultant model for specialized case management where a participant could receive case management during periods of higher acuity or as a coach for the basic case manager in order to build skills.

In order to create an entry-level for new case managers, it may also be beneficial to identify a 'case management assistant' with lower qualifications than the basic case manager. The case management assistant would assist with coordination, scheduling, logistics and administrative duties and could provide support to a number of case managers.

Improve and monitor quality of case management and ensure case management and services are driven by participants' goals and evaluated against progress towards participants' goals. Stakeholders agreed that the education and experience qualifications, specified in the current Care Coordinator Conditions of Participation, were adequate to provide a professional case management workforce. However, there are a number of ways in which the monitoring of quality of case management should be improved. Stakeholders identified the following suggestions that should be evaluated for their benefit and effectiveness:

- Specify components of continuing education and an annual number of units to be completed.
- Require each case manager to identify a mentor or supervisor.
- Require and facilitate each case manager to participate in an annual 360 degree evaluation where participants, family members, service providers and service managers would provide feedback on quality of case management services to the State.
- Identify performance measures for case managers and institute a clear process to monitor enforcement and impose sanctions when measures are not met. Performance measures should monitor timeliness of plan submission, responsiveness to participants and service managers, completion of visits, and evaluation against participants' goals.

Some stakeholders expressed concern that increasing the professional requirements for case managers will make recruitment difficult. Others strongly expressed that improving the quality of

case management necessitates strengthening the requirements and performance measures for case managers and that this should be required statewide.

Clearly define plan for transition from current practice to conflict-free case management; build upon what is working well now. In order to ensure that participants and care coordinators have the maximum amount of time to transition to conflict-free case management, as needed, and to ensure that the case management workforce is maintained and increased, the State should draft and publicize an implementation plan that clearly communicates the steps towards conflict-free case management with participants, family caregivers, current care coordinators, service providers and other stakeholders.

Stakeholders voiced significant concern that the transition to conflict-free case management be handled in a manner that ensures there is sufficient capacity to provide case management during the transition and beyond. Some agency representatives reported that current care coordinators were considering leaving the field or leaving their agencies to form independent care coordination agencies. Others voiced concern that participants would experience gaps in services if plans of care expire and are not renewed in a timely manner.

In keeping with the values articulated through this process, it is important to ensure a person-centered rollout of conflict-free case management for each participant. Strategies identified by stakeholders to ease the transition included identifying organizations that can provide interim conflict-free case management during the transition such as tribal health organizations, community health centers or Aging and Disability Resource Centers.

Stakeholders agreed to continue to meet in order to advise the State on the transition to conflict-free case management and to facilitate regional and community-level meetings in order to identify for the various regions of the state how best to structure this service.

Provide high quality conflict-free case management to participants across Alaska, including rural and remote communities. Stakeholders strongly agreed that improving the quality of case management, increasing the efficiency of the system and maintaining participant choice were important goals to balance as the State transitions to conflict-free case management.

Revise reimbursement structures to support the more expansive view of case management. In order to maintain capacity to provide case management and to incentivize new businesses and organizations to provide conflict-free case management, stakeholders need to be able to assess the business case for providing this service. The State should expedite the rate-setting process in order to determine a reasonable rate to provide this service in Alaska. Specific elements of the rate include:

- Geographically adjusted rates by location of waiver participants rather than the location of the agency; ensure travel costs are built into rates for rural participants and ensure rate exists for telemedicine visits.

- Higher rate for specialized case management and possibly a lower rate for case management assistance.

- Ensure there are no barriers to case managers also serving additional populations including participants in HCBS grant-funded services, those receiving PCA, other Medicaid participants and potentially other populations such as high utilizers and behavioral health clients.

- Ensure documentation requirements are not burdensome.

The following Long-term Implementation Plan for Building Comprehensive Case Management Infrastructure identifies the preliminary steps in the process. This will need to be refined and added to as the implementation phase unfolds.

