IMPLEMENTING SELF-DIRECTED WAIVER SERVICES IN ALASKA

Prepared for the Independent Living Network of Alaska
by Applied Self-Direction

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Introduction & Approach

With financial support from the Alaska Mental Health Trust, Independent Living Center (ILC) contracted with Applied Self-Direction to develop recommendations for implementing self-directed waiver services in Alaska, focusing on the Adults with Physical and Developmental Disabilities Waiver and the Individualized Supports Waiver. The state currently does not have self-direction options for Medicaid-funded services, although the Alaska Veterans Administration and ILC successfully implemented a Veteran-Directed Care (VDC) program in 2015 for Veterans to self-direct their services and supports. The VDC program has now been replicated in three other Aging and Disability Resources Centers (ADRC) in the state; SAIL in Southeast Alaska, LINKS in the Matanuska Susitna Valley and ADRC North in the Fairbanks region.

The first phase of this project was to support ILC in identifying the needs, priorities, and other preferences of potential program participants and other stakeholders, emphasizing unmet needs for which self-direction could provide potential solutions. ILC provided Applied Self-Direction with contact information of individuals using Medicaid waiver services and AARP's Director of Advocacy in Alaska. We also spoke with staff with Alaska Senior and Disabilities Services.

A total of seven video conference interviews were held during August and September 2024, including six with program participants. We were able to discuss these individuals' experiences with their services and to give an opportunity for them to ask questions about self-direction. The issues raised in these interviews are as follows:

1. Most individuals indicated they primarily had residential habilitation to address their needs.
    a. A few people said that they do not need habilitation because they do not need to learn new skills. They just need hands-on assistance to complete daily tasks due to physical disability.
    b. Some people also said that residential habilitation was the only available option to provide the number of hours of assistance needed.
    c. One individual said the residential habilitation provided 24/7 coverage but was strictly in-home only. Any assistance in the community or while traveling had to be privately paid.
    d. Another individual said that he might be able to get day habilitation for community access if he could find a person qualified to provide services. His trusted friend had a criminal background and would most likely not qualify.
2. Several individuals mentioned the challenge of living in extremely rural communities, making filling staffing needs difficult.

3. An AARP representative referred for an interview discussed how the state had engaged in a "Shared Vision" workgroup that included stakeholders who work with and/or utilize services through Centers for Independent Living (CIL), developmental disabilities agencies, and aging entities to identify system-wide goals for home and community-based services. The outcome of this work was agreed-upon goals for the state to:
    a. Adopt the use of the InterRAI system statewide so evaluations can level-set identification of individual needs across programs.
    b. Adopt the option for self-directed supports in the 1915(c) Waivers
    c. Eliminate the wait list for developmental disabilities services.

State staff told Applied Self-Direction (ASD) that they are in the process of working through the Advanced Planning Document (APD) process with CMS to obtain 90/10 enhanced funding for the information technology work to implement the InterRAI assessment statewide., This report will describe self-direction options that can be implemented regardless of timeline or assessment methodology. This includes the possibility of establishing a pilot program in the interim until the InterRAI is implemented. It should be noted that changing assessment parameters when the InterRAI is implemented may be difficult, particularly for individuals who may have reduced service allocations. However, the negative impacts could be mitigated by informing participants up front that initial authorizations for hours would be only a pilot in order to give people the opportunity to begin hiring workers to self-direct.

How would self-direction address identified issues?

Self-direction inherently addresses gaps in service delivery systems because the tasks and means of assistance are customized to each person's needs and preferences. Neighbors, acquaintances, relatives, and friends are potential staff and may significantly expand the potential worker pool. Most importantly, self-direction upholds the principle that every person has the right to self-determination and the right to exercise authentic choice and control over their daily lives.

Many times, hesitation for self-direction comes from the feeling of responsibility for participants' safety and well-being. Indeed, Medicaid programs require states to ensure the health and welfare of beneficiaries in home and community-based programs. However, person-centered planning is a powerful tool to identify and ameliorate risk in a personalized way that makes sense for the individual. Studies show that people utilizing self-direction are

more satisfied with their lives and have a drastic reduction in unmet needs[1]. Self-direction does not result in increased misuse of Medicaid funds or abuse of participants[2]. Self-direction increases the freedom and control in the lives of people from every disability population, age group, and socioeconomic status. There is evidence that self-direction can mitigate the worker shortage by increasing the number of willing workers to include family and friends.[3] Both peer-reviewed research and the surging nationwide demand for self-directed services demonstrate that systems that support people to live their lives how–and where–they wish will lead to better outcomes and, ultimately, a better quality of life.

