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 a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

In this waiver renewal, level of care assessments, currently completed by home and community-based agency nurses, will be done by State RN nurse assessors.

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*):

Children with Complex Medical Conditions

C. Type of Request: renewal

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
Waiver Number: AK.0263.R04.00
Draft ID: AK.05.04.00

D. Type of Waiver *(select only one):*

Regular Waiver

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

07/01/11

Approved Effective Date: 07/01/11

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 in42 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 the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR 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 Eligiblity 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 300 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

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/MR.

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:

The State secures public input on development of this waiver through a variety of methods including:

information-sharing teleconferences with care coordinators and other waiver services providers;

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: Poppe-Smart

First Name: Kimberli

Title: Deputy Commissioner

Agency: Department of Health & Social Services

Address: 3601 C Street, Suite 902

Address 2:

City: Anchorage

State: **Alaska**

Zip: 99503

Phone: (907) 269-7827 **Ext:** ☐ **TTY**

Fax: (907) 269-0060

E-mail: kimberli.poppe-smart@alaska.gov

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

Last Name: Mayes

First Name: Duane

Title: Director

Agency: Division of Senior & Disabilities Services

Address: 550 W. 8th

Address 2:

City: Anchorage

State: **Alaska**

Zip: 99501

Phone: (907) 269-2083 **Ext:** ☐ **TTY**

Fax: (907) 269-3639

E-mail: duane.mayes@alaska.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.
Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: Joanne Gibbens

State Medicaid Director or Designee

Submission Date: Oct 17, 2011

Last Name: Sherwood

First Name: Jon

Title: Medical Assistance Administrator IV

Agency: Department of Health & Social Services

Address: P.O. Box 110660

Address 2:

City: Juneau

State: **Alaska**

Zip: 99811-0660

Phone: (907) 465-5820

Fax: (907) 465-3068

E-mail: jon.sherwood@alaska.gov

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

N/A

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   ⦿ **The waiver is operated by the State Medicaid agency.**

   Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

   ⦿ **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

   Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

   Division of Senior & Disabilities Services

   (Complete item A-2-a).

   ○ **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

   Specify the division/unit name:

   In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the

waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

   a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

   All functions associated with administering this waiver are performed by the Division of Senior and Disabilities Services.

   Senior and Disabilities Services is currently in the process of developing a Memorandum of Agreement (MOA) with the DHSS Commissioner's office that will outline the SDS administrative responsibilities associated with providing waiver services and clarifies that the waiver services specified in the approved waivers are accessible in a timely manner and are provided in accordance with state and federal laws and regulations, DHSS policies and procedures, and the CMS approved waiver plans.

   b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
   As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

   ○ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
   Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

   ◉ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

   ◉ **Not applicable**

   ○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.
   Check each that applies:

   ☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

   Specify the nature of these agencies and complete items A-5 and A-6:

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency
Participant waiver enrollment	☑
Waiver enrollment managed against approved limits	☑
Waiver expenditures managed against approved levels	☑
Level of care evaluation	☑
Review of Participant service plans	☑
Prior authorization of waiver services	☑
Utilization management	☑
Qualified provider enrollment	☑
Execution of Medicaid provider agreements	☑
Establishment of a statewide rate methodology	☑
Rules, policies, procedures and information development governing the waiver program	☑
Quality assurance and quality improvement activities	☑

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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.

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.

n/a

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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.

n/a

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

Responsible Party *(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: n/a	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: n/a

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 Administrative Authority that are currently non-operational.

- (●) **No**
- ( ) **Yes**

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

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
( ) **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**			[ ]
( ) **Mental Retardation or Developmental Disability, or Both**					
	[ ]	**Autism**			[ ]
	[ ]	**Developmental Disability**			[ ]
	[ ]	**Mental Retardation**			[ ]
( ) **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.

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).

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	275
Year 2	283

Year 3	290
Year 4	300
Year 5	305

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	
Year 5	

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 first submit an SDS Verification of Diagnosis form completed by a physician, physician's assistant or advanced nurse practitioner. An SDS RN nurse assessor then performs an initial screening using the SDS CCMC Screening Tool. Part one of the tool verifies that 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 proceed to a level of care assessment.

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:

All other mandatory and optional groups specified in the State 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: 1656

☐ **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 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 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 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-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: 1

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:

Registered nurse licensed in the State of Alaska.

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.

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:

Applicants submit required information about medical needs and functional abilities for an initial screening. SDS reviews these materials to determine whether an in-depth assessment is warranted. If so, an SDS-trained registered nurse conducts an assessment using the Nursing Facility Assessment Form for Children and determines if the applicant meets NFLOC. A registered nurse within the SDS NFLOC Unit reviews the assessment tool and determines if the applicant meets a nursing home level of care.

Participants are reevaluated at least annually by a state-licensed registered nurse using the same tool.

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):*

The Senior and Disabilities Services waiver information management system, known as DS3, includes an on-line "reports manager" function. Each week the SDS Research and Analysis Unit generate a report of upcoming CCMC reassessment dates. No later than 60 days before the expiration of a participant's nursing facility level of care approval, NFLOC Unit staff notifies the care coordinator and the RN assessor of the need to renew. In addition, SDS policy specifies timelines for the scheduling and completion of the assessment, as well as the SDS review and level of care determination.

Reevaluation timeliness is also tracked as an element of the SDS Continuous Quality Improvement Plan. The performance measure "number and percent of participants receiving annual LOC within 12 months of initial determination or previous LOC determination" is tracked monthly with review of 100% sample size.

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:

Evaluations and reevaluations of the need for level of care are maintained in the participant's official file in the Anchorage office of the Division of Senior and Disabilities Services for a minimum of three years. An electronic copy is also uploaded into DS3 and maintained indefinitely.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
 # and % participants who received initial LOC determination indicating need for institutional LOC

prior to receipt of waiver services. Numerator = # participants who received initial LOC determination prior to receipt of waiver services within the reporting period. Denominator = # of participants who entered the waiver program 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*(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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Financial records (including expenditures)
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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
 # and % participants who received annual LOC within 12 months of initial determination or previous LOC determination. Numerator = # participants who received annual LOC determination within 12 months of the initial or previous LOC determination and were due to receive a LOC determination in reporting period. Denominator = # participants due to receive a LOC determination in 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*(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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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/indicator the State will use to assess compliance with the statutory assurance complete the

following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
 # and % of LOC determinations completed by a Registered Nurse as required in waiver. Numerator = Number of participant who received a level of care determination by a Registered Nurse in the reporting period. Denominator = Number of participants who received a level of care 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*(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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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:	☐ **Annually**

	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
 # and % of initial and annual LOC determined using approved forms. Numerator = Number of participants who received a level of care determination using approved forms in the reporting period. Denominator = Number of participants who received a level of care 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*(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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
 # and % of initial and annual LOC determinations completed with criteria applied correctly by RN as identified in approved waiver. Numerator = Number of initial and annual LOC determinations completed with criteria applied correctly as identified in approved waiver. Denominator = Initial and annual LOC determinations completed.

Data Source (Select one):
Record reviews, on-site
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 = 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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 is comprised of Managers of the Nursing Facility Level of Care Unit (Co-Chair), IDD Unit (Co-Chair), 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.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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 NFLOC Unit and the IDD Waiver 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.

ii. Remediation Data Aggregation

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

Responsible Party *(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:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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 their 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 participant's 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.

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.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service		
Statutory Service	**Care Coordination**		
Statutory Service	**Day Habilitation**		
Statutory Service	**Residential Habilitation**		
Statutory Service	**Respite**		
Statutory Service	**Supported Employment**		
Other Service	**Chore**		
Other Service	**Environmental Modifications**		
Other Service	**Intensive Active Treatment**		
Other Service	**Meals**		
Other Service	**Nursing Oversight and Care Management**		
Other Service	**Specialized Medical Equipment**		
Other Service	**Transportation**		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Care Coordination

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Care coordination services assist waiver applicants to access needed services by providing an initial screening to ascertain if the applicant may reasonably be expected to require home and community-based services, and by providing assistance with waiver application documents. Care coordinator services also help the applicant by coordinating with SDS for a timely initial functional assessment. For waiver participants, care coordination services assist participants in gaining access to needed waiver and other State plan services, as well as medical, social, and educational services through development of an annual plan of care, help with securing identified services. To ensure the health, safety and welfare of participants, care coordination services provide ongoing monitoring and support, coordination of multiple services and providers, review and needed revisions to the plan of care, and facilitation of annual waiver renewal including assistance with renewal documents and coordination with SDS for a timely functional reassessment. Care coordinators are required to conduct at least one face-to-face visit per month with participants. Care coordination services also assist with case terminations to ensure participants transitioning off a waiver have adequate community

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Alaska regulations at 7 AAC 130.240 authorize payment for only one plan of care development per year unless required by a change in the participant's status or condition. The state will not pay a care coordinator for providing any other home and community-based waiver service to a participant while that care coordinator is providing ongoing care coordination, nor will it pay for services provided at any time the care coordinator is actively serving more than 40 participants. All are coordination services must be pre-authorized.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified home and community-based service provider
Individual	Care Coordinator

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Care Coordination

Provider Category:

Agency

Provider Type:

Certified home and community-based service provider

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

SDS Certified Care Coordination Agency under 7AAC 130.214, Provider certification and enrollment

Other Standard *(specify):*

"SDS Standards for Care Coordinators" adopted by reference at 7AAC 130.240

SDS promulgated these the Standards under the authority of Alaska statute at AS 47.07.045, Home and community-based services, which gives the Department of Health and Social Services (DHSS) the authority to establish regulations for the operation of home and community-based waiver services in a manner that protects and promotes the health, safety and welfare of waiver participants. These standards are adopted by reference in regulations at 7 AAC 130, Home and Community-Based Waiver Services. Failure to comply with these standards may result in sanctions pursuant

