

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State of Alaska** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:

Children with Complex Medical Conditions

C. Waiver Number: AK.0263

Original Base Waiver Number: AK.0263.90.R2

D. Amendment Number:

E. Proposed Effective Date: (mm/dd/yy)

04/01/21

Approved Effective Date of Waiver being Amended: 07/01/16

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

The purpose of this amendment is to create a similar path to level of care determinations for nursing facilities as exists in the approved waivers serving people who meet an intermediate care facility for individuals with intellectual disabilities (ICF/IID) level of care. Amendments to the CCMC waiver serving children who meet a nursing facility level of care will allow level of care determinations to be made using the State of Alaska Nursing Facility Assessment Form for Children (the relevant assessment tool) or an Interim File Review (IFR). The IFR will be done for two years between use of the assessment tool, in situations when 1) an applicant, annually applying for waiver renewal, has already found to meet level of care as a result of two assessments and 2) the renewal application does not indicate a change of condition. The IFR will include review of 1) the complete reapplication, including medical documentation and a medical verification of diagnosis, 2) prior assessment results, and 3) any critical incident or other reports made to SDS concerning the applicant. An assessment using the State of Alaska Nursing Facility Assessment Form for Children may be done 1) if the comprehensive file review indicates a significant change in functioning has occurred or 2) at the discretion of SDS. The assessment tool will be used to determine level of care every third year, at a minimum.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently (*check each that applies*):

Component of the Approved Waiver	Subsection(s)
Waiver Application	Main 6-I, 7, 8
Appendix A Waiver Administration and Operation	
Appendix B Participant Access and Eligibility	B-6 d, f, i, j
Appendix C Participant Services	
Appendix D Participant	

Component of the Approved Waiver	Subsection(s)
Centered Service Planning and Delivery	
Appendix E Participant Direction of Services	<input data-bbox="496 353 1382 403" type="text"/>
Appendix F Participant Rights	<input data-bbox="496 479 1382 528" type="text"/>
Appendix G Participant Safeguards	<input data-bbox="496 589 1382 638" type="text"/>
Appendix H	<input data-bbox="496 667 1382 716" type="text"/>
Appendix I Financial Accountability	<input data-bbox="496 748 1382 797" type="text"/>
Appendix J Cost-Neutrality Demonstration	<input data-bbox="496 857 1382 907" type="text"/>

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment (*check each that applies*):

- Modify target group(s)**
- Modify Medicaid eligibility**
- Add/delete services**
- Revise service specifications**
- Revise provider qualifications**
- Increase/decrease number of participants**
- Revise cost neutrality demonstration**
- Add participant-direction of services**
- Other**
Specify:

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

- A.** The **State** of **Alaska** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).
- B. Program Title** (*optional - this title will be used to locate this waiver in the finder*):

C. Type of Request: amendment

Requested Approval Period: (*For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.*)

3 years 5 years

Original Base Waiver Number: AK.0263

Draft ID: AK.005.05.11

D. Type of Waiver (select only one):

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/16

Approved Effective Date of Waiver being Amended: 07/01/16

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (check each that applies):

Hospital

Select applicable level of care

Hospital as defined in 42 CFR §440.10

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160

Nursing Facility

Select applicable level of care

Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I

Waiver(s) authorized under §1915(b) of the Act.

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or

previously approved:

Specify the §1915(b) authorities under which this program operates (check each that applies):

§1915(b)(1) (mandated enrollment to managed care)

§1915(b)(2) (central broker)

§1915(b)(3) (employ cost savings to furnish additional services)

§1915(b)(4) (selective contracting/limit number of providers)

A program operated under §1932(a) of the Act.

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

A program authorized under §1915(i) of the Act.

A program authorized under §1915(j) of the Act.

A program authorized under §1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

This waiver provides services for individuals who are eligible for both Medicare and Medicaid.

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The purpose of the Children with Complex Medical Conditions (CCMC) waiver is to ensure that statewide, Medicaid-eligible children with serious medical conditions have the option of remaining in their homes or in a home-like setting. The goal is to provide effective and adequate home and community-based service to medically complex children who otherwise would reside in a skilled nursing facility for more than 30 days per year.

The objective of this waiver is to serve approximately 315 children per year who have severe, chronic medical conditions that result in a prolonged dependency on medical care or technology to maintain health and well-being and who experience episodes of acute exacerbation of life-threatening conditions; need extraordinary supervision or observation; and need frequent or life-saving administration of specialized treatments or are dependent on mechanical support devices.