While it did not come up directly in our conversations with stakeholders, fraud in self-direction is often a concern for policymakers. Again, extensive history has demonstrated that solid participant education, sound service plan development, and strong FMS oversight make fraud a rare occurrence and almost non-existent on any scale. Using data from the Centers for Medicare and Medicaid Services (CMS) Office of Inspector General (OIG), Applied Self-Direction demonstrated the rarity of fraud in self-direction and its small scale when it happens[4].

Applied Self-Direction recognizes the competing priorities facing limited state government staff. However, we believe the core component of self-direction—employer authority—could be implemented efficiently. This approach would allow participants to hire and manage their own workers. While comprehensive self-direction should eventually include budget authority for purchasing goods and services, initial implementation would be more feasible if focused first on employer authority. Under this model, participants would develop schedules based on their needs, similar to how service hours are currently authorized. In addition, participants would set their workers' wages within an established hourly range. For many individuals, this simplified approach could significantly impact daily routines and community engagement, with minimal additional administrative burden on the State**.**

What is needed for a streamlined self-direction model?

There are three components to a Medicaid self-directed model. The first is the service (or services) that is actually being self-directed. Alaska has all of its personal care services currently

[1] Phillips, B., Mahoney, K., Simon-Rusinowitz, L., Schore, S., Barrett, S., Ditto, W., Reimers, T., & Doty, P. (2003). Lessons from the implementation of Cash & Counseling in Arkansas, Florida, and New Jersey. Mathematica Policy Research Inc.

[2] Applied Self-Direction. (2022). Fraud in self-directed personal care services: What does the data tell us? www.appliedselfdirection.com

[3] Murray, K., Morris, M., Edwards-Orr, M., Sciegaj, M., Flinn, B. (2024). National inventory of self-directed long-term services and supports. AARP Policy Institute.

[4] Applied Self-Direction. (2022). Fraud in self-directed personal care services: What does the data tell us? www.appliedselfdirection.com

provided through its Community First Choice 1915(k) state plan benefit, so it is recommended that the self-directed service to be added to the 1915(c) waivers be something such as "Self-Directed Home and Community Supports". Although we recommend amending the 1915(c) waivers as the most straightforward path to initial implementation, the state may want to consider amending the 1915(k) Community First Choice or adopting a 1915(j) self-direction state plan amendment to expand the options. Considerations for all of these options are outlined in Appendix B at the end of this report.

There is also a need for two types of support services to aid participants in self-direction, regardless of the model used. Financial Management Services (FMS) supports the individuals by screening for provider qualifications such as age, driver's license, if applicable, and facilitating a criminal background check. The FMS entity also processes payroll, deductions, and withholding, and is often responsible for monitoring and reporting on adherence to the person's service plan. The FMS is also responsible for billing Medicaid for the services that have been delivered. The other support component is Information and Assistance (I&A), a service that supports the individual through the interview and hiring process and helps troubleshoot any issues that arise. In many states, I&A is known as Support Brokerage.

Self-Directed Home and Community Supports could be an added service to any of the existing waivers and/or the Community First Choice (CFC) state plan option. If the state chose to keep the self-directed service centered around personal care (ADL and IADLs), The self-directed model could be added to the CFC with extended state plan definitions added to the 1915(c) waivers. A suggested basic service definition can be found in Appendix A. The key to the definition is to specify it covers assistance for Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and community access supports, and that it is directed by the waiver participant or their designated representative. Alaska already includes legally responsible adults as allowed providers for most services and we recommend keeping this approach for this service as well. We believe this service would address the need identified by multiple stakeholders for a service that does not emphasize a habilitative component.

