

**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 a group 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 waiver target group, check each of the subgroups in the selected target group 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
<input checked="" type="radio"/> <b>Aged or Disabled, or Both - General</b>					
	<input type="checkbox"/>	Aged	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)	<input type="text"/>	<input type="text"/>	
	<input type="checkbox"/>	Disabled (Other)	<input type="text"/>	<input type="text"/>	
<input type="radio"/> <b>Aged or Disabled, or Both - Specific Recognized Subgroups</b>					
	<input type="checkbox"/>	Brain Injury	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
<input checked="" type="radio"/> <b>Mental Retardation or Developmental Disability, or Both</b>					
	<input checked="" type="checkbox"/>	Autism	0 <input type="text"/>	<input type="text"/>	<input checked="" type="checkbox"/>
	<input checked="" type="checkbox"/>	Developmental Disability	0 <input type="text"/>	<input type="text"/>	<input checked="" type="checkbox"/>
	<input checked="" type="checkbox"/>	Mental Retardation	0 <input type="text"/>	<input type="text"/>	<input checked="" type="checkbox"/>
<input type="radio"/> <b>Mental Illness</b>					
	<input type="checkbox"/>	Mental Illness	<input type="text"/>	<input type="text"/>	
	<input type="checkbox"/>	Serious Emotional Disturbance	<input type="text"/>	<input type="text"/>	

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

The target group of the People with Mental Retardation and Developmental Disabilities Waiver is people of any age, who meet ICFMR level of care.

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:

**Appendix B: Participant Access and Eligibility**

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*):

- 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:

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**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:

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**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	1152

Year 2	1352
Year 3	1552
Year 4 (renewal only)	1752
Year 5 (renewal only)	1952

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	
Year 2	
Year 3	
Year 4 (renewal only)	
Year 5 (renewal only)	

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**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).

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**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:

Entrance to the MRDD Waiver is covered under DSDS Policy 100-3, dated October 1, 2003:

Individuals who are eligible to access services funded through the DSDS must be identified on the Waitlist to be selected for services through the MRDD HCB waiver or Community Development Disability Grant Services.

To keep the Waitlist moving at a reasonable pace DSDS conducts a routine selection from the Waitlist at periodic intervals during the year. Within the limits of legislative appropriation, selection from the Waitlist is based on who has the highest need and who has been waited the longest for services.

The number of people selected is limited by the amount of legislative appropriations, or the resources that become available when a person leaves the program.

Highest need is defined as those applicants whose circumstances are determined to require immediate and comprehensive long-term supports. If the consumer is not currently on the Waitlist, a Waitlist assessment must be completed and submitted to substantiate the level of need. A person on the Waitlist may submit a reassessment that reflects current needs if their situation changes.

When compared to other people on the Waitlist, some people have been waiting for a long time. Those individuals receive DSDS grant services while they wait.

Daily circumstances can mitigate the selection process. People will be selected based on what is known about urgent circumstances that may place them at imminent risk of harm. When the need for an immediate intervention arises the individual may be selected from the Waitlist according to these crisis situations listed below. An individual:

- who is in imminent risk of substantial harm or significant regression;
- who is living in an unsafe or unhealthy circumstance;
- without supports who is at risk of involvement with the Justice system;
- who has been living with a caregiver who no longer is able to continue in that capacity.

At the point where an individual has been selected for services, the applicant begins the process of providing proof of medical conditions, age at onset of the condition, and is referred for an ICAP for functional assessment.

Once all documentation has been completed, the application packet is reviewed by a Division of Senior and Disability Services Qualified Mental Retardation Professional (QMRP), who makes the determination of whether an applicant meets the level of care of an ICFMR. Once the individual has been approved at this level, the care coordinator is authorized to complete a Plan of Care.

## 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. **State Classification.** The State is a (*select one*):

- §1634 State
- SSI Criteria State
- 209(b) State

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 (TWWIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
- Working individuals with disabilities who buy into Medicaid (TWWIA 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
- 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:*

All other mandatory and optional groups under the plan are included.

**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 spenddown 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 4)

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 State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

- 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 (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 4)

#### 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

*Specify:*

\$1656 unless recipient resides in licensed assisted living home

\$1396 if recipient resides in licensed assisted living home

- 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:*



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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:*



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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)**
- 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 4)

**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 4)

**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, a family allowance, and an amount for incurred expenses for medical or remedial care.

**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:*

\$1656 unless the recipient resides in a licensed assisted living home

\$1396 if the recipient resides in an licensed assisted living home

- Other**

*Specify:*

- 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)**  
 **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-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 an entity 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:

The ICAP is performed by an individual who meets the education criteria of: Bachelor or Master Degree in a social science discipline and at least three (3) years experience as a professional working with special needs populations. Evaluation of an application (whether initial or renewal) for an HCB Waiver is performed by a Qualified Mental Retardation Professional, as defined in federal regulation, who is employed by the Division of Senior and Disabilities Services.

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.

The assessment tool for this waiver is the Instrument for Client and Agency Planning (ICAP) .

