

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

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver’s target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

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:

Alaskans Living Independently

C. Waiver Number:AK.0261

Original Base Waiver Number: AK.0261.90.R2

D. Amendment Number:

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

01/01/17

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 twofold:

- 1) To provide details of a mediation process that will be used in advance of fair hearings.
- 3) To remove reference to using the Truncated Consumer Assessment Tool (TCAT) for reassessments, and to revert to using the Consumer Assessment Tool (CAT) for both assessments and reassessments.

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)
<input type="checkbox"/> Waiver Application	
<input type="checkbox"/> Appendix A – Waiver Administration and Operation	
<input checked="" type="checkbox"/> ix B – Participant Access and EI	B-6
<input type="checkbox"/> Appendix C – Participant Services	

Component of the Approved Waiver	Subsection(s)
<input type="checkbox"/> Appendix D – Participant Centered Service Planning and Delivery	
<input type="checkbox"/> Appendix E – Participant Direction of Services	
<input checked="" type="checkbox"/> Appendix F – Participant Rights	F-2
<input type="checkbox"/> Appendix G – Participant Safeguards	
<input type="checkbox"/> Appendix H	
<input type="checkbox"/> Appendix I – Financial Accountability	
<input type="checkbox"/> Appendix J – Cost-Neutrality Demonstration	

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:

Add details in Appendix F-2 of a mediation process used in advance of the fair hearing process.
 Remove references to using Truncated Consumer Assessment Tool (TCAT) for reassessments in Appendix B-6

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):

Alaskans Living Independently

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.0261

Draft ID: AK.004.05.01

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

The State completes the level of care assessment and evaluates nursing facility level of care using the Consumer Assessment Tool (CAT) in accordance with 7 AAC 130.230. Except in parts of rural Alaska where computer connectivity is limited, assessors use the E-CAT, the identical but computerized, on-line version of the CAT.

The tool collects information on diagnosis, and scores the applicant on the need and frequency of need for professional nursing services, medications, treatments and therapies. Also scored is the applicant's memory and cognition, behavior including mood and problem behaviors, ability to communicate, vision, nutritional and dental status, continence, balance, and skin condition. The applicant is also scored on physical functioning as indicated by the ability to perform activities of daily living (ADL) and instrumental activities of daily living (IADL). In the final "Eligibility Determination" section of the CAT, the assessor enters the applicant's scores. The results indicate whether or not the applicant meets the nursing facility level of care, and is therefore eligible for services under this 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.

While applicants for admission to a nursing facility must meet the same level of care standard as that for the waiver, SDS uses a different tool for admission to institutional care, the SDS "Long Term Facility Authorization (AK-LTC-1). The AK-LTC-1 and the Consumer CAT collect the same information on the applicant's health status, ability to function in home and community settings and the informal community supports available. All nursing facility and waiver level of care evaluations are made using the same criteria by qualified assessors trained to the same standards, working within the same unit in SDS. The CAT tool collects additional information so a Plan of Care can be written without the need to do an additional assessment.

- 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 Consumer Assessment Tool (CAT). Reevaluations are performed by individuals with the same qualifications, using the same assessment tool (CAT).

The State has developed telehealth policy for conducting assessments and reassessments. These assessments will occur where signed agreements with rural health care providers exist. The 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 or reassessed using telehealth. The State intends to conduct assessments and reassessments in the recipient's own home using telehealth once secure technology and connectivity is in place.

When a recipient's reassessment 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 assessor making the finding of material improvement begins the MIRP with a review of 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 requesting any additional documentation the recipient believes may contribute to an understanding of their current condition. Next, the assessor's supervisor, an RN, conducts a quality control review

will develop the request in writing and ensure that it is delivered to Xerox.

All fair hearings in the State of Alaska are centralized and conducted by the Alaska Department of Administration and heard before an Administrative Law Judge. Fair Hearing Representatives within the SDS Operations and Training unit are responsible for preparing the case for adverse action and representing SDS at hearing.

The applicant or participant may choose to represent him or herself at the fair hearing, or may be represented by a guardian, attorney, friend or family member. Due to conflict of interest concerns the participant's care coordinator or other service providers may not represent the participant at the fair hearing, but may accompany the participant to the hearing, act as an advocate, offer assistance throughout the process, and refer the participant to additional sources of assistance as appropriate. In addition, upon oral or written request from the applicant or participant, the Division of Health Care Services (DHCS) will provide assistance in obtaining representation, preparing the case, and gathering witnesses and/or documents to be used in presenting the claim.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

- a. Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- No. This Appendix does not apply
- Yes. The State operates an additional dispute resolution process

- b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The State offers a process for mediation in advance of fair hearing to address disputes in regards to all services provided through SDS.

