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)
☐ **Waiver Application**	
☐ **Appendix A – Waiver Administration and Operation**	
☐ **Appendix B – Participant Access and Eligibility**	

Component of the Approved Waiver	Subsection(s)
☑ Appendix C – Participant Services	C-1/C-3
☐ Appendix D – Participant Centered Service Planning and Delivery	
☐ Appendix E – Participant Direction of Services	
☑ Appendix F – Participant Rights	F-2
☐ Appendix G – Participant Safeguards	
☐ Appendix H	
☐ Appendix I – Financial Accountability	
☑ 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

○ **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 Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**
If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

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

◉ **Not applicable**

○ **Applicable**
Check the applicable authority or authorities:

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

☐ **Waiver(s) authorized under §1915(b) of the Act.**
Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

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

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

☐ **§1915(b)(2) (central broker)**

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

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

☐ **A program operated under §1932(a) of the Act.**
Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

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

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

☐ **A program authorized under §1115 of the Act.**
Specify the program:

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

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

The waiver is administered by the Alaska Department of Health and Social Services (DHSS), the state's single Medicaid Agency (SMA), and is operated by the DHSS Division of Senior and Disabilities Services (SDS) within applicable federal regulations. Applicants access the waiver through SDS-certified conflict-free (in five designated urban areas and where available in rural areas) care coordinators. In order to ensure that individuals have access to care coordination in rural and remote regions in Alaska, the State has developed a process for approving exceptions to the "conflict free care coordination" policy.

Care coordinators screen applicants, assist in completion of an initial application, and deliver the application to SDS. SDS maintains a master list of certified care coordinators on its website. Services are delivered through traditional methods by SDS-certified home and community-based provider agencies.

3. Components of the Waiver Request

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

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. **Participant-Direction of Services.** When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- ○ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ◉ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. **Participant Rights. Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. **Participant Safeguards. Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. **Quality Improvement Strategy. Appendix H** contains the Quality Improvement Strategy for this waiver.

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

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

4. Waiver(s) Requested

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

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

- ○ **Not Applicable**
- ◉ **No**
- ○ **Yes**

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

- ◉ **No**
- ○ **Yes**

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

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

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

5. Assurances

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

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

   1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

   2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

   3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

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

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

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

   1. Informed of any feasible alternatives under the waiver; and,

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

A. **Service Plan**. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. **Inpatients**. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. **Room and Board**. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. **Access to Services**. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. **Free Choice of Provider**. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. **FFP Limitation**. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. **Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. **Quality Improvement**. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. **Public Input.** Describe how the State secures public input into the development of the waiver:
In general, the State secures public input on operational implementation of its waivers and amendments through a variety of methods including:
• Information-sharing teleconferences and webinars with care coordinators and other waiver services providers;
• Conversations with physicians who treat the participants and medical staff of hospitals who refer patients to the waiver program;
• Regular communication with the State of Alaska's statutorily-mandated advocacy board, the Governor's Council on Disabilities and Special Education, and related advocacy coalitions that comprise the agencies serving recipient populations, the Key Coalition and the Alaska Association of Developmental Disabilities, both for people with developmental disabilities;
• Interactive presentations to the Alaska Native Health Care Consortium (ANTHC) Long Term Care Committee.

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: Deb

First Name: Etheridge

Title: Deputy Directory

Agency: Senior and Disabilities Services, Department of Health & Social Services

Address: PO Box 110680

Address 2:

City: Juneau

State: **Alaska**

Zip: 99811-0680

Phone: (907) 465-5481 **Ext:** ☐ **TTY**

Fax: (907) 465-1170

E-mail: deb.etheridge@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: none

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

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Alaska**

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

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.

This language will also amend regulations found by SDS and CMS to be "silent" on settings requirements.

The Department of Health and Human Services will establish a stakeholder group called the interagency settings compliance committee (ISCC). ISCC will have a person-centered focus that is transparent to participants and the community while providing accountability to all parties involved. The overarching mission for the ISCC will be to ensure that the State is not only in compliance with the CMS settings rule but also that the rule is ingrained in the practice of HCBS providers.