LONG-TERM IMPLEMENTATION PLAN FOR BUILDING COMPREHENSIVE CASE MANAGEMENT					
Action Step		**Who**	**Timeframe**	**Status**	**Notes**
Medium Term Reforms: Building Capacity to Improve and Assure Quality of Conflict-free Case Management, July 2016 – July 2017					
21	State determines qualifications and tiered rate structure for Specialized Case Management.	State of Alaska Senior and Disabilities Services	July – October 2016		
22	State determines rate structure that bills using a 15-minute increment for case management, both basic and specialized.	State of Alaska Senior and Disabilities Services	July – October 2016		
23	State determines assessment and approval process for participants to identify which type and how much case management to allocate for each participant.	State of Alaska Senior and Disabilities Services	July – October 2016		Consider including amount and frequency of face-to-face requirement as part of assessment, to tailor to individual needs and location.
24	State identifies criteria for receiving different levels of case management as part of a person-centered plan. Options may include 1) no or minimal case management; 2) a coaching model of case management; 3) basic case management; and 4) specialized comprehensive (including medical) case management.	State of Alaska Senior and Disabilities Services	July – October 2016		
25	State identifies process for interface between ADRC, STAR grantee agencies and other intake staff and conflict-free case managers to develop person-centered plans.	State of Alaska Senior and Disabilities Services	July – October 2016		
26	Conflict-free case management agencies and case managers renew certification with new requirements and billing structure.		July 2017		

Action Step		Who	Timeframe	Status	Notes
Long term: Comprehensive Case Management Across Programs for Medicaid Participants, July 2016 and ongoing					
27	Once conflict-free case management system is operational, DHSS identifies additional areas where conflict-free case management would improve participant outcomes. As these programs are renewed and new RFPs are developed, DHSS will direct opportunities to the conflict-free case managers and agencies.	Alaska DHSS			

5. CONCLUSION

AREAS OF CONCERN

As we noted earlier, this brief process did not result in a consensus plan for meeting the conflict-free case management requirements. The following are the areas of concern expressed during the interviews and stakeholder meetings that may be preventing a consensus from emerging:

- The first, and perhaps most notable, focuses on the type of infrastructure needed to organize the services and support the case managers. Opinions vary amongst stakeholders about which type and level of infrastructure would be most effective to achieve the goals identified in this report. Because client needs and provider capacities are so diverse across the different regions of the state, stakeholders recommended holding facilitated regional forums through which the State could gather additional information. In this report, we have tried to clarify the options and their pros and cons to facilitate a decision.

- Providers also expressed concern about whether or not there was a solid business case for organizations to choose to start up (or transition to) a case management organization. Many felt that current reimbursement rates, coupled with low client numbers in some areas, could prove challenging. Understanding that the rate change was unlikely to happen in the short term, recommendations included possible grant funding to incentivize the start-up of regional entities to support conflict-free case management. Potentially, Medicaid Administrative match funds could be used for this purpose.

- A related but separate concern is the transition to a 15-minute increment for billing case management. This is a significant departure from the current flat monthly fee structure. CMS will likely encourage Alaska to use a 15-minute increment for billing because it allows the volume of service to better match the acuity of participant needs and it allows for more direct oversight and performance management of case management. This will need significant discussion with stakeholders as this transition occurs.

- A particular concern of providers focused on maintaining case manager capacity during the implementation phase. Depending on decisions made around training requirements, caseloads, supervision, and administrative oversight, providers expressed concern that the pool of existing case managers could shrink. The State must provide clear and consistent communication including transition options for existing care coordinators and case managers during the planning and implementation phases to assure a smooth transition to a conflict-free case management system.

- Finally, the short amount of time that remains before the deadline for compliance with the conflict-free case management requirement is of concern to all stakeholders. The number of decisions that need to be made, processes to be developed, and regulations to be changed or

modified requires that a fast and focused pace be kept when defining and implementing the plan. The State should continue to work with stakeholders to monitor the timeline for reform and to communicate clearly when the timeline changes.

NEXT STEPS

The initial work to shift Alaska's Medicaid waiver programs to a conflict-free case management model involves a series of short-term actions that will ensure the State is compliant with the requirement that all waiver participants have a conflict-free case manager by July 1, 2016. Immediate next steps that will bring the State to a July 2015 solicitation to determine the availability of conflict-free case management in all census areas are listed below.

1. The informal group of stakeholders who have advised this report, should continue to meet on a regular basis. This group should consider the inclusion of waiver participants in their discussions. Key tasks for these stakeholders will be to:
    - Continue to advise the State on the transition process.
    - Coordinate and facilitate regional and community level meetings to help each region of the state identify how best to structure services.
2. SDS is responsible for most of the initial work between March and July 2015. Tasks include:
    - Communication and alignment
        - Identify and communicate to participants, care coordinators and service providers the key dates in the implementation plan.
        - Develop and implement a communication plan that will align policy makers and legislators with the project and ensure an understanding of the need to work quickly to ensure compliance.
    - Determine the infrastructure to support conflict-free case management
        - Conduct regional forums to identify local resources and solutions to deliver conflict-free case management.
        - Begin to develop the identified infrastructure.
    - Begin the rate-setting process for basic conflict-free case management.
    - Work closely with stakeholders to determine criteria for the following:
        - Supporting infrastructure.