Verification of Provider Qualifications

Entity Responsible for Verification:

SDS Provider Quality Assurance Unit, Provider Certification Section

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Care Coordination

Provider Category:

Individual

Provider Type:

Care Coordinator

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

SDS Certified Care Coordinator under 7AAC 130.214, Provider certification and enrollment

Other Standard *(specify):*

"SDS Standards for Care Coordination" adopted by reference at 7AAC 130.240

SDS promulgated these the Standards under the authority of Alaska statute at AS 47.07.045, Home and community-based services, which gives the Department of Health and Social Services (DHSS) the authority to establish regulations for the operation of home and community-based waiver services in a manner that protects and promotes the health, safety and welfare of waiver participants. These standards are adopted by reference in regulations at 7 AAC 130, Home and Community-Based Waiver Services. Failure to comply with these standards may result in sanctions pursuant

Verification of Provider Qualifications

Entity Responsible for Verification:

SDS Provider Quality Assurance Unit, Provider Certification Section

Frequency of Verification:

Every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Day habilitation services assist participants with acquisition, retention or improvement of self-help, socialization, and adaptive skills that takes place in a non-residential setting, separate from the participant's private residence or other residential living arrangement. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence and personal choice. Day habilitation services promote the development of the skills needed for independence, autonomy, and full integration into the community, and reinforce skills taught in school, therapy or other settings. Day habilitation is provided at either the provider's facility designed for habilitation purposes, or in the community at locations chosen to promote socialization and community inclusion.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

None

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified home and community-based service agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:

Agency

Provider Type:

Certified home and community-based service agency

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

SDS Certified Day Habilitation Provider under 7AAC 130.214, Provider certification and enrollment

Other Standard *(specify):*

"SDS Standards for Day Habilitation" adopted by reference at 7AAC 130.260

SDS promulgated these the Standards under the authority of Alaska statute at AS 47.07.045, Home and community-based services, which gives the Department of Health and Social Services (DHSS) the authority to establish regulations for the operation of home and community-based waiver services in a manner that protects and promotes the health, safety and welfare of waiver participants. These standards are adopted by reference in regulations at 7 AAC 130, Home and Community-Based Waiver Services. Failure to comply with these standards may result in sanctions pursuant

Verification of Provider Qualifications

Entity Responsible for Verification:

SDS Provider Quality Assurance Unit, Provider Certification Section

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Residential habilitation assists participants to reside in the most integrated setting appropriate to his or her needs by providing individually tailored supports that assist with the acquisition, retention or improvement in skills related to living in the community. Supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, and social and leisure skills development.

Residential habilitation services may be provided in the participant's living arrangement or in the surrounding community. If residential habilitation is furnished in a provider owned or leased facilities, the facility must be in compliance with the Americans with Disabilities Act.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

none

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Foster Home
Agency	Assisted Living Home

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:

Individual

Provider Type:

Foster Home

Provider Qualifications

License *(specify):*

State of Alaska under AS 47.35 and Alaska regulations at 7 AAC 50

Certificate *(specify):*

n/a

Other Standard *(specify):*

"SDS Standards for Residential Habilitation" adopted by reference at 7AAC 130.265

SDS promulgated these the Standards under the authority of Alaska statute at AS 47.07.045, Home and community-based services, which gives the Department of Health and Social Services (DHSS) the authority to establish regulations for the operation of home and community-based waiver services in a manner that protects and promotes the health, safety and welfare of waiver participants. These standards are adopted by reference in regulations at 7 AAC 130, Home and Community-Based Waiver Services. Failure to comply with these standards may result in sanctions pursuant

Verification of Provider Qualifications

Entity Responsible for Verification:

License: AK Department of Health and Social Services, Office of Children’s Services

Frequency of Verification:

License: every two years
Certification: every two years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:

Agency

Provider Type:

Assisted Living Home

Provider Qualifications

License *(specify):*

State of Alaska Assisted Living Home under AS 47.33 and Alaska regulations at 7AAC 75.020

Certificate *(specify):*

SDS Assisted Living Home provider certification under 7AAC 130.214, Provider certification and enrollment

Other Standard *(specify):*

"SDS Standards for Residential Habilitation" adopted by reference at 7AAC 130.265

SDS promulgated these the Standards under the authority of Alaska statute at AS 47.07.045, Home and community-based services, which gives the Department of Health and Social Services (DHSS) the authority to establish regulations for the operation of home and community-based waiver services in a manner that protects and promotes the health, safety and welfare of waiver participants. These standards are adopted by reference in regulations at 7 AAC 130, Home and Community-Based Waiver Services. Failure to comply with these standards may result in sanctions pursuant

Verification of Provider Qualifications

Entity Responsible for Verification:

License: AK Division of Health Care Services, Licensing and Certification Unit
Certification: SDS Provider Quality Assurance Unit, Provider Certification Section

Frequency of Verification:

License: Probationary - not to exceed two years; Standard – two years
Certification - every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Respite care assists participants by providing temporary relief from caretaking duties for the participant's primary unpaid caregiver, court-appointed guardian, foster parent, or providers of family habilitation services. Hourly respite may be provided in the participant's home or the private residence of the respite provider. Per diem respite services may be provided only at a nursing facility, a general acute care hospital, an assisted living home licensed under AS 47.32 that is not the participant's residence or a foster home licensed under AS 47.32 that is not the participant's residence. When respite is provided in these other locations, the state will also reimburse for the cost of room and board incurred during the respite care. The state will not pay for respite care services to provide oversight for additional minor children in the home. A participant may also receive personal care assistance under 7 AAC 125.010-199 or habilitation services under 7 AAC 130.260-265 on the same day as respite services if the state determines that the participant would be at risk of institutionalization without additional services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Alaska regulations at 7 AAC 130.280, daily (per diem) respite is limited to 14 days per year, and hourly respite is limited to 520 hours per year unless the state determines that no other service options are available and that without respite services, the participant's health and/or safety would be at risk or the participant would be at risk of institutionalization.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Skilled Nursing Facility
Agency	General Acute Care Hospital
Agency	Asisted Living Home
Agency	Certified home and community-based service agency
Individual	Foster Home

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Skilled Nursing Facility

Provider Qualifications

License *(specify):*

State of Alaska under AS 47.32 and Alaska regulations at 7 AAC 12.610

Certificate *(specify):*

n/a

Other Standard *(specify):*

n/a

Verification of Provider Qualifications

Entity Responsible for Verification:

State of AK, DHSS, Division of Public Health, Healthcare Licensing and Certification Unit

Frequency of Verification:

Probationary - not to exceed two years; regular – two years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

General Acute Care Hospital

Provider Qualifications

License *(specify):*

State of Alaska under AS 47.32 and Alaska regulations at 7 AAC 12.610

Certificate *(specify):*

n/a

Other Standard *(specify):*

n/a

Verification of Provider Qualifications

Entity Responsible for Verification:

License: AK Dept. of Health and Social Services, Division of Health Care Services, Health Facility Licensing and Certification Unit

Frequency of Verification:

License: Probationary - not to exceed two years; Standard – two years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Asisted Living Home

Provider Qualifications

License *(specify):*

State of Alaska Assisted Living Home under AS 47.33 and Alaska regulations at 7AAC 75.020

Certificate *(specify):*

SDS Certified Respite Service Provider under 7AAC 130.214, Provider certification and enrollment

Other Standard *(specify):*

"SDS Standards for Respite Services" adopted by reference at 7AAC 130.280

SDS promulgated these the Standards under the authority of Alaska statute at AS 47.07.045, Home and community-based services, which gives the Department of Health and Social Services (DHSS) the authority to establish regulations for the operation of home and community-based waiver services in a manner that protects and promotes the health, safety and welfare of waiver participants. These standards are adopted by reference in regulations at 7 AAC 130, Home and Community-Based Waiver Services. Failure to comply with these standards may result in sanctions pursuant

Verification of Provider Qualifications

Entity Responsible for Verification:

License: AK Dept. of Health and Social Services, Division of Health Care Services, Licensing and Certification Unit
Certification: SDS Provider Quality Assurance Unit, Provider Certification Section

Frequency of Verification:

License: Probationary - not to exceed two years; Standard – two years
Certification: Every two years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Certified home and community-based service agency

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

SDS Certified Respite Provider under 7AAC 130.214, Provider certification and enrollment

Other Standard *(specify):*

"SDS Standards for Respite Services" adopted by reference at 7AAC 130.280

SDS promulgated these the Standards under the authority of Alaska statute at AS 47.07.045, Home and community-based services, which gives the Department of Health and Social Services (DHSS) the authority to establish regulations for the operation of home and community-based waiver services in a manner that protects and promotes the health, safety and welfare of waiver participants. These standards are adopted by reference in regulations at 7 AAC 130, Home and Community-Based Waiver Services. Failure to comply with these standards may result in sanctions pursuant

Verification of Provider Qualifications

Entity Responsible for Verification:

SDS Provider Quality Assurance Unit, Provider Certification Section

Frequency of Verification:

Every two years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Foster Home

Provider Qualifications

License *(specify):*

State of Alaska under AS 47.35 and Alaska regulations at 7 AAC 50

Certificate *(specify):*

n/a

Other Standard *(specify):*

"SDS Standards for Respite Services" adopted by reference at 7AAC 130.280

SDS promulgated these the Standards under the authority of Alaska statute at AS 47.07.045, Home and community-based services, which gives the Department of Health and Social Services (DHSS) the authority to establish regulations for the operation of home and community-based waiver services in a manner that protects and promotes the health, safety and welfare of waiver participants. These standards are adopted by reference in regulations at 7 AAC 130, Home and Community-Based Waiver Services. Failure to comply with these standards may result in sanctions pursuant