The purpose of this committee is to:
• Evaluate State Statute and Regulations to ensure compliance with CMS Rule
• Regulatory changes will be released for public comment prior to promulgation. Revised service definitions, standards and provider qualifications that will ensure all services provided through the 1915(c) waivers are compliant with the CMS rule will be subject to a public comment period.
• Develop interagency policies that increase oversight and compliance to rule and improve outcomes for consumers
• Engage stakeholder community on regulation changes and department updates

Membership in the ISCC will include:
• Division of Senior and Disabilities Services
• Division of Health Care Services
• Division of the Office of Children Services
• Office of the Long Term Care Ombudsman
• Division of Pioneer Homes

Internal Review of Waiver Programs
Alaska operates four home and community based services waiver programs: Intellectual and Developmental Disabilities (IDD), serving those who experience only intellectual or developmental disabilities and who meet the level of care for an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID); Alaskans Living Independently (ALI), serving those 21+ who experience only physical disabilities and meet the nursing facility level of care (NFLOC); Adults with Physical and Developmental Disabilities (APDD), for those 21+ who have both physical and developmental disabilities and meet NFLOC; and Children with Complex Medical Conditions (CCMC), serving those up to age 21 who meet NFLOC.

In addition to the systemic regulatory review for CMS, SDS conducted an internal review of its certification and compliance activities to determine which services and settings in each of its four waivers (IDD, ALI, APDD, and CCMC) would need to be evaluated for compliance with the federal settings requirements. Through this internal review, SDS determined that because the following services are provided in private homes, evaluation for compliance is not required:
• Care coordination (all waivers)
• Respite (in home) (all waivers)
• Chore (all waivers)
• Environmental Modifications (all waivers)
• Intensive Active Treatment (IDD, APDD, CCMC)
• Nursing Oversight and Care Management (IDD, CCMC)
• Specialized Medical Equipment (all waivers)
• Meals (home-delivered) (all waivers)
• Specialized Private Duty Nursing (IDD, APDD)

Additionally, SDS found that the following services are provided in settings that will need to comply with the CMS settings regulations:

Residential
• Licensed assisted living home - Residential habilitation- Group home: IDD, APDD
• Licensed foster home - Residential habilitation,-Family home habilitation (child): IDD, CCMC,
• Licensed foster home - Residential habilitation,-Family home habilitation (adult): IDD, APDD
• Licensed assisted living home - Residential supported living: ALI, APDD
• Provider-owned, leased or operated housing- Supported living: IDD, APDD

Non-residential
• Facility-based – Day habilitation: IDD, APDD, CCMC

• Facility-based – Adult day: ALI, APDD
• Employment site – Supported employment*: IDD, APDD
• Facility-based – Meals, congregate: IDD, APDD, CCMC, ALI

* The Supported Employment service has two billing codes and rates, Group and Individual, but the service is the same. The settings analysis will focus on provider-owned, leased, or operated supported employment sites, rather than supported employment in community-based settings or group versus individual supported employment.

SDS also conducted an internal review to gather information on possible institutional settings, services provided on the grounds or adjacent to a public institution, and settings that might be perceived as isolating recipients from the greater community.

Because there were no intermediate care facilities for Alaskans with intellectual and developmental disabilities, residents needing services were relocated outside of Alaska prior to 1961. Thereafter, the opening of Harborview Developmental Center, a state-owned and operated residential facility in Valdez Alaska, made it possible for 175 Alaskan residents to receive services in-state. Following amendment of the Social Security Act in 1981, the State developed a home and community-based services program that included the certification of provider-owned or -controlled intermediate care facilities. As more families found community supports, the number of Harborview residents dropped to 80 individuals making the cost of maintaining the facility unsustainable. The State was able to transition the remaining residents into their communities because the necessary home and community-based services infrastructure was in place. Harborview Developmental Center was closed in 1997; at the same time, the state decertified all provider-owned or -controlled intermediate care facilities for individuals with intellectual and developmental disabilities, making Alaska free of IDD institutional facilities.