Medical diagnosis criteria to meet ICFMR and qualifying ICAP scores are in State regulation (7 AAC 43.300): Individual has a severe, chronic disability that meets one of the five following qualifying conditions:

1. Mental Retardation: Individual must experience an IQ of less than 70 (plus or minus 5 points) as determined by an individually administered, standardized intelligence evaluation (DSM-IV).
2. Other mental retardation related condition: Individual must experience a condition other than mental illness, psychiatric impairment, serious emotional or behavioral disturbance found to be closely related to mental retardation

because this condition results in impairment of general intellectual functioning and adaptive behavior similar to that of a mentally retarded persons, and requires treatment or services similar to those required for these persons.

3. Cerebral Palsy: Individual must experience cerebral palsy as diagnosed by a licensed physician. A deficit in intellectual ability need not be present.

4. Epilepsy: The individual must experience epilepsy, diagnosed by a licensed physician (preferably by a board certified neurologist). A deficit in intellectual ability need not be present.

5. Autism: Individual must experience autism, diagnosed by a mental health professional clinician (as defined in 7 AAC 43.1990 (46) ) with the condition meeting the criteria for DSM-IV code 299.00 Autistic disorder: When an individual displays 6 or more of 12 symptoms listed across three major areas including social interaction, communication, and behavior.

AND:

The condition above must have originated before the age of 22 and must constitute a substantial disability to the individual's ability to function in society, as evidenced by the individual's Broad Independence score on the Inventory for Client and Agency Planning (ICAP) administered under 7 AAC 43.1030 and compared with the DHSS/DSDS Table of ICAP scores (as defined in 7 AAC 43.300).

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:

Recipients are evaluated at least annually. Reevaluations are performed using the same assessment tool and qualified individuals to perform it as the initial evaluation at least annually.

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*):

DSDS uses a database to track reevaluations. Recipients' care coordinator and the state assessor are informed of

reevaluation dates at least 60 days prior to the due dates to ensure timely completion of reevaluations. State staff monitors timelines at least monthly and follows up on reevaluations that are out outside of this time frame. There are no limitations as to when a care coordinator may request an amendment to a recipient's Plan of Care. They may be generated at any time there is a change in health, welfare or change in living situation.

Agencies providing services may also monitor evaluation timeliness. They are aware that prior authorizations are only issued for 12 months at a time and new authorizations cannot be issued without prior completion and state approval of a new assessment and new plan of care.

As part of the waiver quality management strategy, DSDS QA periodically reviews the timeliness of reevaluations to ensure quality standards are being met.

- 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 §74.53. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Evaluations and re-evaluations of level of care are maintained in the recipient's official files in the Anchorage or Juneau offices of the Division of Senior and Disability Services for a minimum of 3 years.

## 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).

During the period of time information is gathered to determine Medicaid Waiver eligibility, all applicants are informed by DSDS staff and care coordinators of feasible alternatives in community based grant programs, Medicare, and Tribal services as well as those available under HCB waiver programs, and allows individuals to choose either institutional or wavier services or no services at all.

Upon acceptance of a HCB Waiver Plan of care, the recipient or their legal representative completes Section VI of the plan of care "Client choice". The individual, parent or legal guardian initials a series of bullets defining the participant centered care plan, their agreement (or disagreement) with the plan of care, and is informed of following rights:

- self determination
- privacy and confidentiality
- fair and comprehensive assessment of the recipient's health and functional, psychosocial and cognitive abilities
- access to health and social services
- knowledge of the frequency, scope, duration and cost of services before receiving care
- notification in writing of any change, termination or discharge of services and the right (and instructions on how) to appeal any decision
- refuse any portion of the plan of care
- change service providers at any time
- withdraw from the waiver process at any time
- if the recipient's rights have been violated a phone number to call
- grievance procedure
- and the ability to choose waiver services, community services, regular Medicaid services, a combination of all three or no services at all

Once signed by the recipient and parent or legal representative, the care coordinator, all HCB agencies who have agreed to provide services and DSDS staff, this document becomes part of the legal records of the individual so is kept on file at the State (and a copy given to the recipient). All providers of this individual's plan of care services

receive a copy of the plan of care from the care coordinator.

Each year, as part of the renewal process, this document is signed by all participants of the care team, recipient and/or legal representative and kept as part of the individual's file.

- b. Maintenance of Forms.** Per 45 CFR §74.53, 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.

Freedom of Choice forms signed by the recipient or recipient's legal representative are maintained in the recipient's official files in the Anchorage or Juneau offices of the Division of Senior and Disability Services for a minimum of 3 years.

## **Appendix B: Participant Access and Eligibility**

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### **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):

Equal access will be provided to people who are Limited English Proficient seeking waiver services. DHSS Division of Public Assistance performs eligibility functions for HCB Waivers. They hire bilingual staff, arrange for interpreters and arrange for translation of written eligibility related materials.

Care Coordinators, who perform the functions of care planning and monitoring waiver services for persons with Limited English Proficiency are either bilingual, arrange for interpreters to perform these functions in the recipient's language of choice.

The SMA arranges for translation of written program materials when necessary.

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.

All case information in official State files is maintained in English.