Verification of Provider Qualifications

Entity Responsible for Verification:

License: AK Dept. of Health and Social Services, Office of Children's Services

Frequency of Verification:

License: every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Supported Employment services assist participants to more fully integrate into their community through preparation for and participation in regular, non-sheltered employment. The services consist of intensive, ongoing supports that enable participants, for whom competitive employment at or above the minimum wage is unlikely absent the provision of support, and who, because of their disabilities, need supports to perform in a regular work setting. Supportive employment services include benefits analysis (if the participant is ineligible for services from the Division of Vocational Rehabilitation), teaching basic job skills, job placement and job coaching, as well as the elements of "Customized Employment" including discovery (comprehensive assessment of the participants work skills, strengths and desires), development of a participant's vocational assessment profile, planning, job development and ongoing work supports.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

none

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title

Agency	**Certified home and community-based service agency**

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

Certified home and community-based service agency

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

SDS Certified Supported Employment Provider under 7AAC 130.214, Provider certification and enrollment

Other Standard *(specify):*

n/a

Verification of Provider Qualifications

Entity Responsible for Verification:

SDS Provider Quality Assurance Unit, Provider Certification Section

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Chore

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**

○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Chore services assist the participant to maintain a clean, sanitary and safe environment. Chore services consist of regular cleaning of the residence used by the participant including washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture, snow shoveling or snow plowing in order to provide safe access and egress, hauling water, hauling or disposing of human excreta, collecting and chopping firewood, if firewood is used as a heat source for the participant's home, and other services that the state determines necessary to maintain a healthy and safe residence.

Payment for chore services will not be made if any other relative or caregiver, or any community or volunteer agency or third-party payer is capable of or responsible for the provision of chore services, or if the participant's residence is a rental property, and the state determines those services to be the responsibility of the

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Chore services are limited to five hours per week, not to exceed 260 hours per plan of care duration. However, a participant who has a documented history of respiratory illness may receive up to 10 hours per week, not to exceed 520 hours per plan of care duration.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified home and community-based service agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Chore

Provider Category:

Agency

Provider Type:

Certified home and community-based service agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

SDS Certified Chore Provider under 7AAC 130.214, Provider certification and enrollment

Other Standard *(specify):*

"SDS Standards for Chore Services" adopted by reference at 7AAC 130.245

SDS promulgated these the Standards under the authority of Alaska statute at AS 47.07.045, Home and community-based services, which gives the Department of Health and Social Services (DHSS) the authority to establish regulations for the operation of home and community-based waiver services in a manner that protects and promotes the health, safety and welfare of waiver participants. These standards are adopted by reference in regulations at 7 AAC 130, Home and Community-Based Waiver Services. Failure to comply with these standards may result in sanctions pursuant

Verification of Provider Qualifications

Entity Responsible for Verification:

SDS Provider Quality Assurance Unit, Provider Certification Section

Frequency of Verification:

Every 2 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental Modifications

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Environmental modifications assist participants by allowing the participant to function with greater independence in the home and community. Environmental modifications make physical adaptations to the participant's private residence or the participant's family residence necessary to meet the accessibility needs identified in their plan of care, and that are necessary to ensure the health, welfare and safety of the participant. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant. The cost of environmental modifications for a participant include the cost of labor, building materials, parts, supplies, permits, demolition and other goods that are necessary to accomplish the modification s in the participant's home.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The cost of environmental modifications have been raised to $18,500 per participant in a continuous 36 month period, except if the excess is for repair or replacement of a previous environmental modification, not to exceed $500, or, the excess results from the cost of freight to deliver materials and supplies to a remote community or for shipping and item not available in the participant's community.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Certified and bonded contractor
Agency	Tribal Housing Authority
Agency	Certified home and community-based service agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:

Individual

Provider Type:

Certified and bonded contractor

Provider Qualifications

License *(specify):*

State of Alaska Certificate under AS 08.18

Certificate *(specify):*

n/a

Other Standard *(specify):*

Bonding requirements under AS 08.18

Verification of Provider Qualifications

Entity Responsible for Verification:

Alaska Department of Commerce, Community and Economic Development, Division of Corporations, Business and Professional Licensing

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:

Agency

Provider Type:

Tribal Housing Authority

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

SDS Certified EMOD Provider under 7AAC 130.214, Provider certification and enrollment

Other Standard *(specify):*

Tribal Housing Authority under Native American Housing Assistance and Self-Determination Act of 1996 (NAHASDA), 25 U.S.C. §§ 4101-4243.

Verification of Provider Qualifications

Entity Responsible for Verification:

SDS Provider Quality Assurance Unit, Provider Certification Section

Frequency of Verification:

Every two years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:

Agency

Provider Type:

Certified home and community-based service agency

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

SDS Certified EMOD Provider under 7AAC 130.214, Provider certification and enrollment

Other Standard *(specify):*

n/a

Verification of Provider Qualifications

Entity Responsible for Verification:

SDS Provider Quality Assurance Unit, Provider Certification Section

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Intensive Active Treatment

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Intensive Active Treatment (IAT) assists a participant who needs immediate intervention to treat a medical or decelerate behavior regression that, if left untreated, would place the recipient at risk of institutionalization. IAT is provided by a professional licensed under AS 08 or under the supervision of a licensed professional who must submit contemporaneous documentation indicating that IAT services provide specific treatment or therapy needed to maintain or improve effective function of the participant, that the intervention is time-limited and addresses the participant's specific personal, family, social, behavioral or psychiatric problem, and that each intervention requires the precision and knowledge possessed only by specially-trained professionals in specific disciplines whose services are not covered under Medicaid or as habilitation services under 7 AAC 130.260. IAT services do not include training and oversight of other direct service providers or monitoring of other health-related home and community-based waiver services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

None

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified home and community-based service agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Intensive Active Treatment

Provider Category:

Agency

Provider Type:

Certified home and community-based service agency

Provider Qualifications

License *(specify):*

Professional license under AS.08

Certificate *(specify):*

SDS Certified IAT Provider under 7AAC 130.214, Provider certification and enrollment

Other Standard *(specify):*

n/a

Verification of Provider Qualifications

Entity Responsible for Verification:

SDS Provider Quality Assurance Unit, Provider Certification Section

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Meals

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Meal services provide participants with nutritious meals in a congregate setting, other than an assisted living home, or through home-delivered meals. A congregate setting refers to a non-institutional facility offering a group dining experience that facilitates social interaction. While the State of Alaska does not have congregate meal settings specifically for people with intellectual and developmental disabilities, individuals on the waiver who reside in housing for seniors and the disabled may receive meals in the residence congregate meal facility. In addition, individuals on the waiver who reside with a senior may accompany the senior to a congregate facility and receive a meal.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A maximum of two (2) meals per day are available for recipients over age 18. A full meal regime is prohibited.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified home and community-based service

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Meals

Provider Category:

Agency

Provider Type:

Certified home and community-based service

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

SDS Certified Meal Provider under 7AAC 130.214, Provider certification and enrollment

Other Standard *(specify):*

"SDS Standards for Meal Services" adopted by reference at 7AAC 130.295

SDS promulgated these the Standards under the authority of Alaska statute at AS 47.07.045, Home and community-based services, which gives the Department of Health and Social Services (DHSS) the authority to establish regulations for the operation of home and community-based waiver services in a manner that protects and promotes the health, safety and welfare of waiver participants. These standards are adopted by reference in regulations at 7 AAC 130, Home and Community-Based Waiver Services. Failure to comply with these standards may result in sanctions pursuant

Verification of Provider Qualifications

Entity Responsible for Verification:

SDS Provider Quality Assurance Unit, Provider Certification Section

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Nursing Oversight and Care Management

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Nursing Oversight and Care Management (NOCM), provided by licensed nurses within the scope of the State's Nurse Practice Act, assists fragile or unstable participants by providing treatment and oversight of the participant's medical condition on an individual and continuous or part time or intermittent basis. The intermittent, part time care may provide assessment, development of a nursing plan, delegating, supervising, and evaluating the performance of nursing duties by others, identifying training needs and providing training to the participant or participant's care giver, and monitoring service delivery. The nurse develops a nursing plan of care, which supports the client's waiver plan of care. These services are provided to an individual at home. NOCM services, available to participants of any age, are tailored to the specific needs of a particular participant and are necessary to prevent institutionalization.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified Home and Community-Based Service agency
Agency	Private Duty Nursing Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Nursing Oversight and Care Management

Provider Category:

Agency

Provider Type:

Certified Home and Community-Based Service agency

Provider Qualifications

License *(specify):*

Nurse licensed under AS 08

Certificate *(specify):*

SDS certified NOCM provider under 7AAC 130.214, Provider certification and enrollment

Other Standard *(specify):*

n/a

Verification of Provider Qualifications

Entity Responsible for Verification:

License: State of AK Department of Commerce, Community and Economic Development, Division of Corporations, Business and Professional Licensing
Certification: SDS Provider Quality Assurance Unit, Provider Certification Section

Frequency of Verification:

every two years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Nursing Oversight and Care Management

Provider Category:

Agency

Provider Type:

Private Duty Nursing Agency

Provider Qualifications

License *(specify):*

State of Alaska Licensing under AS 32

Certificate *(specify):*

Certification under 42 CFR 484

Other Standard *(specify):*

n/a

Verification of Provider Qualifications

Entity Responsible for Verification:

State of AK, DHSS, Division of Public Health, Healthcare Licensing and Certification Unit

Frequency of Verification:

annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Specialized Medical Equipment