- Requirements for conflict-free case managers and case management agencies.
- Affiliation between independent case managers and case management agencies, if any required.
- Whether and how to regionalize services
- Mitigation strategies for establishing conflict-free case management in areas where no conflict-free agency exists
- Documentation and billing requirements and processes.

With the above tasks completed, the State should be in a good position to draft and release a July 2015 solicitation of interest to determine the availability of conflict-free case management in all census areas.

APPENDICES

- List of Steering Committee members
- Matrix of current case management models in Alaska
- Summaries of Interviews with Other States

LIST OF STEERING COMMITTEE MEMBERS

Lizette Stiehr	Alaska Association on Developmental Disabilities
Amanda Lofgren	Alaska Mental Health Trust Authority
Sandra Heffern	Community Care Coalition
Karl Garber	Alzheimer's Resource of Alaska + AgeNet
Allison Lee	ResCare Alaska + Alaska PCA Providers Association
Rachel Greenberg	Mat-Su Senior Services+ AgeNet
Angela Salerno	DHSS Senior and Disabilities Services

MATRIX OF CURRENT CASE MANAGEMENT MODELS IN ALASKA

The consultant team conducted a series of key informant interviews in December 2014 and January 2015 and review of regulations to gather the information in this matrix.

Current Case Management Models in Alaska

	A	B	C	D	E	F	G	H	I
1	**Case Management Program**	**Population**	**What is it Called?**	**Description of Services**	**CM Core Components**	**Oversight**	**Funding**	**Reimbursement**	**Gate Keeper**
2	**Adults Living Independently (ALI), Adults with Physical and Developmental Disabilities (APDD) and Children with Complex Medical Conditions (CCMC)** Medicaid waiver care coordination	For Medicaid-eligible people who meet Nursing Facility Level of Care (NFLOC). ALI Waiver is available to adults age 21 and over. The APDD waiver is available to persons age 21 and over who have been determined to be Developmentally Disabled. The Children with Complex Medical Conditions (CCMC) waiver serves children and young adults under the age of 22 years who experience medical fragility and are often dependent on frequent life saving treatments or interventions and/ or are dependent on medical technology.	Care Coordination	Develop plan of care; submit level of care; two visits per month; ensure plan of care is being followed, suggest additions.	Support planning Monitoring	SDS Nursing Facility Level of Care Waiver Unit	Medicaid	As of July 2014 for care coordination: **Case Management:** Per Month $240.77 for ALI, APDD, CCMC, IDD **Screening:** one initial and one additional, per SDS approval, $90.33 for ALI, APDD, CCMC (no IDD) **Plan of Care Development:** one annual $384.81 for ALI, APDD, CCMC, IDD	SDS assessment
3	**Intellectual and Developmental Disabilities (I/DD)** Medicaid Waiver care coordination	Individuals with intellectual and developmental disabilities under the following diagnoses 1) Intellectual Disability; 2) Other Intellectual Disability – Related Condition; 3) Cerebral Palsy; 4) Epilepsy; 5) Autism	Care Coordination	Develop plan of care; submit level of care; two visits per month; ensure plan of care is being followed, suggest additions.	Support planning Monitoring Participant Empowerment	SDS Intellectual & Developmental Disabilities (IDD) Waiver Unit	Medicaid	See above.	State assessment
4	State HCB **grant services** case management	Seniors, people with developmental disabilities or TBI who do not qualify for the waiver.	Case Management	Develop plan of care; care coordination for those not covered by Medicaid services, e.g. for people on GR, some oversight of PCA, helping find homes; case notes on individuals; no requirements for documentation or monitoring.	Gate Keeping Support Planning	SDS	State General Funds	Grant pays salaries of grantee organization case managers based on percentage of time spent doing case management, reporting is done in 15m increments.	Referred by other service providers, if they are receiving PCA, they can access care management through grant services.
5	**Tribally targeted** case management	Tribal members; target population varies	Case Management	Tribes present target group case management strategy for MCD approval. For example, TCC provides documented check in on all elders using PCA each year, make sure they are getting services they need and are eligible for; two contacts per month once enrolled.	Gate Keeping Support Planning Monitoring	SDS	Medicaid 100% FMAP	Varies	TCC: Nurse case manager provides functional assessment of each elder during community visit.