On the basis of a review of this history, provider certification policies, and a comparison of the physical addresses where waiver services are provided to the physical addresses of Alaska's public institutions, SDS finds that there are no waiver services provided in institutions, and only a few service settings located in a building on the grounds of, or immediately adjacent to, a public institution in Alaska. SDS is prepared to work with these providers to bring each into settings compliance, or bring forward to CMS for heightened scrutiny, once the providers have completed the mandatory settings self-assessment. For the few services authorized to be provided out of state (when there are no providers for certain services within Alaska), SDS will require proof of settings compliance from those other states' Medicaid entities.

Using the expertise of staff in Provider Certification and Compliance, Quality Assurance, and Operations Units and other state staff in Residential Licensing, as well as the physical addresses of waiver services, SDS identified three areas where waiver services could be viewed as being provided in possibly isolating settings. These areas are farmstead-model programs, day habilitation centers, and supported employment sites. SDS conducted several initial site visits using a checklist based on the materials provided in the CMS Toolkit. The checklist is contained in the Transition Plan as Appendix B.

While SDS believes the providers for each of these services and programs will be able to become settings-compliant with time, SDS will wait for each provider to complete the mandatory self-assessment before making a determination whether the setting should be forwarded to CMS for heightened scrutiny.

Voluntary Provider Self-Assessment of Settings

SDS created the Provider Self-Assessment of Settings survey for providers for two purposes: 1) to serve as a teaching tool to inform providers of the new federal regulations, and 2) to be used as a tool to evaluate the extent to which the provider meets the new settings requirements. The survey was constructed so that each element of the settings characteristics was emphasized by presenting it as a question for provider evaluation. SDS conducted two statewide webinars to train providers on how to complete the survey. The online survey was made available on the SDS website, and was open for participation October 1 through November 14, 2014.

The survey could be printed for the provider's self-assessment, or alternatively, providers could participate in an online survey. The online survey was structured so that a provider of services need only fill out the survey once, while taking into consideration every setting where home and community-based services were provided when formulating a response. The survey consisted of two parts: the first set of questions pertained to all home and community-based settings; the second set of questions were applicable only to provider-owned or controlled residential settings. All questions used a Yes/No format, followed by a text box for the respondent to provide additional information in narrative form.

All providers, except for those providing care coordination services only, were strongly encouraged to participate in the survey. The survey responses came from providers that represent locations statewide and offer services in all types of settings.

Ninety (21%) of the 439 certified home and community-based services providers responded. Of these 90 responses, 11 (12%) were considered to be incomplete because the provider did not answer all the questions. The remaining 88% responses were split evenly between two categories: those that were deemed complete and needing no further action (44%), and those that were complete but, based on the responses, need follow-up.

SDS concluded from this voluntary self-assessment of settings that many settings will likely be categorized as partially compliant, and more work is needed to help providers understand the settings requirements and become fully compliant. Accordingly, SDS has decided that participation in the self-assessment must be mandatory for all providers of services not provided in a recipient's own home.

A copy of the Provider Self-Assessment of Settings survey is available in the SDS News Archives portion of the SDS website, as are links to a variety of home and community-based settings training materials, including a Settings Checklist and Exploratory Questions, Frequently Asked Questions, a PDF version of the survey itself, and copies of the training webinar PowerPoint presentation.

ACTIVITIES TO ACHIEVE SETTINGS COMPLIANCE

Mandatory Provider Self-Assessment of Settings

SDS developed and offered the voluntary Provider Self-Assessment of Settings so that providers could evaluate their settings and make corrections if settings requirements were not met. Because the response rate for use of this tool was inadequate, SDS has planned another approach to training and provider evaluation that will require review and reporting on the status of all settings in which residential habilitation, residential supported living, day habilitation, adult day, supported employment, and congregate meal services are provided.

Beginning in February, 2016, SDS will offer training regarding settings through webinars and self-paced formats that will address settings requirements and use of the setting assessment tool. The training will be mandatory, with completion of the training, as evidenced by passing of a final exam, required not later than February 29, 2016, or SDS will begin the provider decertification process. Program administrators responsible for the service categories that are not provided in a person's own home must attend the training.