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Specialized Medical Equipment (SME) assists the participant to maintain independence by providing devices, controls or appliances that enable a participant to perform activities of daily living or to perceive, control or communicate with the environment, or is equipment necessary for the proper functioning of that item. The state will consider items to be SME if they are identified in the department's Specialized Medical Equipment Fee Schedule, adopted by reference in 7 AAC 160.900, and include the cost of the equipment as well as the cost of training in the equipment's proper use and routine fitting of and maintenance on the equipment necessary to meet applicable standards of manufacture, design and installation. SME must be rented if the equipment is a personal emergency response system or if the state determines that renting the equipment is more cost-effective than purchasing. Once purchased, SME becomes the property of the participant.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

None

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medical Supply Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Medical Equipment

Provider Category:

Agency

Provider Type:

Medical Supply Provider

Provider Qualifications

License *(specify):*

Alaska Business License under AS 43.70

Certificate *(specify):*

n/a

Other Standard *(specify):*

Medical Supply Provider enrolled with the State Medicaid Agency Claims Payment System. SME is not a provider type we certify outside of the Durable Medical Equipment enrollment at this time. 7 AAC 130.220.(b)(4) Provider certification and enrollment

Verification of Provider Qualifications

Entity Responsible for Verification:

State Claims Payment System

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transportation

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Transportation services enable a participant (and any necessary escort) to gain access to waiver and other community services, activities and resources, as specified by the plan of care. This services is offered in addition to medical transportation required under42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a), and does not replace them. Transportation services under the waiver are offered in accordance with the participant's plan of care. Whenever possible, family, neighbors, friends or community agencies that can provide this service without charge will be utilized.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

None

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified home and community-based service agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Certified home and community-based service agency

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

SDS Certified Transportation Provider under 7AAC 130.214, Provider certification and enrollment

Other Standard *(specify):*

"SDS Standards for Transportation Services" adopted by reference at 7AAC 130.290

SDS promulgated these the Standards under the authority of Alaska statute at AS 47.07.045, Home and community-based services, which gives the Department of Health and Social Services (DHSS) the authority to establish regulations for the operation of home and community-based waiver services in a manner that protects and promotes the health, safety and welfare of waiver participants. These standards are adopted by reference in regulations at 7 AAC 130, Home and Community-Based Waiver Services. Failure to comply with these standards may result in sanctions pursuant

Verification of Provider Qualifications

Entity Responsible for Verification:

SDS Provider Quality Assurance Unit, Provider Certification Section

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

  Check each that applies:

  - ☑ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
  - ☐ **As an administrative activity.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Alaska Statute at 47.05.310 requires any "direct service care provider," including providers of home and community based waiver services, to undergo a criminal background check. Per Alaska regulations at 7 AAC 10.900, providers are required to submit background check applications, including fingerprints, and receive "provisional clearance" prior to being issued a state license, certification as an administrator/owner, beginning employment, volunteering at or residing in a entity.

The Alaska Department of Health and Social Services Licensing and Certification section, Background Check Unit conducts the background check, which includes a review of records from both Alaska and those states the individual has lived in for the prior 10 years, to search for "barrier crimes" that would make the applicant

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- ◉ **No. The State does not conduct abuse registry screening.**
- ○ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations

and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

○ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**

⦿ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Licensed Assisted Living Home	
Licensed Foster Home	

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Alaska Statute at 47.33.005 affirms that the State of Alaska promotes the establishment of assisted living homes that provide a homelike environment, help the elderly age in place, help people with disabilities integrate into the community and reach their highest level of functioning, and encourage growth and independence in all residents. Statute at 47.33.230 stipulates that the participant's "assisted living plan" must promote the resident's participation in the community and increased independence through training and support; describe the resident's preference in roommates (the resident has the right to share a room with a spouse if both are residents of the home), living environment, food, recreational activities, religious affiliation, and relationships and visitation with friends, family members and others.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Licensed Assisted Living Home

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Nursing Oversight and Care Management	☐
Environmental Modifications	☐
Chore	☐
Transportation	☐
Care Coordination	☑
Specialized Medical Equipment	☑
Residential Habilitation	☑
Day Habilitation	☐
Supported Employment	☐
Intensive Active Treatment	☑

Respite	☑
Meals	☐

Facility Capacity Limit:

There is no statutory or regulatory limit on the number of individuals that may reside in an assisted living home. Single occupancy bedroom must have 80 sq, ft.; double occupancy, 140 sq. ft.

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Licensed Foster Home

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Nursing Oversight and Care Management	☐
Environmental Modifications	☑
Chore	☐
Transportation	☑
Care Coordination	☑
Specialized Medical Equipment	☑

Residential Habilitation	☑
Day Habilitation	☑
Supported Employment	☐
Intensive Active Treatment	☑
Respite	☑
Meals	☐

Facility Capacity Limit:

six children

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- ◉ **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ○ **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

○ **The State does not make payment to relatives/legal guardians for furnishing waiver services.**

◉ **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

State regulations at 7 AAC 130.202(2) allows the state to make payments for waiver services furnished by a legal guardian who is the spouse, adult child, parent or sibling of the participant, if a court has authorized the guardian to provide those services under AS 13.26.145(c). The court must determine that any potential conflict of interest is insubstantial and that the appointment would clearly be in the best interests of the participant.

Payment may be made for any waiver services for which the relative/guardian is qualified to furnish, except for further restrictions on care coordination and residential supporting living (assisted living home. To protect against conflict of interest, regulations at 7AAC 130.240(e) prohibit the provision of care coordination

○ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Senior and Disabilities Services administers an open and continuous provider certification process. The SDS web "front page" contains a "Provider Certification and Training" link to the complete Home and Community-Based Waiver Services Certification Application Packet. The packet can be downloaded, or, SDS will mail a copy to interested parties. SDS accepts all applications for review, and provides extensive technical assistance to those applicants needing help with completion.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

i. Sub-Assurances:

a. *Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
 # and % of providers who were certified prior to providing waiver services. Numerator = Number of waiver providers who were certified prior to providing waiver services within the reporting period. Denominator = Number of waiver providers within the reporting period. *Using MMIS edits: 615, 616. Looks back 1 year to insure all billing claims have been received.

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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Financial records (including expenditures)
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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
 # and % of providers who continue to meet state certification requirements following initial certification. Numerator = Number of providers who continue to meet state certification requirements following initial certification. Denominator = Number of providers 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*(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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Financial records (including expenditures)
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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
 # and % of providers who are in compliance with critical incident report training requirements.
Numerator = Number of waiver providers that are in compliance with the state's critical incident report training requirements and that are currently certified within the reporting period.
Denominator = Number of waiver providers.

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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
 # and % of care coordinators who are in compliance with required SDS training. Numerator = Number of waiver care coordinators that are in compliance with required SDS training, and that are currently certified within the reporting period. Denominator = Number of waiver care coordinators.

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*	**Frequency of data collection/generation***(check*	**Sampling Approach***(check each that applies):*

each that applies):	*each that applies):*	
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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 "Qualified Providers Review" Task Committee is comprised of Managers of the Quality Assurance Provider Unit (chair), System Development and Support Unit, Operations Integrity Unit as well as the SDS Training Coordinator and staff from the SDS Certification Unit.
These individuals are the first line of discovery and are charged with identification of problems with provider certification and performance through monitoring and evaluation of established performance measure data.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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 that a provider is not in compliance with SDS certification or training standards, the Manager of the "Providers Quality Assurance Unit" is responsible for remediation activities.

When a provider not currently certified by SDS bills Medicaid for services to a waiver participant, that information is captured in an MMIS "error report" compiled by the Division of Health Care Services (DHCS) and reviewed monthly by the Qualified Providers Task Committee as part of discovery efforts. The Providers Quality Assurance Manager, as committee Chair, then coordinates with the Division of Health Care Services to initiate payment withholding or recovery. If appropriate, the Manager directs staff in the Provider Certification section of the unit to assist the provider complete an application or reapplication for

ii. Remediation Data Aggregation

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

Responsible Party *(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:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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 Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

◉ **Not applicable** - The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Plan of Care

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

☐ **Registered nurse, licensed to practice in the State**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**

☐ **Licensed physician (M.D. or D.O)**

☑ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

☐ **Social Worker.**
Specify qualifications:

☐ **Other**
Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

○ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

⦿ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Because an agency that provides care coordination services many also provide other home and community-based services, SDS has developed safeguards to protect against conflict of interest and to ensure the plan of care is developed in the best interests of the participant.

Required, SDS-provided care coordinator training includes content regarding participant choice and conflict of interest. Topics include "the six assurances" of the Medicaid waiver program, highlighting "service plan" and stresses that each participant must be given the opportunity to choose providers and to convey his/her choice in the planning document. The training materials focus on the care coordinators responsibility to assist the participant in understanding his or her options in choice of service providers and states "The care coordinator role is to explain and facilitate understanding about options. Choice of service provision means that

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Either the participant or participant's legal representative are required to be present at and/or be a part of the planning team meetings. Participants are actively engaged in selecting the care plan teams and development of the Plan of care. When the care plan document is complete, the recipient and/or legal guardian are required to sign the plan of care document in agreement with, or with noted disagreements. The recipient and/or legal representative are given a copy of the plan of care and the cost sheet which lists their chosen provider(s), frequency, scope, duration and costs of all services.