Current Case Management Models in Alaska

	A	B	C	D	E	F	G	H	I
1	**Case Management Program**	**Population**	**What is it Called?**	**Description of Services**	**CM Core Components**	**Oversight**	**Funding**	**Reimbursement**	**Gate Keeper**
6	**Behavioral health** case management	People with serious mental illness, TBI or substance abuse	Case Management	Models are often blended: brokered case management, assertive case management, clinical case management, general case management; some services.	Gate Keeping Support Planning Monitoring Participant Empowerment	DBH	Medicaid	$16/15 minute increment	Clinical assessment by provider agency; court order.
7	Medicaid **high utilizers utilization management**	High utilizers, voluntary enrollment	Case Management	Telephonic "soft touch" case management goal is to get people to use appropriate medical resources for their needs; getting people to apt; follow up; offer case management services for family if desired.	Gatekeeping Support Planning Monitoring Participant Empowerment	HCS	Medicaid	Flat rate per person: $3.34/member per month	Cold call of high utilizers (5+ in 18 mos.); Voluntary; asked to participate.
8	Medicaid **high utilizers care management**	High utilizers, involuntary program, "lock-in."	Care Coordination	Designated insurance card, pharmacy, doctor for high utilizers.	Support Planning N/A	HCS	Medicaid	Flat rate per month built into contract	Limited to the 300 highest utilizers.
9	Medicaid **high utilizers case management**	High utilizers	Case Management	Clinical case management	Gatekeeping Support Planning	HCS	Medicaid	Billed on monthly, billed by the hour	Anyone who is in hospital 3 days or more.
10	SDS General Relief Assisted Living	Very low income, at risk for homelessness.	No case management provided	No case management provided.	No case management provided	SDS	State General Funds	No case management provided	SDS
11	DBH General Relief Assisted Living	Very low income, at risk for homelessness, behavioral health diagnosed and referred by community behavioral health provider.	Case Management	Case management provided as part of behavioral health services.	Support Planning Monitoring Participant Empowerment	DBH	Medicaid	$16/15 minute increment	DBH

Current Case Management Models in Alaska

	A	J	K	L	M
1	**Case Management Program**	**Who Provides?**	**Number Served**	**Case Load**	**How Often?**
2	**Adults Living Independently (ALI), Adults with Physical and Developmental Disabilities (APDD) and Children with Complex Medical Conditions (CCMC)** Medicaid waiver care coordination	Individuals and provider orgs/agencies.	ALI: 2059 APDD: 78 CCMC: 251	20-40	Twice per month
3	**Intellectual and Developmental Disabilities (I/DD)** Medicaid Waiver care coordination	Individuals and provider orgs/agencies.	IDD: 1,963	15-35	Twice per month
4	State HCB **grant services** case management	Grantee organizations	Senior:1,235 DD: 954	30-50	Flexible
5	**Tribally targeted** case management	Currently Tanana Chiefs Conference (TCC) and Southcentral Foundation; tribal organizations	Varies	Varies	Flexible

Current Case Management Models in Alaska

	A	J	K	L	M
1	**Case Management Program**	**Who Provides?**	**Number Served**	**Case Load**	**How Often?**
6	**Behavioral health** case management	Community Behavioral Health Providers	Data not collected	15-60	Once per month (very min)- 5/week
7	Medicaid **high utilizers utilization management**	Medical expert, private contractor	6, 500 high utilizers; 149 called, 44 in-depth conversations; 30 people asked to call back; 3 currently "enrolled"	Team approach	As needed
8	Medicaid **high utilizers care management**	Primary care physician	300	N/A	N/A
9	Medicaid **high utilizers case management**	Medical professionals, hospital staff through Qualis Health	715 in 2014; 544 in 2013	Team approach	For duration of hospital stay.
10	SDS General Relief Assisted Living	-	-	-	-
11	DBH General Relief Assisted Living	Community Behavioral Health Providers	Data not collected	15-60	Once per month (very min) to 5/week

