

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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

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

B. Program Title:
Children with Complex Medical Conditions

C. Waiver Number: AK.0263
Original Base Waiver Number: AK.0263.90.R2

D. Amendment Number:

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

01/01/17

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

2. Purpose(s) of Amendment

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

The purpose of this amendment is twofold:

- 1) To provide details in Appendix F-2 of a mediation process that will be used in advance of fair hearings.
- 2) To remove, as of the date of CMS approval, the Intensive Active Treatment (IAT) service in Appendix C-1/C-3 and provide a transition plan in Main-Attachment 1, as the IAT service is transitioned to a regular Medicaid EPSDT service for children and youth.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
<input type="checkbox"/> Waiver Application	
<input type="checkbox"/> Appendix A – Waiver Administration and Operation	
<input type="checkbox"/> Appendix B – Participant Access and Eligibility	

Component of the Approved Waiver	Subsection(s)
<input checked="" type="checkbox"/> Appendix C – Participant Services	C-1/C-3
<input type="checkbox"/> Appendix D – Participant Centered Service Planning and Delivery	
<input type="checkbox"/> Appendix E – Participant Direction of Services	
<input checked="" type="checkbox"/> Appendix F – Participant Rights	F-2
<input type="checkbox"/> Appendix G – Participant Safeguards	
<input type="checkbox"/> Appendix H	
<input type="checkbox"/> Appendix I – Financial Accountability	
<input checked="" type="checkbox"/> Appendix J – Cost-Neutrality Demonstration	J-2

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

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

Specify:

add details in Appendix F-2 for implementing a mediation process in advance of the fair hearing process

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: amendment

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

- 3 years 5 years

Original Base Waiver Number: AK.0263

Draft ID: AK.005.05.01

D. Type of Waiver (select only one):

Regular Waiver

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

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

1. Request Information (2 of 3)

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

- Hospital

Select applicable level of care

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Alaska**

Zip:

Phone: Ext: TTY

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

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

- Replacing an approved waiver with this waiver.
- Combining waivers.
- Splitting one waiver into two waivers.
- Eliminating a service.
- Adding or decreasing an individual cost limit pertaining to eligibility.
- Adding or decreasing limits to a service or a set of services, as specified in Appendix C.
- Reducing the unduplicated count of participants (Factor C).
- Adding new, or decreasing, a limitation on the number of participants served at any point in time.
- Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.
- Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

A draft State Plan Amendment adding Intensive Active Treatment (IAT) as a regular Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service was submitted to CMS in mid-September, and the Division of Behavioral Health (DBH) is responding to informal questions from CMS. DBH is also preparing regulatory amendments and communicating with the Division of Health Care Services (DHCS) about changes to the Medicaid Management Information System (MMIS) about billing codes, provider enrollment and training. Tribal consultation will commence when regulations are issued for public comment. For recipients of IAT, the transitions should be fairly seamless, as the providers and payment rates are expected to remain the same. SDS has already notified each the recipients of IAT who will be affected by this change (there are fewer than 20,

and none of them are nearing age 21) and their care coordinators about the removal of IAT as a waiver service, the anticipated timing for IAT to become regular Medicaid State Plan service, and how the transition will work. DBH plans to contract with an independent Board Certified Behavioral Analyst (BCBA) to conduct all initial and review assessments. ABA regulations will stipulate that all current ABA recipients will require a new assessment and families will have three months to obtain this new assessment. If a current ABA recipient no longer qualifies due to the results of the assessment the family will be notified and have opportunity to appeal the decision. Additional information, including information on the opportunity to request a Fair Hearing, will be relayed in November and December, via letters, phone calls and communications with care coordinators. DBH is prepared to absorb 100% of the cost of paying providers to provide IAT services to recipients with a medical need until the SPA, regulations and MMIS are amended and the service is available through EPSDT. The IAT service will be renamed Applied Behavioral Analysis (ABA) when offered through DBH, once the amendment is approved by CMS with an effective date.

During the period when IAT is no longer a waiver service and until it becomes ABA as a Medicaid service, DBH will have both providers of IAT (there are currently only two) complete contracts with DBH to provide ABA Services. As contract providers, the two will be provided access to AKAIMS, which will be utilized as both the Electronic Health Record (EHR) as well as the billing system for the next six months, or until the MMIS is set up to accept ABA service billings. Funds utilized to pay for ABA between the period beginning with the effective date of this amendment through June 30, 2017 will be State General Funds. ABA services will be provided to any children who may become IDD Waiver-eligible during this time frame and qualify for ABA Services.

DBH staff will review and adjudicate all claims submitted through AKAIMS.

Upon the completion of system changes to the MMIS, DBH will request the Division of Health Care Services (DHCS) run all paid claims through the MMIS to capture the Federal Medicaid match. This match will be reimbursed to the General Fund.

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

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

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

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

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

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

The State assures that the settings transition plan included with this waiver amendment will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. The State will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to this waiver when it submits the next amendment or renewal.

Systemic Review of State Statutes and Regulations

To gauge the extent to which current state regulations ensure compliance with federal setting requirements, SDS reviewed state statutes and regulations governing Medicaid waiver services, assisted living home licensing, foster care licensing, and the home and community-based services provider standards in the SDS Conditions of Participation.

Because SDS refined its philosophy and practices, including updating its regulations and policies, as new directives were issued, SDS concludes that the state regulations and policies applicable to waiver services are consistent with the new federal regulations, and support integrated settings, full access to the community, and recipient initiative, autonomy, and independence; nonetheless, SDS finds that the requirements regarding settings can be clarified through additional language in SDS regulations and Conditions of Participation, as outlined in Part 3, the State Plan for Achieving Compliance section.

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

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

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	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:

Service:

Alternate Service Title (if any):

Care Coordination

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

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

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

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

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

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

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

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

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

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

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

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

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

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

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

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

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

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

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

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

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

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

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

If the complaint is about the behavior of an SDS employee or an SDS administrative process (e.g., conduct considered negligent, rude, or discourteous, timeliness of actions, request for unreasonable or unnecessary documentation or clarification, and treatment different than others without reasons related to regulations) the