Regulations at & AAC 130.230 (d) provide the participant the authority to decide who should be included in the POC development process. The care coordinator is responsible for alerting those individuals identified, and coordinating the meeting at a time convenient for all.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

By regulation at 7AAC 130.230, the care coordinator is required to convene a comprehensive, person centered planning team consisting of the participant, the participant's family and/or legal guardian, and providers chosen by the participant who are expected to provide services prior to developing the Plan of Care (POC). This meeting is scheduled at a time and location convenient to the participant and those he/she wishes to participant. The POC is written by the care coordinator in accordance with the needs, preferences, goals and requests of the participant or participant's legal representative and the person-centered team, and by SDS policy must be submitted no later than 60-days after the determination of nursing facility level of care. A new POC must be submitted annually that reflects changes in the participant's health, life plans and goals.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The state licensed registered nurse administering the Consumer Assessment Tool also identifies risks. As part of the care planning team, Care Coordinators, identify and address potential risks to the applicant and their families as one part of the planning process. Applicant needs and preferences in service providers are incorporated into the plan of care. Each service is reviewed to determine the relevance of the service and the risks that may be encountered with delivery. If the participant or the participant's family or legal representative believes that the risks are great, another service may be chosen.

The care planning team develops an "Emergency Response and Back up System Plan" as a section of the plan of care. Each backup and contingency plan is unique to meet the needs and circumstances of the participant and includes emergency and evacuation protocols, a contingency plan of how the agency will provide services in the

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The SDS Standards for Care Coordinators requires care coordinators to help participants explore options when choosing a service provider. The care coordinator provides the participant with a list of certified and enrolled providers who offer services in their area and the participant picks those providers that fit their needs as outlined in the plan of care and have the capacity to serve them. In addition, the plan of care document includes a "Participant Choice of Service" section in which the participant confirms that their care coordinator has given them a list of certified providers in their community from which they may choose a provider. If the care coordinator works for an agency that provides other types of waiver services, they are required to disclose this "conflict of interest" and ensure that the participant understands that they still have the right to choose a provider from other that the care coordinators agency.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

SDS exercises routine oversight of POCs to ensure that plans are developed according to state policy and that participant's health and welfare are protected.

Every POC is reviewed and signed by the participant or the participant's legal representative before being submitted to SDS for review. Each month the Manager of the SDS Service Quality Assurance Unit is responsible for completing a retrospective review of a sample of POCs (at the + or - 5% confidence level) for suitability and adequacy based on the participant's need and level of care assessment, the inclusion of participant goals, discussion of health and safety factors and for the participant's signature.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☑ **Medicaid agency**
- ☐ **Operating agency**
- ☐ **Case manager**
- ☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

Care Coordinators have responsibility for implementation and ongoing monitoring of the participant's plan of care. Using telephonic and in-person contacts, the care coordinator ensures that services are provided as identified in the POC, monitors the effectiveness and quality of services received from providers, evaluates the need for specific services or changes in services and, with the participant, revises the plan of care as needed. In addition, the care coordinator coordinates multiple services and providers, including non-waiver services such as primary health care. The care coordinator also reviews and modifies the participant's service back-up plan as needed to ensure participant health, safety and welfare, and to ensure that participants have free choice of providers, responds to participant requests for changes in providers by providing service options, linking the participant with a new provider, and facilitating the transition as needed.

b. Monitoring Safeguards. *Select one:*

○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**

⊙ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Plans of Care (POC) are monitored by a care coordinator, who may work for the Certified Home and Community-Based Agency that is permitted to provide other waiver services. The following safeguards assure the participant or the participant's legal guardian has free choice of providers:

Prior to POC development, the care coordinator informs applicants and participants of their rights and provides the participant with the SDS "Recipient's Rights" form. By signing the form, the applicant or participant attests to the fact that they understand their rights, including the right to make choices about their service providers, to request a POC amendment and to change providers at any time.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
 # and % of waiver participants who have service plans that are adequate and appropriate based on the needs identified in the assessment. Numerator = Number of participants reviewed whose service plans were adequate and appropriate based on the needs identified in the assessment Denominator = Number of participants.

Data Source (Select one):
Record reviews, on-site
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 = 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
 # and % of participants who have documented personal goals indentified in the service plan.
Numerator = Number of participants reviewed whose service plans had documented personal goals
Denominator = Number of participants reviewed

Data Source (Select one):
Record reviews, on-site
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 = 5%
☐ **Other**	☐ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
 # and % of waiver participants whose service plans address health and safety factors. Numerator = Number of participants reviewed whose service plans addressed health and safety factors Denominator = Number of participants reviewed

Data Source (Select one):
Record reviews, on-site
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 = 5%

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
 # and % completed service plans submitted to SDS within required regulatory timeframes.
Numerator = # of service plans submitted to SDS within the regulatory timeframes that were due for submission within the reporting period. Denominator = # of service plans due for submission to SDS within the regulatory timeframes(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*(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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
 # and % of service plans that were submitted on approved forms. Numerator = Number of service plans that were submitted within the reporting period on approved forms Denominator = Number of service plans that were submitted within the reporting period.

Data Source (Select one):
Record reviews, on-site
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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
 # and % of service plans that include participant signature indicating participation in plan development. Numerator = Number of service plans reviewed that included participant signature

indicating participation in plan development Denominator = Number of participants reviewed

Data Source (Select one):
Record reviews, on-site
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 = 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
 # and % of service plans reviewed and updated as needed prior to annual redetermination date. Numerator = Number of service plans reviewed and updated as needed prior to the annual redetermination date. Denominator = Number of service plans due for an annual redetermination 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*(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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
 # and % of participants whose service plan was revised as needed to address changing needs. Numerator = Number of participants whose service plan was revised as needed to address changing needs Denominator = Number of participants reviewed

Data Source (Select one):
Record reviews, on-site
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 = 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
 # and % of participants who received services as documented in the service plan by type of service. Numerator = Number of participants reviewed who received services by type of service as identified in the service plan Denominator = Number of participants reviewed

Data Source (Select one):
Financial records (including expenditures)
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 = 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and**	☐ **Other**

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Record reviews, on-site
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 = 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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:	☐ **Annually**

	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
 # and % of participants who received services as documented in the service plan in the amount, duration and frequency described in the service plan. Numerator = Number of participants reviewed who received services in the amount, duration and frequency described in the service plan, and who were included in the case review sample. Denominator = Number of participants reviewed

Data Source (Select one):
Financial records (including expenditures)
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 = 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Record reviews, on-site
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 =

		5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
 # and % of participant records with an appropriately completed Program Recipient Rights form that

specified choice was offered among waiver services. Numerator = Number of service plans that include freedom of choice form as evidence that participant received a choice in waiver services. Denominator = Number of participants reviewed

Data Source (Select one):
Record reviews, on-site
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 = 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
 # and % participant records with documentation that the participant received list of qualified providers and was provided a choice of providers. Numerator = # of service plans that included evidence that participant received list of providers and was provided a choice in providers. Denominator = Number of participants reviewed.

Data Source (Select one):
Record reviews, on-site
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 = 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
 # and % participant records with a completed/signed freedom of choice form that specified choice was offered between institutional care and home and community-based waiver services. Numerator = # of service plans that included evidence the participant signed an affirmative statement of choice between institutional care and HCB waiver service. Denominator = Number of participants reviewed.

Data Source (Select one):
Record reviews, on-site
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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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:	☐ **Annually**
	☑ **Continuously and Ongoing**

	☐ **Other** Specify:

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 "Service Plan" Task Committee is comprised of Managers of the Quality Assurance Provider Unit (chair), Nursing Facility Level of Care Unit, IDD Unit, Operations Integrity Unit and Research and Analysis Unit. These managers are the first line of discovery and are charged with identification of POC problems within the waiver program through monitoring and evaluation of established performance measure data.

Initial discovery is the responsibility of the Service Plan Review Committee Chair 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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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.

The care coordinator is responsible for a participant's POC development and implementation. When discovery activities reveal that a POC has not been submitted in a timely fashion, or is inadequate to meet the participant's needs identified in the LOC assessment or the changing needs of the participant, does not identify personal goals, is deficient in addressing health and safety factors or is unsigned, the Manager of the "Providers Quality Assurance Unit" (PQA) is responsible for remediation activities.

The PQA Manager identifies the care coordinator who submitted the POC and prepares a "report of findings" outlining POC deficiencies or lack of timeliness. The report must include a description of the evidence supporting the finding of deficiencies as well as the specific standard, policy, regulation, or statute that is

ii. Remediation Data Aggregation

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

Responsible Party *(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:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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 Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

○

- ○ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ⦿ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ○ **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- ○ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

(5 of 6)

E-2: Opportunities for Participant-Direction

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) 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. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Alaska's Administrative Code at 7 AAC 49 provides applicants for and recipients of Medicaid waiver services the right to notice of adverse actions, an appeal of such adverse actions and a fair hearing. A notice of adverse action must be given to individuals who are denied a request for an application, when their request for services is not acted upon with reasonable promptness, if not given the choice of home and community-based services as an alternative to institutional care, are denied the service(s) of their choice or the provider(s) of their choice; or, whose services are denied, suspended, reduced or terminated.

During the initial application process, an applicant for waiver services is informed of their rights to notice of adverse action and fair hearing when the care coordinator assisting them with the application process gives them the Senior and Disabilities Services Notice of Adverse Actions, Hearings and Appeals information sheet. SDS ensures that the

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.