This waiver employs the nursing facility level of care (NFLOC) standard to evaluate and reevaluate the need for waiver services. The assessment tool is the State of Alaska Nursing Facility Assessment Form for Children, approved July 1, 2004. Criteria considered include the applicant or participant's health condition as indicated by the primary and secondary diagnoses, the appropriateness of weight and height to age and development, the performance of activities of daily living and the need for assistive devices. Also considered are services that, absent home and community-based services, would require institutionalization including dependence on technology (i.e., ventilator or feeding tube) or the need for 24-hour support or monitoring. Additional criteria include the applicant or participant's cognitive status, including socially inappropriate or dangerous behaviors and significant problems with mood or social functioning, and the availability of voluntary and information supports.

The waiver is administered by the Alaska Department of Health and Social Services (DHSS), the State's single Medicaid Agency (SMA), and is operated by the DHSS Division of Senior and Disabilities Services (SDS) within applicable federal regulations. Applicants access the waiver through a cadre of private SDS certified care coordinators who assist individuals with the completion of an initial application for SDS to assess level of care. Care coordinators then assist with all subsequent waiver renewals and redeterminations. SDS maintains a master list of certified care coordinators, located across the State, on its website. Services are delivered by SDS certified home and community-based provider agencies.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the state provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

Yes. This waiver provides participant direction opportunities. Appendix E is required.

No. This waiver does not provide participant direction opportunities. Appendix E is not required.

- F. Participant Rights.** Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy.** Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):

Not Applicable

No

Yes

C. Statewideness. Indicate whether the state requests a waiver of the statewideness requirements in §1902(a)(1) of the Act (*select one*):

No

Yes

If yes, specify the waiver of statewideness that is requested (*check each that applies*):

Geographic Limitation. A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state. *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

Limited Implementation of Participant-Direction. A waiver of statewideness is requested in order to make *participant-direction of services* as specified in Appendix E available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state. *Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:*

5. Assurances

In accordance with 42 CFR §441.302, the state provides the following assurances to CMS:

A. Health & Welfare: The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in Appendix C, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any state licensure or certification requirements specified in Appendix C are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are

provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the

participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the state secures public input into the development of the waiver:

In general, the State secures public input on operational implementation of its waivers and amendments through a variety of methods, including:

- Information-sharing teleconferences and webinars with care coordinators and other waiver services providers;
- Regular communication with the State of Alaska's statutorily-mandated advocacy board, the Governor's Council on Disabilities and Special Education, and related advocacy coalitions that comprise the agencies serving recipient populations, the Key Coalition and the Alaska Association of Developmental Disabilities, both for people with developmental disabilities.
- Solicitations for interactive presentations to the Alaska Native Health Care Consortium (ANTHC) Long Term Care Committee.

In the interests of transparency, the State is conducting a joint public comment for tribal consultation period for all three waivers that are being amended and for related amendments to governing regulations.

The State made copies of the proposed amendments to the three waivers available to the public at all three SDS offices, and posted the proposed waiver amendments to the SDS website. The State posted notice of the proposed amended waivers via an advertisement in the state's largest newspaper, an Online Public Notice, and an E-Alert sent to 1700+ subscribers. The E-Alert was then circulated to specific membership list-serves by each advocacy group.

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

Newman

First Name:

Anthony

Title:

Deputy Director, Division of Senior and Disabilities Services

Agency:

Department of Health and Social Services

Address:

PO Box 110680

Address 2:

none

City:

Juneau

State:

Alaska

Zip:

99811-0680

Phone:

(907) 465-5481

Ext:

TTY

Fax:

(907) 465-1170

E-mail:

anthony.newman@alaska.gov

B. If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

Newman

First Name:

Anthony

Title:

Deputy Director, Division of Senior and Disabilities Services

Agency:

Department of Health and Social Services

Address:

PO Box 110680

Address 2:

none

City:

Juneau

State:

Alaska

Zip:

99811

Phone:

(907) 465-5481

Ext:

TTY

Fax:

(907) 465-1170

E-mail:

anthony.newman@alaska.gov

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

[Signature Line]

State Medicaid Director or Designee

Submission Date:

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State:

Alaska

Zip:

Phone:

Ext:

TTY

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

Replacing an approved waiver with this waiver.

Combining waivers.

Splitting one waiver into two waivers.

Eliminating a service.

Adding or decreasing an individual cost limit pertaining to eligibility.

Adding or decreasing limits to a service or a set of services, as specified in Appendix C.

Reducing the unduplicated count of participants (Factor C).

Adding new, or decreasing, a limitation on the number of participants served at any point in time.

Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.

Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The state assures that this waiver amendment will be subject to any provisions or requirements included in the state's most recent and/or approved home and community—based settings Statewide Transition Plan. The state will implement any required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix D-1-b, continued:

The State has provided for this in the Appointment for Care Coordination Services form, which each recipient must complete as part of the application for waiver services and when transferring to another care coordinator. The form includes acknowledgement of receipt of an explanation of when and how to use the Central Intake system, the State's complaints and grievance process, as well as receiving copies of the Recipient Rights and Responsibilities and the Notice of Adverse Action and Fair Hearing Rights forms.

Criteria used for making determinations for which census areas would be allowed to apply for exceptions to conflict-free care coordination:

- (1) The number of conflict-free care coordinators could not meet the capacity for the number of recipients in the census area.
- (2) The number of conflict-free care coordinators certified by waiver type could not meet the capacity to serve recipients by waiver type.
- (3) Only one conflict-free agency or care coordinator serves the census area, eliminating the recipient's opportunity for choice of care coordinator.
- (4) There were no recipients or providers of HCB services or care coordination in a census area.

The process for obtaining an exception was involved submitting a complete application. SDS used the following criteria for determining whether an agency was granted an exception:

- (1) Review of narrative description ensuring administrative separation of HCB services from care coordination:
 - a. Include a basic description of the duties of the HCB services supervisor(s) and the care coordination supervisor(s).
 - b. Explain how recipients are given choice of care coordinator.
 - c. Explain how recipients are given choice of HCB services and other natural supports or services offered in the community.
 - d. Explain how the agency ensures that the care coordinator is free from influence of direct service providers regarding recipient care plans.
- (2) Evidence of administrative separation on organizational chart that includes position titles and names of staff
- (3) Attestation by agency owner/administrator of the following:
 - 1.I attest that the agency has and uses a plan/policy/procedure to ensure administrative separation of HCB services from care coordination. This plan/policy/procedure ensures that:
 - a. The agency has administrative separation of supervision of care coordination and HCB services.
 - b. The attached organization chart shows two separate supervisors, one for care coordination and one for HCB services.
 - c. Care coordination recipients are offered choice for HCB services between and among available service providers.
 - d. Care coordination recipients are not limited to HCB services provided only by this agency.
 - e. Care coordination recipients are given choice of care coordinators within the agency.
 - f. Disputes between care coordination and HCB services units are resolved.
 - 2.I attest that the agency has and uses a plan/policy/procedure to implement dispute resolution. This plan/policy/procedure ensures that:
 - a. Recipients are free to choose or deny HCB services without influence from the internal agency care coordinator and HCB service staff.
 - b. Recipients choose how, when, and where to receive their approved HCB services.
 - c. Recipients are free to communicate grievance(s) regarding care coordination and/or HCB services delivered by the agency.
 - d. The grievance/complaint procedure is clear and understood by recipients and legal representatives.
 - e. Grievances/complaints are resolved in a timely manner.
 - 3.I attest that outcomes/evidence of the above methods are or will be made available by report to Senior and Disabilities Services upon request.
 - 4.I attest and understand that the agency must have each individual care coordinator complete a Conflict of Interest Assurance form for each recipient, and maintain this form in the recipient's file.
 - 5.I attest and understand that each individual care coordinator may not have any conflict of interest with recipients they serve.

6.I attest and understand that my agency may not submit claims to Medicaid for care coordination services provided by an individual care coordinator that has a conflict of interest with recipients they serve.

7.I attest and understand that failure to mitigate conflict by implementing the requirements herein may result in a revocation of the exception to conflict-free requirements at any time.

I understand that any false statement, misrepresentation, omission, or concealment in this document may subject me to criminal, civil, or administrative penalties. Under penalty of perjury, I certify that the information I have provided is true, accurate, and complete to the best of my knowledge.

A management-level SDS committee approves applications for exceptions after thorough vetting, including requests for additional information, if needed. Exceptions are awarded for three years, to provide agencies with sufficient program operation time before revisiting the continued need for an exception. During the three year exception period, SDS has the right, per 7 AAC 130.220, to review agency policies and operations, whether based on complaints filed with Central Intake (by recipients or other providers) or random surveys and investigations.

All documents relating conflict-free care coordination and the exception process are available on the SDS website at <http://dhss.alaska.gov/dsds/Pages/conflictFree.aspx>

Appendix I-3-c, continued:

The state originally agreed to a two year pilot and at the end of the two year period, if the data captured on this pilot showed it was building capacity and improved the quality in the delivery of person-centered conflict-free care coordination services, the enhanced rate could be made permanent. If the data showed the opposite result or if provider(s) did not maintain compliance with the contractual agreement during the two year period, the payment for the enhance care coordination services would revert to the basic care coordination rate.