We recommend that the Self-Directed Home and Community Supports initially be offered with full employer authority and limited budget authority so that participants may set wage amounts. Under this approach, participants would select and hire staff of their choosing (provided each worker meets provider qualifications set by the state), schedule, train and manage their workers, and set their workers' rates of pay. In a budget authority context, different workers may be paid different hourly wages to provide the same Medicaid service. This flexibility offers significant benefits for participants. For example, a participant may wish to pay a higher wage to fill a difficult-to-cover shift, or may choose to start a new worker at a lower rate and provide wage increases over time as the worker gains experience. States may set

reasonable minimums (typically minimum wage) and maximum wages participants may pay (often a percentage of state minimum wage, e.g., 200-300%). These numbers vary, though, given that there is wide variance in state minimum wages across the country. The Bureau of Labor Statistics (BLS) publishes average wages for each region that can be the basis for wage ranges allowed by Alaska.

FMS can be managed as an administrative cost via contract with the Medicaid agency or as a service in a waiver. There is already a private FMS entity providing services in Alaska. ARIS Solutions provides FMS services for the Veteran-Directed Care program. As a result, the state could take advantage of this service that is already in place and negotiate a Medicaid contract with this entity. State rules for contracting will need to be followed, but given the relatively small numbers of participants who might be expected to be early adopters of a self-directed model, it may make sense to explore sole-source contracting options instead of competitive bidding. This would streamline the implementation process considerably. Even if a competitive procurement process is needed, a statewide FMS contract would be easier and more cost-effective to manage than having multiple FMS entities to monitor during the start-up phase of the program.

We recommend that self-directing participants have regular meetings with state and program staff to discuss and troubleshoot issues regarding implementation of the Pilot self-directed program, including the initial FMS contract. The goal would be to add a second FMS entity once self-direction enrollment is sufficiently high to support costs of an additional FMS provider. Where Alaska has a Federal Medical Assistance Percentage (FMAP) of just over 50%, there would be very little difference in state cost between the FMS being an administrative activity or service, but participants who self-direct overwhelmingly prefer to have a choice of providers.

I&A is a critically important support, especially for people new to self-direction. The research showed that individuals who had I&A supports that were experts in self-direction had higher success and satisfaction than those who only had traditional care coordinators to assist[5]. Following the model of many states, we recommend partnering with Centers for Independent Living (CILs) to provide this service. Since several of Alaska's CILs already have expertise in self-directed services from their work with the Veteran-Directed Care program, bringing them on to support a new, simplified State Medicaid option should not require extensive training on the part of the State.

[5] Phillips, B., Mahoney, K., Simon-Rusinowitz, L., Schore, S., Barrett, S., Ditto, W., Reimers, T., & Doty, P. (2003). Lessons from the implementation of Cash & Counseling in Arkansas, Florida, and New Jersey. Mathematica Policy Research Inc.

Criminal background checks were identified by at least one waiver participant as a potential barrier to locating workers. It can be especially frustrating when the person is a close friend or family member, and the offense happened years ago. The state may want to consider a process where self-directing individuals may appeal a finding of a potential worker found ineligible when extenuating circumstances may demonstrate the individual is not a threat.

Service hours would continue to be authorized through the current process, with care coordinators maintaining their role in monitoring participants' health and welfare. The implementation of the InterRAI system will improve confidence that the participants' needs are assessed consistently across the state. However, in the interim period before InterRAI adoption, the Medicaid waiver costs could be used as the basis for a self-directed budget relatively easily. Also, since current hourly rates for care include agency overhead costs, these amounts could be used to cover the costs of the FMS and I&A services.

As the program rolls out, a key consideration is how to identify individuals who will self-direct. Studies dating back to the early 2000s, along with decades of program experience, has consistently shown that anyone can self-direct with proper support.[6] Adequate support for participants typically includes some form of I&A. In certain cases, it may also involve appointing a representative to make decisions based on the participant's wishes and fulfill employer responsibilities on their behalf. Given these findings, "self-selection" emerges as the most effective approach. If an individual expresses interest in self-direction after fully understanding the associated responsibilities, they can generally succeed in this model.