	A	N	O	P	Q	S	T
1	**Case Management Program**	**For How Long?**	**Where?**	**Percent of Clients Served by Independent Care**	**Potential Conflict**	**Qualifications + Training**	**Strengths**
2	**Adults Living Independently (ALI), Adults with Physical and Developmental Disabilities (APDD) and Children with Complex Medical Conditions (CCMC)** Medicaid waiver care coordination	Indefinite	Once per month in person, once via telephone Quarterly in person if remote.	ALI: 68% APDD: 41% CCMC:19%	Agencies that provide both case management and direct services might directly or indirectly persuade case managers to prescribe more direct services than necessary, or only share/know about services within the agency.	Must complete the SDS basic training course once every two years.	Works well with PCA for most part; ensures quality of care is high.
3	**Intellectual and Developmental Disabilities (I/DD)** Medicaid Waiver care coordination	Indefinite	Once per month in person, once via telephone Quarterly in person if remote.	IDD: 17%	Agencies that provide both case management and direct services might directly or indirectly persuade case managers to prescribe more direct services than necessary, or only share/know about services within the agency.	Must complete the SDS basic training course once every two years.	Care coordinators are with people for a long time and know their needs, know their communities, and their school; CC is consistent person in life. Helpful to have people trained to waiver type (IDD CCMC have a bigger menu, goal directed). Networks are driving the professionalism of care coordination up. CC gather information for the State for document coordination and submittal.
4	State HCB **grant services** case management	Work with someone intensely in the beginning and then tapers off	Flexible	N/A	Funding from state subsidizes cost of providing Medicaid waiver care coordination; sustainability of care/case management is intertwined.	Unknown	Grant funds supplement CC/waiver services; grant funds can be used for travel, subsidize cost of Medicaid waiver care coordination, if traveling to same area, gets access to people who aren't receiving care coordination or case management through waiver.
5	**Tribally targeted** case management	Indefinite	In person + other options	N/A	Rural areas more likely to have exemption from conflict-free requirements.	Varies	TCC model: Covers all elders that the provider reaches, and then looks for first way to get billing through; less duplicative.

	A	N	O	P	Q	S	T
1	**Case Management Program**	**For How Long?**	**Where?**	**Percent of Clients Served by Independent Care**	**Potential Conflict**	**Qualifications + Training**	**Strengths**
6	**Behavioral health** case management	Indefinite	Face to face	Case management is a direct service so not thought of in terms of conflict.	Agencies that provide both case management and direct services might directly or indirectly persuade case managers to prescribe more direct services than necessary, or only share/know about services within the agency.	Bachelors degree + work experience.	Conflict of interest is not really an issue, because case management is a service, it is the nature of the approach. Issues are more around whether agency can actually provide that much service. Case manager is often the main person a client works with. Not seeing duplication.
7	Medicaid **high utilizers utilization management**	Indefinite	Telephone	N/A	None. Often people on Medicaid are part of other case management program such as through BH or Southcentral. When they find out there is another case manager, they work directly with the case manager.	844 CMS panels, all types, pharmacy, etc.	Very new program, but response has been positive, if the individual wants them to case manage the whole family, they will.
8	Medicaid **high utilizers care management**	One year	N/A; policy	N/A	N/A	N/A	Allows highest utilizers to have access to primary care to prevent unnecessary use of ER and save money.
9	Medicaid **high utilizers case management**	For duration of hospital stay	Hospital	N/A	N/A	Medical professional degrees: RNs, pharmacist, physicians.	
10	SDS General Relief Assisted Living	-	Assisted Living	N/A	No incentive for ALH providers to help individuals get to more independent housing.	-	ALH providers work on behalf of GR clients to get them on the waiver so that they can get reimbursed for ALH services. ALH providers work as de facto, if conflicted, case managers.
11	DBH General Relief Assisted Living	Indefinite	Assisted Living	N/A	Same as BH services, in general.	Bachelors degree + work experience.	Case managers help residents get on waiver or find more suitable housing.

	A	U
1	**Case Management Program**	**Weaknesses**
2	**Adults Living Independently (ALI), Adults with Physical and Developmental Disabilities (APDD) and Children with Complex Medical Conditions (CCMC)** Medicaid waiver care coordination	Mostly focuses on waiver services, so some things get missed. Some clients don't communicate well via phone. State PCA program is outside of waiver, one of few states like this. There is a difference in care coordination between ALI and IDD waiver; minimal care coordination in a lot of rural communities; more care coordinators for IDD in rural areas (much longer, person centered planning has been in place longer). Sometimes a rural community has services, but there are no care coordinators - they need a care coordinator, can't have services without a plan, can't bill for adult day, respite. Hard to do care coordination in rural areas outside of grant. Independent care coordinators don't pencil in rural areas. Independents not paid for travel time. Agencies aren't either but they have grants and in-house referrals. People expect case management but are getting care coordination.
3	**Intellectual and Developmental Disabilities (I/DD)** Medicaid Waiver care coordination	Turnover means one person writes the goal, but the next person doesn't know why. Lack of expertise, when someone doesn't have expertise, some people don't know what they are monitoring. First training is overwhelming, rely on agencies for next level of training. Hard to move between children and adults. IDD care coordinators have lower case loads. Care coordinators don't have any authority, if they don't work for the agency, the agency doesn't have to abide. Once they have the waiver, care coordination is on a tight timeline to get services. More turnover in Anchorage and urban areas than in rural areas
4	State HCB **grant services** case management	
5	**Tribally targeted** case management	There is so much turnover in smaller organizations with limited capacity. Organizations want to focus on clinics, not HCBS, which are fee rather than flat rate. Tribal organizations reluctant to get into HCBS. Also, HCBS not funded through IHS historically. If the services aren't available through entity, or in community, why would you provide case management? Lack of ability of tribes to come up with cost reporting for that specific service; hard to break out cost center for case management. Hard to find care coordinators to serve rural areas.