At the end of the two year period, the state determined that it did not have enough data to make a decision either way on its study, due to the length of time it took to get the pilot up and running. The state believes by extending the pilot an additional two years, the additional data gathered will allow the state to conduct a better analysis of the results of the pilot project. With a two year extension, data would be analyzed in time for the pilot project to end June 30, 2020.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
Aged or Disabled, or Both - General					
		Aged			
		Disabled (Physical)			
		Disabled (Other)			
Aged or Disabled, or Both - Specific Recognized Subgroups					
		Brain Injury			
		HIV/AIDS			
		Medically Fragile	0	21	
		Technology Dependent			
Intellectual Disability or Developmental Disability, or Both					
		Autism			
		Developmental Disability			
		Intellectual Disability			
Mental Illness					
		Mental Illness			
		Serious Emotional Disturbance			

b. Additional Criteria. The state further specifies its target group(s) as follows:

Children with a severe, chronic physical condition who, absent home and community-based services would receive long-term care in a facility for more than 30 days per year and who have prolonged dependency on medical care or technology to maintain health and well-being and who

- experience episodes of acute exacerbation of life-threatening conditions;
- need extraordinary supervision or observation; and
- need frequent or life-saving administration of specialized treatments or are dependent on mechanical support devices.

The participant must be willing to utilize home and community based waiver resources as described in this application.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (*select one*):

Not applicable. There is no maximum age limit

The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.

Specify:

When a participant is enrolled in the CCMC waiver, families or legal representatives are educated regarding the age limit and the need to plan early for continued waiver eligibility. Care coordinators are trained in procedures needed to meet this requirement.

During their 21st year, a participant in this waiver must reapply and be found eligible for continued waiver services. If the participant does not experience an intellectual or developmental disability and an assessment confirms NFLOC, he or she will be enrolled in waiver 0261, Adults Living Independently (ALI). If the participant does experience an intellectual or developmental disability, has been found DD eligible under AS 47.80.900, and after an assessment verifying NFLOC, he or she will be enrolled in the 0262 waiver, Adults with Physical and Developmental Disabilities (APDD).

At least 60 days prior to the participant's 21st birthday, SDS notifies the participant, the care coordinator, and the participant's parents or legal representative of the participant's pending ineligibility for the CCMC waiver and if appropriate, the need to begin the process of transitioning to another waiver. The care coordinator then facilitates the application process and an SDS nurse assessor completes the eligibility assessment. If the participant is found to meet the NFLOC, he or she will be enrolled in the Adults with Intellectual or Developmental Disabilities and Physical Disabilities waiver.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*). Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

No Cost Limit. The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

Cost Limit in Excess of Institutional Costs. The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

The limit specified by the state is (*select one*)

A level higher than 100% of the institutional average.

Specify the percentage:

Other

Specify:

Institutional Cost Limit. Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

Cost Limit Lower Than Institutional Costs. The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver

participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the state is (select one):

The following dollar amount:

Specify dollar amount:

The dollar amount (select one)

Is adjusted each year that the waiver is in effect by applying the following formula:

Specify the formula:

May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.

The following percentage that is less than 100% of the institutional average:

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant (check each that applies):

The participant is referred to another waiver that can accommodate the individual's needs.

Additional services in excess of the individual cost limit may be authorized.

Specify the procedures for authorizing additional services, including the amount that may be authorized:

Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	<input type="text" value="296"/>
Year 2	<input type="text" value="305"/>
Year 3	<input type="text" value="314"/>
Year 4	<input type="text" value="324"/>
Year 5	<input type="text" value="334"/>

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)* :

The state does not limit the number of participants that it serves at any point in time during a waiver year.

The state limits the number of participants that it serves at any point in time during a waiver year.

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	<input type="text"/>
Year 2	<input type="text"/>
Year 3	<input type="text"/>
Year 4	<input type="text"/>
Year 5	<input type="text"/>

Waiver Year	Maximum Number of Participants Served At Any Point During the Year		

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State (*select one*):

Not applicable. The state does not reserve capacity.

The state reserves capacity for the following purpose(s).

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):

The waiver is not subject to a phase-in or a phase-out schedule.

The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity.

Select one:

Waiver capacity is allocated/managed on a statewide basis.

Waiver capacity is allocated to local/regional non-state entities.