(a) State Agency Operating the Process: Mediation services are provided by a third party contractor who is a lawyer and who operates under the Office of Administrative Hearings (OAH) within Department of Administration.

(b) Procedures and Timeframe: Recipients (or care coordinators of behalf of recipients) that have requested a fair hearing are automatically scheduled for an informal mediation session. OAH sends a notice to the appellant with a date and time for the informal mediation session, generally 10 days from the time OAH receives the case referral. A Calendar Call (a short scheduling conference to set a date and time for the fair hearing if the case is not settled in mediation) is also identified within this notice. The notice also states that the mediation is voluntary, is not a prerequisite or substitute for a fair hearing, and that the appellant retains the right to a fair hearing if the disputes are not resolved during the mediation, as set forth in 7AAC 49.010, Chapter 49 Hearings. Appellants can let the OAH know at any time up to and during the mediation session that they do not want to pursue settlement through mediation.

In addition, both the appellant and the State may request a formal mediation in which an Administrative Law Judge, who is not assigned to preside over the case, will act as a mediator. Both parties have to agree to undergo a formal mediation, and the mediator will make a recommendation for settlement. Use of formal mediation does not preclude the right to a Fair Hearing if the disputes are not resolved during the informal or formal mediation, as set forth in 7AAC 49.010, Chapter 49 Hearings.

Types of Disputes: During both the informal and formal mediation sessions, the parties may discuss new information including medical documentation and other potential environmental changes, and how these affect the appellant's eligibility for Level of Care or specific services. The types of disputes addressed through this mediation process include initial waiver denial, material improvement and waiver termination decisions, eligibility for services such as chore, respite, and day habilitation, determination of developmental disability decisions, denials of enhanced payments for acuity, and any disagreements stated by the appellant which are addressed in the state's notice

authorizing or denying services. Any matters discussed during mediation remain confidential. Partial resolutions are allowable, if documented, and remaining unresolved issues can proceed to fair hearing.

(c) Preserving Right to Fair Hearing: The appellant retains the right to a fair hearing if the disputes are not resolved during informal or formal mediation, as set forth in 7AAC 49.010, Chapter 49 Hearings. The appellant has the ability to bypass mediation and continue to schedule a fair hearing at any time during this process.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- No. This Appendix does not apply
- Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

The Division of Senior and Disabilities Services has a “Complaint Management” policy and procedure outlining a system that offers a number of approaches to resolve problems and issues with program operations or services. This system, which includes provider grievance processes as well as state agency processes, fosters the identification of problems that, when remediated, lead to improvement in the quality of program operations and to the health, safety, and welfare of participants.

While the system provides latitude for filing complaints, it is not a substitute or a pre-requisite for a Fair Hearing, and filing with SDS does not undermine the participant’s right to request a Fair Hearing. Participants who file complaints with SDS about problems that fall under the scope of the Fair Hearing process are assisted with the information provided in the Notice of Adverse Actions, Hearings and Appeals.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

SDS operates an internal complaint and referral system and accepts complaints/grievances from participants, providers, stakeholders and the public about SDS, any provider or participant concerning any aspect of service provision and/or program compliance, including the quantity and quality of services received or failure of services to be provided.

As part of the initial application process and during waiver renewal, the care coordinator assists the applicant or participant to complete the SDS “Recipient Rights” form. The applicant or participant initials the form affirming they understand that they have a right to file a complaint or grievance about their provider or about SDS at any time. They also initial and affirm that they have a right to a fair hearing in response to adverse action taken by SDS. In addition, the care coordinator provides the applicant or participant with the “Notice of Hearings and Appeals” form that outlines the process for requesting a Fair Hearing. The care coordinator explains the difference between a complaint or grievance and the more formal fair hearing process, and that filing a grievance or making a complaint is not a pre-requisite or a substitute for a Fair Hearing.

Complaints made orally or in writing through Central Intake are reviewed by the Quality Assurance Unit (QA). If the complaint involves a vulnerable adult the report is routed to Adult Protective Services (APS) in addition to QA. If the complaint involves a provider of assisted living home services or a resident, Residential Licensing also receives the intake. Quality Assurance screens the intakes to determine the appropriate response, either through technical assistance or investigation.

If the complaint is about the behavior of an SDS employee or an SDS administrative process (e.g., conduct considered negligent, rude, or discourteous, timeliness of actions, request for unreasonable or unnecessary documentation or clarification, and treatment different than others without reasons related to regulations) the complaint is routed to the appropriate SDS program unit manager within three business days. Deficiencies in SDS