	A	U
1	**Case Management Program**	**Weaknesses**
6	**Behavioral health** case management	Large case loads mean that once people get to a certain level of independence, they don't get additional services. If people get services from more than one provider, they also have multiple case managers/plans of care. Constantly having to train new staff, staffing levels. Not able to provide case management beyond when basic needs are met. For example, when in BH ALH, sometimes not able to help get into a more independent living situation. DBH is limited in funds, so there are people on the SDS ALH list that could benefit from DBH assisted living, accompanying case management, but can't move over.
7	Medicaid **high utilizers utilization management**	Voluntary program, might not be able to case manage the highest utilizers.
8	Medicaid **high utilizers care management**	More care management; case management is not available other than the coordination the primary care provider can provide.
9	Medicaid **high utilizers case management**	Does not extend beyond the hospital; there can be overlaps with other case managers.
10	SDS General Relief Assisted Living	No incentive for ALH providers to help individuals get to more independent housing. Intended as a temporary program but often becomes long-term due to lack of other housing options or case management support to find them.
11	DBH General Relief Assisted Living	General Relief is paying for a services that could potentially be covered through a 1915(i) Medicaid waiver.

SUMMARIES OF INTERVIEWS WITH OTHER STATES

COLORADO

The Colorado Department of Health Care Policy and Finance (HCPF) is also going through an evaluation of their case management and service delivery system in order to address the conflict-free case management (CFCM) requirements. We spoke with representatives from the Developmental Disabilities (DD) section of HCPF about how they are working to meet these requirements under their 1915(c) wavier, through which case management services are offered via targeted case management.

Case management and service provision for individuals with developmental disabilities in Colorado is provided by non-profit Community Centered Boards (CCBs). Each of the CCBs have a provider arm, some of which have different names than the CCB and appear to be separate, but are still part of the same non-profit organization. In conversations with the 20 statewide CCBs, HCPF said that the agency representatives acknowledged that they were out of compliance with the CFCM requirements and wanted to work with the Department to align with the rules. In order to do this, HCPF created a task group comprised of CCB representatives, non-CCB providers, advocates, consumers and other community members. A detailed report has been developed based upon the non-voting group's recommendations, and three primary models were proposed. The HCPF representatives said that while all recommendations were documented in the report, not all of them aligned with the rules, and it will be the job of the Department to make the final say about how to address them. The models proposed by the group were:

- The local agency would be able to provide case management and services, but not for the same person. This was a method that providers in Alaska were interested in further exploring. The CCBs in Colorado liked this approach, but the advocates, consumers, community members, and non-CCB providers did not. They feared that there would be a bias towards agencies that the CCB has friendly relationships or service agreements with, which may result in collusion between provider and case management agencies. HCPF has emailed CMS for further guidance about this approach, but has not heard back as of 12/22/14.

- A second suggestion was that participants could waive their right for CFCM in order to keep the same case manager. This grandfathering system does not appear to be allowable under the rules, and HCPF has received guidance from CMS staff that this would not align with the regulations.

- The third option would be to completely separate the responsibilities, and allow the CCBs to choose whether they wanted to provide case management or direct-care services. This would allow HCPF to meet the CFCM requirements, however, the CCBs had concerns about this strategy, in particular about the impact on funding. CCBs

receive a majority of their funds from local county mill levies. While the funds would support the case management function, how the other functions the CCBs provide, such as the Human Rights Committee, investigations, and waiting list management, would be funded after the case management and service provision split occurred were less clear. The CCBs were also concerned that there would be major disruptions to services for people who have been receiving services and case management on a long-standing basis after the split.