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

The Children with Complex Medical Conditions (CCMC) waiver serves individuals, under the age of 22 years, who require a level of care ordinarily provided in a nursing facility, but who choose to remain in the community. Individuals interested in services contact an Aging and Disability Resource Center or a Short Term Assistance and Referral center for screening that verifies the applicant meets the target population criteria for this waiver, including a chronic physical condition that would result in the need for institutional care for more than 30 days per year or, that results in prolonged dependency on technology to maintain health and welfare, acute or life-threatening exacerbations of the condition, the need for extraordinary supervision and observation, and the need for frequent or life-saving administration of specialized treatments, or dependency on a mechanical support device. The applicant must screen positive for each of these criteria to be referred on to a care coordinator, who submits the application for waiver services with a Verification of Diagnosis form completed by a physician, physicians assistant or advanced nurse practitioner.

Applicants who meet this criteria are then assessed using the State of Alaska Nursing Facility Assessment Form for Children, approved July 1, 2004. Severity of illness, intensity of care, and dependence on technology are among the elements of the assessment, and are key to a decision that nursing facility placement would be required if services were not provided in the home or community.

Because this waiver does not maintain a waitlist, individuals who meet the age, financial eligibility, and level of care requirements are eligible for CCMC program services. When notified of program eligibility, the care coordinator prepares a Plan of Care that must be approved by SDS before reimbursement for services can be authorized.

Once enrolled, participants remain eligible for waiver services as long as both financial and program requirements are met. SDS reviews the need for services and determines whether the participant continues to meet program eligibility requirements annually. The care coordinator then prepares a new Plan of Care, and submits it to SDS for approval, resulting in renewal of the waiver.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

- a. **1. State Classification.** The state is a (*select one*):

§1634 State

SSI Criteria State

209(b) State

- 2. Miller Trust State.**

Indicate whether the state is a Miller Trust State (*select one*):

No

Yes

- b. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

Low income families with children as provided in §1931 of the Act

SSI recipients

Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121

Optional state supplement recipients

Optional categorically needy aged and/or disabled individuals who have income at:*Select one:***100% of the Federal poverty level (FPL)****% of FPL, which is lower than 100% of FPL.**Specify percentage: **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)****Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)****Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)****Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)****Medically needy in 209(b) States (42 CFR §435.330)****Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)****Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)***Specify:*

§42 CFR

§435.110 Parents and other caretaker relatives.

Sec 1925 Transitional Medical Assistance (TMA)

§435.115 Extended Medicaid due to increased spousal support.

§435.117 Newborn children.

§435.119 Coverage for individuals age 19 or older and under age 65 at or below 133 percent FPL.

§435.120 Individuals receiving SSI.

§435.122 Individuals who are ineligible for SSI or optional State supplements because of requirements that do not apply under title XIX of the Act.

§435.130 Individuals receiving mandatory State supplements.

§435.131 Individuals eligible as essential spouses in December 1973

§435.133 Blind and disabled individuals eligible in December 1973.

§435.134 Individuals who would be eligible except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972).

§435.135 Individuals who become ineligible for cash assistance as a result of OASDI cost-of-living increases received after April 1977.

§435.137 Disabled widows and widowers who would be eligible for SSI except for the increase in disability benefits resulting from elimination of the reduction factor under Pub. L. 98-21.

§435.138 Disabled widows and widowers aged 60 through 64 who would be eligible for SSI except for early receipt of social security benefits.

§435.170 Pregnant women eligible for extended coverage.

§435.210 Individuals who meet the income and resource requirements of the cash assistance programs.

§435.232 Individuals receiving only optional State supplements.

Special home and community-based waiver group under 42 CFR §435.217 Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed

No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.**Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

All individuals in the special home and community-based waiver group under 42 CFR §435.217

Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217

Check each that applies:

A special income level equal to:

Select one:

300% of the SSI Federal Benefit Rate (FBR)

A percentage of FBR, which is lower than 300% (42 CFR §435.236)

Specify percentage:

A dollar amount which is lower than 300%.

Specify dollar amount:

Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)

Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)

Medically needy without spend down in 209(b) States (42 CFR §435.330)

Aged and disabled individuals who have income at:

Select one:

100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal post-eligibility rules under §1924 of the Act.*

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.

In the case of a participant with a community spouse, the state elects to (*select one*):

Use spousal post-eligibility rules under §1924 of the Act.

(Complete Item B-5-b (SSI State) and Item B-5-d)

Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)

(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.

(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

The state uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

The following standard included under the state plan

Select one:

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

(select one):

300% of the SSI Federal Benefit Rate (FBR)

A percentage of the FBR, which is less than 300%

Specify the percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the state Plan

Specify:

The following dollar amount

Specify dollar amount: If this amount changes, this item will be revised.