Following the training, program administrators will be given a "key" to a self-assessment tool. Like the voluntary self-assessment tool, this tool will be based on the CMS Toolkit example, but it will also incorporate formatting changes based on suggestions for clarity and flow that were made by providers who participated in the voluntary self-assessment. The tool will be finalized by the end of January, so that program administrators can obtain the key and complete the self-assessment soon after attending the training and passing the exam.

The tool will include questions regarding settings compliance and will include space to provide information about how and when a provider will become compliant with the requirement. The responses to the remediation sections will be considered the first provider remediation plan.

For tracking purposes and to ensure 100% completion of the self-assessment, SDS will cross reference open "keys" with the addresses of all residential and non-residential settings that must be evaluated. SDS will require that providers with multiple service locations complete, not later than April 30, 2016, a separate assessment for each address to capture the degree of compliance in each. Through the SDS electronic e-Alert system, SDS will send bi-weekly reminders of the requirement of completion of the settings assessment by that date. SDS will contact and offer technical assistance to providers that do not submit settings assessments by April 1, 2016. Providers that do not complete settings assessments by April 30th will be subject to decertification.

Beginning in May, SDS will conduct an initial desk review on all settings assessment responses, and analyze each for completeness and compliance with settings requirements by June 30, 2016. The analysis will include initial categorization of settings in a four-tiered structure, as well as determine whether the remediation plan included in the self-assessment is

adequate and complete. The categories are as follows:

• Fully Compliant. The setting has the characteristics required for home and community-based services, and is integrated in and supports full access by recipients to the greater community.

• Emerging Compliance. The setting does not meet all requirements, but is partially integrated and provides some supports for access by recipients to the greater community; the provider will be able to bring the settings into compliance through remediation.

• Insufficient Compliance (Presumed Institutional). The setting has institutional qualities but, SDS believes that the provider does provide services in a home and community based setting. SDS will submit evidence for heightened scrutiny to CMS for a determination of whether home and community based services can be provided in the setting.

• Non-Compliant. Nursing facilities, ICF/IIDS, hospitals, or located on the grounds of or adjacent to a public institution, as well as those settings that fail to submit a self-assessment, insufficient evidence to make a compliance determination, or indicate they do not intend to comply with settings requirements.

Self-assessment Validation and Settings Verification

In order to validate the findings of the mandatory self-assessment on settings, SDS will initiate a process of further examining a sample of settings self-assessment responses in July, 2016. This sample will be of sufficient size to ensure statistical validity of the information provided in self-assessments at a 95% confidence level, and will be appropriately representative of compliance category (the four tiers identified above), setting type (residential and nonresidential), and geographic area of the state. The exact percentage of sites that will be included in the validation and on-site review samples will be determined once the analysis determining which compliance category each setting falls into has been completed. The Research and Analysis Unit will use software at http://www.raosoft.com/samplesize.html to identify the sample sizes for each.

SDS plans to use two main methods to verify that the sampled settings were appropriately and correctly identified by level of compliance with the CMS settings requirements.

Focused desk review: SDS will conduct a review of self-assessments and related information obtained by Provider Certification and Compliance Unit through the provider certification process that supports provider self-identification of settings categories. If necessary, SDS may require providers to submit additional documentation. Focused desk reviews could result in assignment to a different category of settings compliance if upon review, there are indicators that cause concern or require more consideration. SDS will review concerns arising from lack of settings documentation, quality oversight activities, incident reports, complaints, recipient surveys, or reviews by partner organizations.

Onsite review: When a focused desk review indicates a need for further evaluation of a particular sampled setting due to participant health, welfare and/or safety concerns as identified in the self-assessment or any other SDS process, SDS will conduct an onsite review. Onsite reviews will evaluate the mandatory self-assessment results against the Settings Checklist (see Appendix C) and evidence of recipient integration into the greater community gathered during the onsite review.

The state can at its discretion conduct additional focused and on-site reviews of settings that present with health and welfare concerns or issues.

SDS will also validate provider self-assessment responses by conducting a recipient survey. SDS is exploring the National Core Indicators survey tool and process to evaluate its capacity for providing recipient data on settings compliance. SDS will also have conversations with stakeholder groups around the state about how each can assist recipients to report on non-compliant settings.