An additional consideration proposed by this group was around how any of the above changes may impact rural populations. The CCB representatives recommended that there be an exceptions process in rural areas that would allow them to provide both case management and direct-care services, as there are fewer providers in the areas and the CCBs could provide the most appropriate services and case management. However, non-CCB providers and other group members said that there would be enough providers even in the rural areas to provide both case management and direct-care services separately, and that it even may allow for the creation of new agencies and expansion of existing agencies.

HCPF has just finished creating the report based on the recommendations of the task work group, and at this time does not have a timeline for implementing the changes. Department representatives said that there will need to be legislative input on the proposed changes, which will not occur for at least another year. They agreed to continue to share guidance with Alaska as they moved forward with the process.

WYOMING

The Wyoming Department of Health, Behavioral Health Division (BHD), is currently in the process of transitioning its Developmental Disabilities and Acquired Brain Injury programs to meet the requirements for conflict-free case management (CFCM). This move predates the publication of the CMS HCBS rules. In 2013, a review of the Medicaid program led to a legislative mandate to make the system conflict free. BHD has developed a plan to comply with this mandate, which is scheduled to be complete implementation by July 2015.

Prior to these changes, the case management system in Wyoming included a mix of both independent and provider employed case managers. In both cases, some of the case management was provided by individuals and some provided through agencies.

State staff cited the following as factors that lead to the decision to change the case management structure:

- Because many of the case managers only do so part-time, the State has a large number of case managers relative to the number of participants they serve. In many cases, a case manager may only be serving a few individuals. This has created issues because 1) a part-time case manager with competing priorities may be less willing to devote the time necessary to learn all of the case management requirements and 2) the larger the number of case managers, the greater the training and monitoring burden on State staff.

- State staff observed that case managers were billing for improper and unallowable activities. This appeared to be related both to a lack of clarity in the policies and rules for case management and a lack of understanding regarding the existing policies and rules.

- Providing case management was a low priority for provider agencies, especially among the smaller provider agencies who may lack the capacity to fulfill the functions of plan development and providing subsequent direct support.

BHD felt that these conflicts impact participant choice and was a barrier in building a person-centered system. In order to determine the most appropriate approach for changing the system, the State conducted research on other states and sought guidance from the National Association of State Directors of Developmental Disabilities Services (NASDDDS).

BHD's original plan excluded providers of HCBS services from also providing case management. However, stakeholders, especially provider case management agencies, reached out to the governor and legislature, and after collaboration with the Behavioral Health Division the plan was altered so that HCBS providers could continue to provide case management, but not provide both services and case management to the same individual.

While BHD staff have concerns about providers playing both roles, they concede that they change may increase flexibility and offer more options in rural and frontier areas.

BHD staff believe that the most important part of the plan is that it provides a stronger definition for case management and more clearly delineates what activities can and cannot be billed as case management. The implementation effort includes and extensive training and monitoring component.

BHD staff believe that as the requirements and oversight are enforced, case managers who are not able to meet these minimum quality standards will self-select out.

BHD staff had several recommendations for Alaska as the State moves forward with its CFCM plan:

1. Allow sufficient time for transition. In most cases, meeting the CFCM requirements requires substantial changes throughout the state. Alaska needs to ensure that it has allotted sufficient time to develop a comprehensive plan in order to think through potential challenges and barriers and effectively address them. It will also be imperative to establish a realizable timeline for agencies to implement the changes so that clear expectations are laid out and enforcement of the requirements can occur. Additionally, in order to facilitate effective planning and subsequent implementation, these changes must include affected parties in order to build buy-in for the effort.

2. Develop effective training and monitoring infrastructure. To ensure that individuals are having a consistent experience regardless of where they are in the system, it is crucial to ensure that all case managers receive standardized training. As implementation occurs, developing quality management and monitoring plans will be essential to ensure that the plan is carried out and sustained.

3. Set clear requirements for case managers to review provider documentation. Case managers will be at the core of ensuring that services are coordinated and that the individual is receiving the most appropriate services.

4. Work closely with your CMS Regional office. Regional offices can provide a tremendous amount of guidance, both about implementing new initiatives and anticipating how current efforts may need to be modified to comply with upcoming change.

HAWAII

The State of Hawaii's Department of Health, Developmental Disabilities Division (DDD), has been reviewing federal requirements around Conflict Free Case Management (CFCM) and person-centered planning in order to determine what steps need to be taken to come into compliance. DDD is housed within the Department of Health (DOH), while the Medicaid agency resides within the Department of Human Services (DHS).