The following formula is used to determine the needs allowance:

Specify:

\$1656 unless participant resides in a licensed assisted living home
\$1396 if participant resides in a licensed assisted living home

Other

Specify:

ii. Allowance for the spouse only (select one):

Not Applicable

The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:

Specify:

Specify the amount of the allowance (select one):

SSI standard

Optional state supplement standard

Medically needy income standard

The following dollar amount:

Specify dollar amount: If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

iii. Allowance for the family (select one):

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

Other

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

Not Applicable (see instructions)*Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

The state does not establish reasonable limits.

The state establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(select one):

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

A percentage of the Federal poverty level

Specify percentage:

The following dollar amount:

Specify dollar amount: If this amount changes, this item will be revised

The following formula is used to determine the needs allowance:

Specify formula:

Other

Specify:

\$1696 unless recipient resides in a licensed assisted living home
 \$1396 if a recipient lives in a licensed assisted living home

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

Allowance is the same

Allowance is different.

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

Not Applicable (see instructions)*Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

The state does not establish reasonable limits.

The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: SSI State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

- a. Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the

provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is:

ii. Frequency of services. The state requires (select one):

The provision of waiver services at least monthly

Monthly monitoring of the individual when services are furnished on a less than monthly basis

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

Directly by the Medicaid agency

By the operating agency specified in Appendix A

By a government agency under contract with the Medicaid agency.

Specify the entity:

Other

Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Individuals performing initial evaluations for CCMC waiver eligibility are Registered Nurses licensed in the State of Alaska who employed by SDS.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

This waiver employs the nursing facility level of care (NFLOC) standard to evaluate and reevaluate the need for waiver services. The assessment tool is the State of Alaska Nursing Facility Assessment Form for Children, approved July 1, 2004. Criteria considered include the applicant or participant's health condition as indicated by the primary and secondary diagnoses, the appropriateness of weight and height to age and development, the performance of activities of daily living and the need for assistive devices. Also considered are services that, absent home and community-based services, would require institutionalization including dependence on technology (i.e., ventilator or feeding tube) or the need for 24-hour support or monitoring. Additional criteria considered include the applicant or participant's cognitive status including decision making skills, orientation, and memory. Information on socially inappropriate or dangerous behaviors is collected including verbal or physical abusive or self abuse.

The nurse assessor considers these factors and using professional judgment, certifies that the applicant or participant meets NFLOC and is eligible for services under the waiver.

- e. Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):

The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.

A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

- f. Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

All level of care eligibility determinations are made by qualified SDS assessors who do not provide home and community-based services.

An applicant for waiver services is evaluated by a qualified state assessor in the applicant's residence, or if transitioning, in a hospital or nursing home, using the Nursing Facility Assessment Form for Children (the "tool"). For recipients who have had at least two consecutive years of assessments using the tool which resulted in approval of waiver level of care, the reevaluation consists of an Interim File Review and a review of current medical records. Reevaluations are performed by SDS nursing staff. If the file review indicates potential improvement or significant decline in recipient's condition, an assessment will be conducted rather than the Interim File Review, to ensure continued approval of level of care and to assist the recipient's planning team to determine if services changes are needed. Recipients may have level of care determinations made using Interim File Reviews for two consecutive years but will undergo an assessment using the tool on every third year, unless the Interim File Review indicates the need for an assessment instead.

The State has a policy on the use of technology to conduct teleassessments. Teleassessments will occur when applicants and state staff agree that a teleassessment will be quicker and more efficient due to potential travel delays. Some rural health care providers have signed agreements in place that allow use of the provider's telehealth technology. These agreements outline the procedures and secure technology requirements for all parties. Recipients must be able to travel to the health care provider clinic to be assessed using the telehealth technology. The State is also working on being able to assess applicants/recipients in their own homes if they can access the necessary secure technology and support. The State conducts assessments by telephone in areas where there is no internet connectivity and where the need to travel would result in significant delays to the assessment and level of care determination.

The State's policy is that an applicant's initial assessment be completed in person, but the State will waive this policy and use other methods if travel is not possible or if it would result in a significant delay in assessing the recipient.

In years following the initial assessment, when a recipient's assessment reveals a change in condition, Alaska Statute at AS 4707.045 (b) requires a finding of "material improvement" before the state may terminate waiver services. Material improvement means that the recipient no longer has a functional limitation or cognitive impairment that would result in the need for nursing home placement, and can demonstrate the capacity to function in a home setting without the need for waiver services. In 2006, a successful court challenge found that the State did not have adequate criteria or a formal process for determining when a waiver recipient's condition materially improved. In response, the State developed the "material improvement review process" (MIRP) to fully assess and confirm that a recipient is no longer eligible for waiver services.