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 developed and operates 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

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

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*
  If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

All service providers are mandatory reporters for abuse, neglect or exploitation and are required to report these types of incidents in accordance with AS 47.17.010 for children and AS 47.24.010 for adults. For incidents of abuse, neglect or exploitation in an assisted living home, service providers are required to report these incidents to the Division of Health Care Services, Certification and Licensing Unit pursuant to AS 47.24.013.
Regulations at 7 AAC 130.215 Recipient safeguards require all providers to report critical incidents. Within 24 hours or one business day of observing or learning of an incident involving a participant for whom services are provided under a service plan, the provider agency or the incident reporter is required to file an SDS Critical Incident Report (CIR). For medication errors, this timeframe must be met only when the error results in the need medical intervention; all other medical errors must be reviewed and documented by the provider on a quarterly basis, and submitted to SDS upon request.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

As part of the initial application process and during the annual reassessment process applicants and participants and/or their legal representatives are informed on reporting abuse, neglect and exploitation, and document that they have been informed by initialing and signing the Senior and Disabilities Services Program Recipient Rights form. The care coordinator explains the participant's rights in detail, and the form identifies the state agencies responsible for investigating reports and provides contact information. After the form is signed by the applicant or participant or their legal representative, the care coordinator and a witness, a copy is given to the applicant or participant or their legal representative.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The SDS Services QA Unit, in collaboration with the SDS Adult Protection Services Unit (APS) is responsible for overseeing the CIR process.
The SDS APS unit receives all reports of harm and Critical Incident Reports (CIR). Within 24 hours or one business day of receipt, APS reviews the SDS CIR to determine if the reported circumstances indicate harm, abuse, neglect, exploitation or a continuing risk for harm, abuse, neglect or exploitation that require APS investigation or referral to the Office of Children's Services (OCS), the Division of Health Care Services Certification and Licensing Unit, or to law enforcement.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Services QA Unit oversees the CIR process and maintains an incident report database to track incidents, to monitor technical assistance and dispositions including requests for additional information regarding incidents and completions of Critical Incident Improvement Plans. For research and analysis purposes the Services QA Unit develops monthly reports summarizing incident data about each SDS program for distribution to and evaluation by SDS program managers and analyzes cumulative incident report data as a risk management method to identify prevalence and patterns of adverse events in the participant population, to evaluate the effectiveness of technical assistance interventions, and to identify areas for quality improvement in both SDS and provider agency operations.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

a. Use of Restraints or Seclusion. *(Select one)*:

○ **The State does not permit or prohibits the use of restraints or seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

⊙ **The use of restraints or seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints or Seclusion. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Because the use of restraints or seclusion may cause harm to or infringe on participant rights, SDS requires use be limited and in compliance with the "Standards for Use of Restraints and Restrictive Interventions," adopted by reference in 7 AAC 160.900 and for licensed assisted living homes, in compliance with 7 AAC 75.295, "Use of intervention and physical restraint."

The SDS "Standards" prohibit the use of seclusion, defined as the "involuntary confinement of a participant to a room by mechanical or physical means." Regulations at 7 AAC 75.295(e) governing operation of assisted living homes allow for "time out" defined as "the restriction of a resident, with that

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

SDS monitors the use of restraints through care coordinator activities, plan of care processing, critical incident reporting management, and quality assurance reviews. Seclusion is not an allowable intervention in home and community-based services, and "time out" as described in regulations at 7 AAC 75.295 is allowed only in licensed assisted living homes.

The SDS QA and APS units in cooperation with the DHSS Licensing and Certification Unit monitor the use of restraints and time-out through application reviews, provider agency reports and training records, licensing inspection reports, investigative reports, care coordinator activities, service plan reviews,

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

⊙ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

Because the use of restrictive interventions have the potential for causing harm to or infringing on participants rights, SDS requires that use be limited and in compliance with the "Standards for Use of Restraints and Restrictive Interventions," adopted by reference in 7 AAC 160.900 and in the case of licensed assisted living homes, in compliance with 7 AAC 75.295, "Use of intervention and physical restraint."

SDS permits the use of restrictive interventions when other types of intervention are ineffective and in two circumstances only: as a response when a participant presents an imminent danger to him or herself or another person's safety, and as an element of a behavioral support plan. In either circumstance, the

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

SDS monitors the use of restrictive intervention through care coordinator activities, plan of care processing, critical incident reporting management, and quality assurance reviews.

The SDS QA and APS units in cooperation with the DHSS Licensing and Certification Unit monitor the use of restrictive intervention through application reviews, provider agency reports and training records, licensing inspection reports, investigative reports, care coordinator activities, service plan reviews, critical incident reporting management, complaints, referrals, and quality assurance provider reviews.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
⊙ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Home and community-based waiver service providers of 24-hour "Residential Habilitation" services, which are always provided in a licensed assisted-living home environment, have ongoing responsibility for their residents' medication management including ongoing monitoring of participant medication regimens.

Assisted living home regulations at 7 AAC 75.240 provide that an assisted living home administrator is responsible and must document that each direct care provider working in the home, within the first 14 days of employment, is oriented to the assisted living home's (ALH) policies and procedures, including monitoring participant medication regimens. In addition, State statute at AS 47.220-240, requires each resident to have an "assisted living plan" developed and approved by the resident that specifies the resident's need for health-related services, and how that need will be met. If the health-related services include

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

Under regulations at 7 AAC 75.320 the Alaska Department of Health and Social Services (DHSS), Division of Health Care Services, Licensing and Certification Unit is responsible for oversight of medication management practices within assisted living homes. Under regulations at 7 AAC 10.1070 the DHSS Office of Children's Services, Community Care Licensing Unit is responsible for oversight of medication management in foster homes.
The annual assisted living home monitoring done by the DHSS Licensing and Certification Unit incorporates a review of resident "assisted living plans" to ensure that, as required, medication management activities have been completed by a licensed nurse at three-month intervals, and that that any concerns or problems with a resident's medication regimen, type of medication used or usage patterns have been documented, addressed and resolved.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

○ **Not applicable.** *(do not complete the remaining items)*
⊙ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

State policies that apply to the administration of medications to waiver participants or to assistance with participant self-administration of medications distinguish between situations in which a nurse has delegated these duties to a home and community-based service provider, and those in which delegation of these duties arises from another licensed health care provider, the participant or the participant's family or legal representative.

State regulations at 12 AAC 44.950-965 provide standards for delegation of nursing duties to other persons, including non-medical, unlicensed personnel, and specifically allow delegation of assistance with participant self-administration of medications and administration of medication to community-based waiver

iii. Medication Error Reporting. *Select one of the following:*

⊙ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

Medication errors are reported to Senior and Disabilities Services. Providers submit the SDS "Critical Incident Report" in accordance with SDS Policy and Procedure 15.1: Critical Incident Reporting and Management.

(b) Specify the types of medication errors that providers are required to *record:*

The provider records and documents the following medication errors occurring while the participant is in the care of or receiving services from the provider, whether medication is self-administered with assistance or administered by the provider:
- failure to document administration of a medication;
- failure to administer a medication at a scheduled time and administration of a medication at a time other than when it was scheduled;
- administration other than by the prescribed route;

(c) Specify the types of medication errors that providers must *report* to the State:

Providers must report all the medication errors cited above as well as their plans of improvement and outcomes to the State at the time of SDS certification renewal. If the error resulted in medical intervention, the provider must report within 24 hours or one business day using an SDS Critical Incident Report.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

As part of discovery efforts, SDS monitors provider compliance with required Critical Incident reporting including provider medication errors that result in the need for medical intervention. When developing the SDS Critical Incident Policy, SDS received feedback from providers indicating that the majority of medication errors were minor and did not pose a serious risk to participants. Reporting every medication error would create an administrative burden a medication for providers, and would not increase assurance of participant health and safety. In response, SDS now requires providers to record all medication errors, and to submit the records to SDS quarterly or upon request. In this way SDS can detect patters or trends that could eventually result in the need for medical intervention.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare
The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
 # and % of participants who received information on reporting abuse, neglect and exploitation. Numerator = Number of participants who received information on reporting abuse, neglect and exploitation.
Denominator = Number of participants reviewed.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data	**Frequency of data**	**Sampling Approach***(check each*

collection/generation*(check each that applies):*	**collection/generation***(check each that applies):*	*that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
 # and % critical incident reports reported by a provider within required timeframes. Numerator = # of critical incident reports reported by a provider within required timeframes, and the critical incident reports were submitted to SDS by a provider within the reporting period. Denominator = # of critical incident reports that were submitted to SDS by a provider within the reporting period.

Data Source (Select one):
Critical events and incident reports
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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
 # and % of critical incident reports reviewed by APS within one business day of receipt. Numerator = Number of critical incident reports reviewed by Adult Protective Services within one business day of receipt, and the report was submitted to SDS within the reporting period. Denominator = Number of critical incident reports submitted to SDS within the reporting period.

Data Source (Select one):

Critical events and incident reports
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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
 # and % of critical incident reports (CIR) involving children reviewed by SDS within one business day of receipt. Numerator = # of CIR involving children that were reviewed by SDS within one business day of receipt, and the report was submitted to SDS within the reporting period. Denominator = # of CIR involving children that were reported to SDS within the reporting period.

Data Source (Select one):
Critical events and incident reports
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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
 # and % of critical incident reports received by type of incident. Numerator = Number of critical incident reports received by type of incident within the reporting period Denominator = Number of critical incident

reports received within the reporting period.

Data Source (Select one):
Critical events and incident reports
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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
 # and % of deaths reviewed by Mortality Review Task Committee. Number and percent of deaths reviewed

by Mortality Review Task Committee. Numerator = Number of deaths reviewed by Mortality Review Task Committee within the reporting period. Denominator = Number of deaths reported within the reporting period and that were unexpected and/or suspicious.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Alaska Department of Health and Social Services, Division of Vital Statistics data

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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Mortality reviews
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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
 # and % of CIRs reporting medication errors that resulted in the need for medical intervention. Numerator = Number of CIRs reporting medication errors that resulted in the need for medical intervention. Denominator = Number of CIRs submitted to SDS 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*(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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
 # and % CIRs that report inappropriate use of restraint. Numerator = number of CIRs that report inappropriate use of restraint. Denominator = number of CIRs that report use of restraint 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*(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 =
☐ **Other**	☐ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
 # and % of CIRs that report the use of restrictive intervention that was prohibited, inappropriate or resulted in the need for medication intervention. Numerator = number of CIRs that report the use of restrictive intervention that was prohibited, inappropriate or resulted in the need for medication intervention. Denominator = number of CIRs that report use of restrictive interventions.