Hawaii has a statewide case management system in which all case managers are State employees. Because the case managers are State employees, the Hawaii DD system already complies with the conflict-free requirements in the CMS rules. The DDD case managers able to serve approximately 1,700 individuals with DD on Oahu (which includes Honolulu) and 900 in the other three counties.

Hawaii had provider case management until the late 1990s. At this time, the State assumed responsibility for case management because there was concern that many of the functions that providers were calling case management were actually functions that benefited the provider agencies more than the individuals receiving services. These concerns were based on several factors, including:

- Providers appeared to be case management funds to perform administrative activities for other services that were not considered by the State to be case management.
- Providers were only offering services that they provided. Individuals did not have the ability to learn about additional services that may be offered by other providers.
- Because they had a financial incentive, provider case managers appeared to be over-estimating client needs to obtain more funding.
- Case managers of the provider agencies were tasked with both advocacy and gatekeeping and were having difficulty meeting both functions.

Upon taking over the case management responsibilities, the State was in a position to mitigate these concerns and better ensure that all individuals were receiving the most appropriate services.

The representative from DDD recommended that Alaska discuss concerns the State may have about providers maintaining control of both case management and direct-care services further with community stakeholders, such as DD Council. This will better allow stakeholders to understand why change may be necessary, and potentially build support for the change.

DDD also said that the change to the State controlling the provision of case management allowed them to standardize and refine the process to ensure that federal standards were being met and individuals were able to make informed decisions about the most appropriate services. Additionally, having control of the case management function at the State level helped DDD develop better

quality measures to ensure that goals laid out in the service plans are being met. The onus is now on the providers to demonstrate progress towards these goals.

Similar to Alaska, Hawaii has a diverse population and many residents are located in remote settings. DDD emphasized that the ability to provide oversight through case management has allowed them to ensure that these potentially vulnerable populations are appropriately served.

As Hawaii moves forward with developing assessment processes and meeting the CMS person-centered requirements, they have been utilizing the experience they have gained through this case management development. They are learning when and how to best involve providers in the feedback process. They are also involving a wider group of stakeholders, including the DD Council and Behavior Committee Review, to obtain feedback and build buy in.

MINNESOTA

The Minnesota Department of Human Services, Disabilities Division, has developed a system that meets the Conflict Free Case Management (CFCM) requirements. Within Minnesota's system, case management is offered across 87 counties by entities known as Lead Agencies. For individuals under age 65, Lead Agencies are typically the counties. Because these agencies are not service providers, they are not out of compliance with the CFCM requirements. However, issues around quality control have arisen due to the preference of many of the counties to contract out case management services. Minnesota is attempting to address these quality control issues and ensure full compliance with federal regulations through a number of initiatives.

Minnesota began transforming its system to meet CMS' person-centered planning requirements and improve processes related to CFCM through the development of the comprehensive, person-centered assessment and support planning system known as MnCHOICES. The policies and procedures related to MnCHOICES also facilitated the separation of the assessment and resource allocation functions from the case management role within the Lead Agencies. The separation of the duties has resulted in "professionalizing" the role of the assessor to better facilitate the development of the person-centered plan. As a result, the State is better able to understand barriers and they are now considering creating new resources to assist the case managers in developing the plans. This is especially important because case managers generally still play the lead role in developing the Community Support Plan.

In addition to the development of the MnCHOICES tool, Minnesota has been working to develop information technology (IT) to support the flow of information from the tool to the case managers and other relevant individuals, such as providers. The Division is now clarifying how and when case managers and providers should be able to access, update, and provide information for the assessment.

To support the enhancement of the system, the Division has been developing mechanisms and protocols to collect provider input. The Division is focusing on transitioning individuals out of more restrictive settings, and has been developing protocols that support an appropriate, safe approach for this process and incorporating provider input.

The Division is also looking at expanding populations receiving case management. This discussion has included moving away from providing case management directly in the waivers and utilizing Targeted Case Management (TCM).

With statewide automation, the Division is able to obtain data for quality control from the assessment and support plan to obtain a view of how well services are meeting individual goals. The Division is also working to develop a process to determine how this data could be used to establish whether unique interventions should become a part of the regular support planning process.

The Division representatives said that they would have some hesitation in allowing service providers to provide case management to clients who they do not provide direct services to. They said that quid pro quo arrangements with other entities would be a primary concern. If Alaska does decide to move forward with this arrangement, Minnesota recommended a strong separation of the administrative functions related to case management and service provision. They also emphasized that having separation of support plan development and implementation is very important, as it helps minimize perverse incentives.