The finding of material improvement begins with the assessor reviewing all existing documentation of the recipient's condition during the 12 months prior to the finding. In addition, the assessor contacts the recipient and/or their representative to request any additional documentation the recipient believes may contribute to an understanding of their current condition. Next, a Registered Nurse (RN) conducts a quality control review (QC) of the assessment findings for scoring validity as well as consistency and completeness, and reviews any newly-received documentation of the recipient's condition. The RN seeks additional clarifying information, if needed, including a review of service utilization to determine if the individual is able to demonstrate the ability to function in a home setting with the need for waiver services.

The RN compares the initial "qualifying assessment," which is the most recent approved assessment, and includes related fair hearing findings and any additional supporting information, with the current "denial assessment". In preparation for this comprehensive analysis comparing the qualifying assessment to the denial assessment, the RN sends a formal notice to the recipient and/or their representative informing them that, before a final eligibility determination with a finding of material improvement is made, SDS will review any additional documentation that may contradict that finding. The RN also requests that the recipient's primary physician complete a "Level of Care Verification" form. The RN then completes the "Material Improvement Reporting for ALI & APDD Waivers" form, adopted by reference into State regulations at 7 AAC 130.219(e)(4)(A)(iv), focusing on the specific ways in which the recipient's condition has changed since their qualifying assessment, analyzing all existing and new information and providing a detailed narrative explanation of how the recipient's physical condition has improved to the point of material improvement.

The final step in the MIRP is submission of the written analysis and supporting documents to the State's contractor for a "third party review" of eligibility. The contractor employs physicians and nurses who independently review the

qualifying and denial assessments and all accompanying documentation. The contractor either upholds or overturns the State’s decision; this becomes the final level of care determination. The recipient has the right to appeal the decision through the fair hearing process.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):

Every three months

Every six months

Every twelve months

Other schedule

Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations (*select one*):

The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.

The qualifications are different.

Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care (*specify*):

All information related to assessments, waivers and levels of care is maintained in the State’s “Harmony” database system. Unit Managers monitor timelines for assessments coming due through reports generated using information from the Harmony system. The Harmony system tracks all timelines and sends notifications to Care Coordinators when renewal applications are due to be submitted. In addition, regulations and policies specify timelines for the scheduling and completion of the assessment, as well as for the SDS review and level of care determination.

Reevaluation timeliness is also tracked as an element of the Unit Manager’s duties. Though SDS does not report on this measure to CMS, timeliness is evaluated and measured by the State to ensure adherence to eligibility processes.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

All documentation related to evaluations and reevaluations of level of care determinations is maintained in the recipient’s official electronic record within the Harmony system for a minimum of three years.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for

evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

- a. Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

LOC 1: # and % of assessments conducted for LOC or needed supports within 60 business days of receiving a complete initial application. Numerator: # of participants for whom an assessment for LOC or needed supports was conducted w/in 60 business days of receiving a complete initial application. Denominator: Sample of complete initial applications submitted within the reporting period.

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content; margin: 5px auto;">95%, +/- 5% and 50% distribution</div>
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

- b. Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. **Sub-assurance:** *The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

LOC 2: # and % of initial LOC determinations completed by the qualified state assessor identified in the waiver application. Numerator: # of participants who received an initial LOC determination by a qualified state assessor in the reporting period. Denominator: Sample of participants who received an initial LOC determination in the reporting period.

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content; margin: 5px auto;">95%, +/- 5% and 50% distribution</div>
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify:

		<input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

LOC 3: # and % of initial LOC determination criteria applied correctly. Numerator: # of initial and annual LOC determination criterion applied correctly. Denominator: # of participants who were included in the case review sample.

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review

Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-left: 20px;">95%, +/- 5% and 50% distribution</div>
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	<div style="border: 1px solid black; width: 100%; height: 40px; margin-top: 10px;"></div>

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Quality Improvement Strategies are founded upon data-driven discovery activities. Task Committees (TC) have been developed to focus on specific areas of performance and to implement systems for data collection. The Level of Care Task Committee comprises Managers of the IDD Waiver Unit and NFLOC Unit (cochairs), Research and Analysis Team, Quality Assurance Unit, Policy and Program Development Unit and the Personal Care Assistance Unit. These managers are the first line of discovery and are charged with identification of Level Of Care problems within the waiver program through monitoring and evaluation of established performance measure data.