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 =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
 # and % of CIRs that report the use of seclusion. Numerator = number of CIRs that report the use of seclusion. Denominator = number or CIRs 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*(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 =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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 "Health and Welfare" Task Committee is comprised of Managers of the Quality Assurance Provider Unit (chair), Quality Assurance Service Provider Unit, Co-Chair, IDD Waiver Unit, NFLOC Unit, Operations Integrity Unit, Adult Protective Services Unit, PCA Unit, Grants Unit and the Policy and Program Development Unit. These individuals are the first line of discovery and are charged with identification of problems with participant health and welfare through monitoring and evaluation of established performance measure data.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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.

The State ensures participant health and welfare by identifying and addressing unsafe conditions, developing effective mechanisms to track safety-related trends in provider agencies, and prevents instances of abuse, neglect, and exploitation through training and technical assistance.

Providers of waiver services have front line responsibility for the health and welfare of the participants they serve. When discovery activities reveal provider deficiencies such as a care coordinator who fails to provide a participant with information on how to report abuse, neglect or exploitation, or a provider who fails to report a participant death, submits a late critical incident report, or reports a greater than expected number of critical incidents, the Manager of the "Providers Quality Assurance Unit" is responsible for remediation activities.

ii. Remediation Data Aggregation

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

Responsible Party *(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:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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 Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**
Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;

- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The SDS Continuous Quality Improvement plan (CQI) is one element of the SDS Quality Improvement Strategy (QIS) that provides for systematic evaluation of SDS activities to ensure health, safety and welfare of participants, facilitates discovery activities through collection of data necessary for remediating individual problems and implementing system improvements, and provides a reporting mechanism for SDS performance to the DHSS leadership. Work involved in the implementation of the CQI plan is done within Quality Improvement Task Committees comprised of SDS Unit Managers, and the Quality Improvement Workgroup (QIW) comprised of SDS Unit Managers and Executive Team. Activities of the QIW are overseen by the DHSS Quality Improvement Steering Committee (QISC) led by the Department Commissioner and Deputy Commissioner.

ii. System Improvement Activities

Responsible Party *(check each that applies):*	**Frequency of Monitoring and Analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☐ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

Quality Improvement Steering Committee (QISC)
The purpose of the Quality Improvement Steering Committee is to provide oversight of the SDS Quality Improvement Strategy, including continuous quality improvement activities, and to report results to Health and Social Services leadership.

While the Commissioner of the Department of Health and Social Services holds ultimate responsibility for quality improvement activities of SDS, the Deputy Commissioner for Family, Community and Integrated Services has been delegated by the Commissioner as the individual responsible to oversee the QISC

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Quality Improvement Steering Committee (QISC) provides oversight to SDS's continuous quality improvement activities. This is a multi-divisional group within DHSS that includes, at a minimum:
- Deputy Commissioner for Medicaid and Health Care Policy;
- Deputy Commissioner for Family, Community and Integrated Services, Committee Chair;
- Director, SDS;

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. 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).

Under Alaska Statute, HCB service providers are subject to the following independent audit schedule:

Alaska statute at 47.05.200 provide for annual provider audits. Each year the department contracts for independent audits of a statewide sample of all medical assistance providers in order to identify overpayments and violations of criminal statutes. These audits may not be conducted by the department or employees of the department. The audits under this section must include both on-site audits and desk audits and must be of a variety of provider types. The contractor, in consultation with the commissioner, shall select the providers to be audited and decide the ratio of desk audits and on-site audits to the total number selected.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. **Methods for Discovery: Financial Accountability**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

i. **Performance Measures**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
 # and % of claims that were coded and paid correctly. Numerator = Number of claims submitted that were coded and paid correctly within the reporting period. Denominator = Number of claims submitted within the reporting period.

Data Source (Select one):
Financial records (including expenditures)
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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
 # and % of claims for services that were prior authorized. Numerator = Number of claims submitted and paid within the reporting period that received the appropriate prior authorization. Denominator = Number of claims submitted within the reporting period.

Data Source (Select one):
Financial records (including expenditures)
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 =
☐ **Other**	☐ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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 "Financial Accountability" Task Committee is comprised of Managers of the PCA Unit, Chair, QA Provider Unit, OIU Manager, System Development and Support Unit as well as representatives from the Division of Health Care Services and the DHSS Program Integrity Office. These individuals are the first line of discovery and are charged with identification of problems with participant health and welfare through monitoring and evaluation of established performance measure data.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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 Financial Accountability, the Manager of the Operations and Integrity Unit is responsible for initiating remediation activities.

As part of monthly discovery activities, the Unit Manager reviews weekly claim cycle reports generated by the Division of Health Care Services through the Medicaid Management Information Systems (MMIS). In addition, the Manager reviews additional information collected from providers to determine if an overpayment has occurred.

ii. Remediation Data Aggregation

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

Responsible Party *(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:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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 Financial Accountability that are currently non-operational.

◉ **No**

○ **Yes**
Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Rates are determined by the Department as described in regulations 7 AAC 145.500 through 7 AAC 145.535 and are summarized below:

Care coordination services (including separate fixed fees for screening, assessment, and plan of care development); Habilitation services (including In-home supports, Family Habilitation, Group Home, Supported Living, Day Habilitation, Supported Employment); Respite; Transportation; Chore Services; Meals; and Intensive Active Treatment services are reimbursed at the lesser of billed charges or a unit rate based upon an established fee schedule with rates based provider costs. The fee schedule is revised at least every 4 years based upon provider reported costs.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Providers of home and community-based services under this waiver make claims for Medicaid reimbursement directly to the State's claim payment system using either hard copy or web-based billing. The state's fiscal agent, Affiliated Computer Services, Inc. (ACS) receives the claim, and enters it into the state's MMIS system. A "Remittance Advice" notice of payments and adjustments is sent to providers after a claim has been received. Once a claim has been received and accepted, it is processed and the appropriate payment is determined. There are no other intermediaries or alternative arrangements, and Alaska has no managed care providers.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

◉ **No. State or local government agencies do not certify expenditures for waiver services.**

○ **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The service provider agrees to frequency, scope and duration of service by signing the cost sheet which is part of the Plan of Care. Based on this document, prior authorizations are issued by SDS limiting frequency, scope and duration to that documented on the plan of care.

The HCB agency provides service to the recipient on the prior authorization and documents that the service was actually rendered on the date shown on the provider billing.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (*select one*):

◉ **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**

○ **Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ **Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

☐ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**

☑ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**

☐ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

◉ **No. The State does not make supplemental or enhanced payments for waiver services.**

○ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

- (●) **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- ( ) **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: *Complete item I-3-e.*

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

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

- ( ) **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- (●) **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ( ) **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- (●) **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ( ) **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ( ) **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- (●) **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

Waiver recipients may choose to have environmental modifications provided by an environmental modifications provider, who has met enrollment criteria, or an HCB Agency acting as an OHCDS provider, who contracts with a contractor who does not choose to enroll in Medicaid directly. Contractors who not desire to enroll in Medicaid may contract with HCB Agencies and so may provide services through an OHCDS provider. The contractor must hold a valid State of Alaska contractor's license.

Waiver participant are offered a list of environmental modification providers that contains both HCB Agencies and environmental modifications providers.

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- (●) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

☑ **Appropriation of State Tax Revenues to the State Medicaid agency**

☐ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

◉ **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.

○ **Applicable**

Check each that applies:

☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related

donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

  Check each that applies:
  - [ ] **Health care-related taxes or fees**
  - [ ] **Provider-related donations**
  - [ ] **Federal funds**

  For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** *Select one:*

- ( ) **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- (●) **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Room and board costs are isolated from waiver costs by calculating and accounting for them separately. The State pays only for the Waiver service component of the recipient's care.

In per diem respite, where room and board is an allowable expense, the licensed facility receives room and board as part of the daily unit cost.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ( ) **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select*

one:

- (●) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

(●)

No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

○ **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	44354.15	49920.26	94274.41	100290.86	13421.21	113712.07	19437.66
2	45234.72	50918.67	96153.39	102296.68	13689.63	115986.31	19832.92
3	45376.93	50918.67	96295.60	102296.68	13689.63	115986.31	19690.71
4	46200.49	51937.04	98137.53	104342.62	13963.43	118306.05	20168.52
5	46401.12	51937.04	98338.16	104342.62	13963.43	118306.05	19967.89

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	**275**	275
Year 2	**283**	283
Year 3	**290**	290
Year 4	**300**	300
Year 5	**305**	305

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

An individual count of days covered was conducted for all waiver participants in FY09 based on the beginning and ending dates associated with their Medicaid waiver eligibility status. The sum of the individual day counts was divided by the number of individuals on the program during FY09. Estimates are based on an average length of stay of 334 days per year.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Population projections were based upon data developed by the Alaska Department of Labor. Based on these population projections, future waiver populations were derived. The current waiver populations were compared to the current total population of Alaska. The ratio of current waiver participants to current Alaskans was applied to the population projections. For each category of service, the ratio of service recipients to total waiver participants was identified and then applied to future population projections. The projected population of service recipients was then used to calculate the cost per service category per year. The sum of all total service category costs was then divided by the total number of projected waiver participants to calculate an average waiver cost per year.

ii. Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

This estimate was calculated based on the average cost of non-waiver services (excluding prescription drugs) for waiver participants. This information is based on the Alaska MMIS paid billing claims for FY09. Rate increases were applied to the average cost for these services in years: 1, 2, and 4. The specific cost increases were applied as follows:

1. Year 1 = 1% increase in average cost of non-Medicaid waiver services
2. Year 2 = 2% increase in average cost of non-Medicaid waiver services

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

This estimate was calculated based on the average cost of skilled nursing facility care, intermediate care facility care, and short-term long term care. The number of participants receiving these various levels of care was proportionally used to compute an average cost that includes the aforementioned facility levels of care. This average cost was then applied to the projected waiver populations to derive an estimated cost of institutional care for the target population.