When a person chooses to self-direct, the I&A service provider is available to help the participant develop worker job descriptions, locate workers, and learn employer skills as needed. One of the issues that would need to be resolved would be the extent of the involvement of the I&A service provider. Would that provider be involved solely in developing a service plan and supporting the participant as they implement their responsibilities, or would that role be broader, including monitoring the implementation of the plan and sharing oversight around health and safety with the care coordinator? The participant will need to work closely with the I&A provider, the care coordinator, and the FMS as a team to ensure care is provided as planned. Some states have the I&A provider take on all of the care coordinator responsibilities for self-directed individuals.

Based on Applied Self-Direction's experience, the new self-directed programs typically follow a pattern as they grow. Programs often start slowly as participants familiarize themselves with the

[6] National Center on Advancing Person-Centered Practices and Systems (NCAPPS). (2024). Everyone can self-direct: Lessons learned from the NCAAPS self-direction learning collaborative [Video]. YouTube. https://www.youtube.com/watch?v=SQNkV8mpQu4

program, and state agencies, along with their partners, refine operational aspects. Over time, these programs tend to grow, particularly among demographics that find traditional agency models inadequate, such as those in rural or frontier areas. The implementation includes first amending applicable waivers and/or state Plan. The 1915(c) waivers require the addition of one or more self-directed services as discussed above (in Appendix C), and completing Appendix E that describes the model for self-direction in the state.

Following an initial adjustment period, programs often experience significant expansion as participants witness the positive impact of self-direction on quality of life. As state staff and providers become more proficient in supporting self-direction, the State may consider evolving towards a full budget authority model. This allows participants greater flexibility in purchasing goods and services to meet their needs.

Appendix A: Sample Service Definitions

Self-Directed Home and Community Supports : A range of assistance to enable waiver participants to accomplish ADLs and IADLs and to support accessing community activities that they would normally do for themselves if they did not have a disability. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cueing to prompt the participant to perform a task. These services may be provided on an episodic or on a continuing basis. Health-related services that are provided may include skilled or nursing care and medication administration to the extent permitted by state law. Self-Directed Home and Community Supports under the waiver differ in scope, nature, supervision arrangements, and/or provider type (including provider training and qualifications) from personal care services in the state plan. It is directed by the individual or their authorized representative.

Information and Assistance in Support of Self-Direction (Supports Brokerage): Service/function that assists the participant (or the participant's family or representative, as appropriate) in arranging for, directing, and managing services. Serving as the agent of the participant or family, the service is available to assist in identifying immediate and long-term needs, developing options to meet those needs, and accessing identified supports and services. Practical skills training is offered to enable families and participants to independently direct and manage waiver services. Examples of skills training include providing information on recruiting and hiring personal care workers, managing workers, and providing information on effective communication and problem-solving.

The service/function includes providing information to ensure that participants understand the responsibilities of directing their services. The extent of the assistance furnished to the participant or family is specified in the service plan. This service does not duplicate other waiver services, including case management.

Appendix B: Options for Self-Direction Implementation

	1915(c) Waiver Note: This option is recommended to start.	1915(j) State Plan Amendment	1915(k) Community First Choice
Steps required for federal approval	Complete Appendix E in applicable waiver(s) to describe program policies. Define self-directed services and associated provider qualifications for each service in Appendix C. Submit to CMS as part of waiver amendment process.	Complete the brief 9 page 1915(j) Pre-Print document, and submit to CMS for approval. The 1915(j) plan must run concurrently with one or multiple waivers, and/or state plan personal care.	Amend the state's existing 1915(k) State Plan Amendment to allow for a self-directed model of attendant services, and submit to CMS for approval.
Population targeting and limits on participants served	Allowable to target by population served. Also allowable to limit availability of self-direction by geographic area. Not allowable to limit self-directing participants by number of participants served.	Allowable to target by population served. Also allowable to limit availability of self-direction by geographic area. Also allowable to limit availability of self-direction by number of participants served (e.g., 1,000 participants.)	Not allowable to target by population served.
Renewal requirements	5 years.	One-time approval.	5 years.
Reporting requirements	Annual reports required.	Annual reports required. Triennial health and welfare reports required.	Annual reports required.
Financial Management Services requirements	FMS can be structured as a waiver service or an administrative activity at state discretion.	FMS must be structured as an administrative activity. FMS for	FMS may be covered as a service or administrative