Initial discovery is the responsibility of the Level of Care Task Committee Manager who performs weekly reviews of participant data found in the SDS management information system, DS3, as well as a sample of case records. Additional methods of discovery include complaints from providers, participants or their representatives, which are reviewed, processed and addressed as they are received, as well as provider onsite visits that include document reviews and participant and provider staff interviews.

The Level of Care Committee prepares standardized monthly reports for the Quality Improvement Workgroup (QIW) based on the Level of Care measures approved by the Department of Health and Social Service Quality Improvement Steering Committee (QISC). QIW reports include at minimum:

- Monthly, quarterly and annual cumulative aggregated data of findings and corrective actions taken at the program/ unit levels as identified through the task committee review activities;
- Historical data for use in comparing similar reporting periods;
- A summary of findings and recommended action, including preliminary trends identified by the task committee.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

When discovery activities reveal problems with the State’s performance in determining level of care (LOC), the Managers of the Nursing Facility Level of Care Unit and the IDD Unit are responsible for initiating remediation activities.

As part of monthly discovery activities, the two Unit Managers review reports generated through the SDS information management system, DS3, which provide data on the appropriateness of initial LOC determinations, the timeliness of LOC re-determinations, the individual who performed the LOC determination and use of the approved forms in LOC determination. In addition, the Managers review a sample of participant case records to determine if the LOC criteria have been applied correctly.

When the data reveals problems in LOC determination activities, the Unit Managers analyze the data to discover if the problem involves performance issues with individual assessors, or, systemic problems in SDS LOC determination processes. For assessor performance issues such as lack of timeliness or incorrect application of LOC determination criteria, the Unit Managers meet personally with an assessor, prescribe additional training, and if performance issues persist, use the State-prescribed progressive discipline process for on-going remediation. Systemic problems regarding the procedures for determining LOC or the forms used by assessors are brought to the Level of Care Task Committee for analysis and development of recommendations for the Quality Assurance Workgroup. If remediation involves amendments to SDS regulations or policy and procedure improvements, responsibility falls to the Chair of the Policy Task Committee who facilitates changes through the State of Alaska regulation development process or the SDS policy and procedure development process as appropriate.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and
- ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

After an applicant is found eligible for the waiver, the participant, and/or the recipient's legal representative, along with the participant's care coordinator, completes a waiver Plan of Care (POC) of feasible service alternatives under the waiver. Section IV of the POC Participant Choice of Services requires the participant or legal representative to initial a series of statements indicating that they understand the choices available either receiving Medicaid-funded care in an institution, through Medicaid home and community-based services, only non-Medicaid services, or receiving no services at all. The section also outlines the assistance SDS and/or the participants care coordinator will provide after a choice is made. Finally, the section requires the participant and/or their legal representative to indicate their choice. The POC is then signed by everyone involved in the planning effort. The "Participant Choice of Services" section of the POC is updated and reviewed with the participant at least annually.

Participants are also given the SDS Medicaid Waiver Brochure listing all of the services available under the waiver.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Signed POCs, including the Participant Choice of Services section are maintained in the participant's official file and stored at the SDS Anchorage office. In addition, the POC is electronically uploaded into the SDS participant database, DS3 and maintained indefinitely.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

People who have limited English proficiency, vision, hearing or other impairments seeking waiver services have equal access to both financial and functional eligibility determinations.

The DHSS Division of Public Assistance (DPA) performs financial eligibility functions for HCB Waivers and uses a telephone-based professional interpreter services for non-English speakers. The majority of DPA offices are located in Job Centers that are equipped with low-vision computers equipment and staff trained in American Sign Language (ASL). DPA also uses the telephone-based Alaska Relay service that links individuals using TTY technology with those using standard telephones.

SDS contracts for language interpreter services needed during the functional level of care assessment. If professional interpreters are not available, as in some rural Alaska Native villages, assessors have either developed relationships with local Health Clinic staff (if available) or use friends and/or family of the participant for interpreter services.

SDS-certified and monitored Care Coordinators, who facilitate plan of care development and monitor waiver services for persons with limited English proficiency, are either bilingual or arrange for interpreters to perform these functions in the recipients language of origin.

When working with blind or deaf participants, SDS and care coordinators often rely on family members who act as interpreters for their children. Those regions with ADRCs or Independent Living Centers (ILC) are sources of assistance with ASL interpreters and other accommodations. SDS and care coordinators also use the Alaska Relay service for telephone communications.

All applicants for Medicaid services are notified of the opportunity for reasonable accommodations in the Medicaid application, during the eligibility processes, and waiver determination of level of care process.