This information is based on the Alaska MMIS paid billing claims for FY09. Rate increases were applied to the average cost for these services in years: 1, 2, and 4. The specific cost increases were applied as follows:

iv. Factor G' Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

This estimate was calculated based on the average cost of non-waiver services (excluding prescription drugs) for participants receiving nursing facility care.

This information is based on the Alaska MMIS paid billing claims for FY09. Rate increases were applied to the average cost for these services in years: 1, 2, and 4. The specific cost increases were applied as follows:

1. Year 1 = 1% increase in average cost of non-Medicaid waiver services

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
Care Coordination	
Day Habilitation	
Residential Habilitation	
Respite	
Supported Employment	
Chore	
Environmental Modifications	
Intensive Active Treatment	
Meals	
Nursing Oversight and Care Management	
Specialized Medical Equipment	
Transportation	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Care Coordination Total:						**658069.84**
Care Coordination	1 month	271	10.90	222.78	**658069.84**	
Day Habilitation Total:						**1125561.36**
Day Habilitation	15 minutes	98	1452.00	7.91	**1125561.36**	
Residential Habilitation Total:						**7860881.60**
Residential Habilitation	15 minutes	187	3440.00	12.22	**7860881.60**	
Respite Total:						**892380.60**
Respite	15 minutes	190	873.00	5.38	**892380.60**	
Supported Employment Total:						**28309.68**
Supported Employment	15 minutes	3	984.00	9.59	**28309.68**	
Chore Total:						**0.00**
Chore	15 minutes	0	0.00	0.10	**0.00**	
Environmental Modifications Total:						**80000.00**
Environmental Modifications	Per project	8	1.00	10000.00	**80000.00**	
Intensive Active Treatment Total:						**216966.10**
Intensive Active Treatment	15 min.	26	249.10	33.50	**216966.10**	
Meals Total:						**0.00**
Meals	Per meal	1	0.00	0.10	**0.00**	
Nursing Oversight and Care Management Total:						**1271414.98**
Nursing Oversight and Care Management	15 min.	257	199.00	24.86	**1271414.98**	
Specialized Medical Equipment Total:						**63403.20**
Specialized Medical Equipment	Per item	20	168.00	18.87	**63403.20**	
Transportation Total:						**403.68**
Transportation	Per ride	3	8.00	16.82	**403.68**	
				GRAND TOTAL:		**12197391.04**
				Total Estimated Unduplicated Participants:		**275**
				Factor D (Divide total by number of participants):		**44354.15**
				Average Length of Stay on the Waiver:		334

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Care Coordination Total:						**691059.56**
Care Coordination	1 month	279	10.90	227.24	**691059.56**	
Day Habilitation Total:						**1171441.20**
Day Habilitation	15 minutes	100	1451.60	8.07	**1171441.20**	
Residential Habilitation Total:						**8229341.57**
Residential Habilitation	15 minutes	192	3439.90	12.46	**8229341.57**	
Respite Total:						**938414.48**
Respite	15 minutes	196	872.10	5.49	**938414.48**	
Supported Employment Total:						**28855.89**
Supported Employment	15 minutes	3	983.50	9.78	**28855.89**	
Chore Total:						**68854.50**
Chore	15 minutes	15	642.00	7.15	**68854.50**	
Environmental Modifications Total:						**50471.20**
Environmental Modifications	Per project	8	1.00	6308.90	**50471.20**	
Intensive Active Treatment Total:						**218432.76**
Intensive Active Treatment	15 min.	26	249.00	33.74	**218432.76**	
Meals Total:						**306.60**
Meals	Per meal	3	10.00	10.22	**306.60**	
Nursing Oversight and Care Management Total:						**1335923.34**
Nursing Oversight and Care Management	15 min.	264	198.99	25.43	**1335923.34**	
Specialized Medical Equipment Total:						**67914.00**
Specialized Medical Equipment	1 unit	21	168.00	19.25	**67914.00**	
Transportation Total:						**411.84**
Transportation	Per ride	3	8.00	17.16	**411.84**	
				GRAND TOTAL:		**12801426.95**
				Total Estimated Unduplicated Participants:		**283**
				Factor D (Divide total by number of participants):		**45234.72**
				Average Length of Stay on the Waiver:		334

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Care Coordination Total:						**708397.98**
Care Coordination	1 month	286	10.90	227.24	**708397.98**	
Day Habilitation Total:						**1206584.44**
Day Habilitation	15 minutes	103	1451.60	8.07	**1206584.44**	
Residential Habilitation Total:						**8443647.34**
Residential Habilitation	15 minutes	197	3439.90	12.46	**8443647.34**	
Respite Total:						**957565.80**
Respite	15 minutes	200	872.10	5.49	**957565.80**	
Supported Employment Total:						**28855.89**
Supported Employment	15 minutes	3	983.50	9.78	**28855.89**	
Chore Total:						**93860.40**
Chore	15 minutes	20	642.00	7.31	**93860.40**	
Environmental Modifications Total:						**50471.20**
Environmental Modifications	Per project	8	1.00	6308.90	**50471.20**	
Intensive Active Treatment Total:						**227192.85**
Intensive Active Treatment	15 min.	27	249.32	33.75	**227192.85**	
Meals Total:						**835.20**
Meals	Per meal	8	10.00	10.44	**835.20**	
Nursing Oversight and Care Management Total:						**1373571.63**
Nursing Oversight and Care Management	15 min.	271	199.00	25.47	**1373571.63**	
Specialized Medical Equipment Total:						**67914.00**
Specialized Medical Equipment	1 unit	21	168.00	19.25	**67914.00**	
Transportation Total:						**411.84**
Transportation	Per ride	3	8.00	17.16	**411.84**	
				GRAND TOTAL:		**13159308.56**
				Total Estimated Unduplicated Participants:		**290**
				Factor D (Divide total by number of participants):		**45376.93**
				Average Length of Stay on the Waiver:		334

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Care Coordination Total:						**745288.59**
Care Coordination	1 month	295	10.90	231.78	**745288.59**	
Day Habilitation Total:						**1266346.81**
Day Habilitation	15 minutes	106	1451.60	8.23	**1266346.81**	
Residential Habilitation Total:						**8875389.19**
Residential Habilitation	15 minutes	203	3439.90	12.71	**8875389.19**	
Respite Total:						**1010938.32**
Respite	15 minutes	207	872.10	5.60	**1010938.32**	
Supported Employment Total:						**29445.99**
Supported Employment	15 minutes	3	983.50	9.98	**29445.99**	
Chore Total:						**119893.50**
Chore	15 minute	25	642.00	7.47	**119893.50**	
Environmental Modifications Total:						**51480.62**
Environmental Modifications	Per project	8	1.02	6308.90	**51480.62**	
Intensive Active Treatment Total:						**236103.03**
Intensive Active Treatment	Per treatment	28	249.18	33.84	**236103.03**	
Meals Total:						**1387.10**
Meals	Per meal	13	10.00	10.67	**1387.10**	
Nursing Oversight and Care Management Total:						**1450901.79**
Nursing Oversight and Care Management	15 min.	280	199.07	26.03	**1450901.79**	
Specialized Medical Equipment Total:						**72552.48**
Specialized Medical Equipment	1 unit	22	168.00	19.63	**72552.48**	
Transportation Total:						**420.00**
Transportation	Per ride	3	8.00	17.50	**420.00**	
				GRAND TOTAL:		**13860147.42**
				Total Estimated Unduplicated Participants:		**300**
				Factor D (Divide total by number of participants):		**46200.49**
				Average Length of Stay on the Waiver:		334

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Care Coordination Total:						**757920.60**
Care Coordination	1 month	300	10.90	231.78	**757920.60**	
Day Habilitation Total:						**1290240.14**
Day Habilitation	15 minutes	108	1451.60	8.23	**1290240.14**	
Residential Habilitation Total:						**9050273.70**
Residential Habilitation	15 minutes	207	3439.90	12.71	**9050273.70**	
Respite Total:						**1030473.36**
Respite	15 minutes	211	872.10	5.60	**1030473.36**	
Supported Employment Total:						**29445.99**
Supported Employment	15 minutes	3	983.50	9.98	**29445.99**	
Chore Total:						**147146.40**
Chore	15 minutes	30	642.00	7.64	**147146.40**	
Environmental Modifications Total:						**51480.62**
Environmental Modifications	Per project	8	1.02	6308.90	**51480.62**	
Intensive Active Treatment Total:						**243877.77**
Intensive Active Treatment	Per treatment	29	248.51	33.84	**243877.77**	
Meals Total:						**1963.80**
Meals	Per meal	18	10.00	10.91	**1963.80**	
Nursing Oversight and Care Management Total:						**1473249.84**
Nursing Oversight and Care Management	15 min.	285	198.59	26.03	**1473249.84**	
Specialized Medical Equipment Total:						**75850.32**
Specialized Medical Equipment	1 unit	23	168.00	19.63	**75850.32**	
Transportation Total:						**420.00**
Transportation	Per ride	3	8.00	17.50	**420.00**	
				GRAND TOTAL:		**14152342.56**
				Total Estimated Unduplicated Participants:		**305**
				Factor D (Divide total by number of participants):		**46401.12**
				Average Length of Stay on the Waiver:		334