For HCB waiver services that are provided out of state, the other state's Medicaid oversight authorities will verify and validate through attestations that each setting is in compliance with settings requirements.

Remediation Plans

By FY17 SDS should have received all self-assessments that include the initial remediation plan for providers with any non-compliance with settings requirements. After initial desk review, SDS will notify the provider of settings status and whether the setting will be part of the sample that will receive a focused desk review or site visit. The notification will also include a determination about whether the initial remediation plan, which is part of the self-assessment, is adequate.

SDS will provide guidance and technical assistance for development of remediation plans found to be insufficient. A remediation plan must include timelines for completion and address changes to agency policy or to the physical environment designed to bring the setting into compliance. Each remediation plan will be tailored by that provider to that provider's settings issues, and will involve particular details addressing the proper course of action. SDS will determine the timeline for compliance with submission of revised provider remediation plans, dependent upon the number of settings or number of issues of non-compliance for each setting. The timelines for submission of a revised remediation plan will be between 30-90 days.

SDS will prioritize work with providers in the validation sample to evaluate remediation plans and corrective actions. Providers not in the sample will still receive notification of their setting compliance category with a timeline for submission if their remediation plan is insufficient. Providers failing to participate or cooperate in a timely manner with any of the mandated requirements for continued compliance with certification will be subject to the decertification and sanction processes, up to and including disenrollment from the Medicaid program per 7AAC 130.220. The goal for settings compliance of all providers is June 30, 2018, so that ample time remains to transition any recipients who receive services in settings that will not be compliant by March, 2019.

Heightened Scrutiny

A standardized home and community-based settings verification report will be the State's primary method for collecting information for the CMS "heightened scrutiny" process for those settings presumed to be institutional or isolating by federal regulation. Whether a setting is considered to isolate recipients will be determined by the provider's responses to the questions about isolation on the self-assessment tool which were taken directly from the CMS Checklist.

The remediation plans developed by providers will be made public in Version 4 of Alaska's Transition Plan in December, 2016, and will be provided to CMS as evidence that a setting overcomes the presumption that isolation makes it institutional in nature. CMS will make a determination based on the evidence provided.

Ongoing Monitoring

SDS will incorporate settings compliance into its existing monitoring processes. Provider certification, quality assurance operations, and SDS partners will incorporate a settings compliance review component into existing monitoring processes. At the time of initial certification, providers will be expected to have taken the program administrator training, and to ensure their setting(s) are compliant. Existing providers will become setting compliant through the self-assessment and remediation process prior to the renewal of their certification. Onsite reviews that are necessitated for reasons other than settings compliance will include concomitant review of settings compliance.

The SDS Provider Certification and Compliance Unit will be conducting site reviews for certified provider settings and will add settings compliance to the Unit's monitoring process. The IDD Unit will commence site reviews of other non-residential settings, supported employment and prevocational services settings in FY17, as needed. To broaden capacity for ongoing monitoring and since over 90% of settings are residential, SDS will work with residential licensing units that are part of other divisions within the Department of Health and Social Services (the Residential Licensing Unit within Division of Health Care Services licenses assisted living homes, and the Office of Children's Services certifies foster homes) so that settings assessments will become a component of the bi-annual onsite surveys conducted by those units. SDS plans to mobilize other willing groups to conduct settings compliance monitoring activities as needed, including SDS grant managers who visit congregate meals sites as part of grant oversight duties, care coordinators, who are required to visit every recipient in every setting contained in the recipient's plan of care at least once a year. SDS will utilize advocacy groups such as the Governor's Council of Disabilities and Special Education, the Office of the Long Term Care Ombudsman, and the Alaska Commission on Aging for supporting provider education. These partners will be trained to evaluate settings compliance and report issues of non-compliance through Central Intake for possible investigation or remediation with providers.

Transition of Recipients from Noncompliant Settings

During the transition period, if a provider receives training and remediation on settings and seeks recertification as a provider of home and community based waiver services but SDS determines the provider remains noncompliant with the settings requirement, SDS will work to relocate recipients. SDS will also relocate recipients in settings that are likely to be non-compliant after July, 2018, the deadline when the recertification period has concluded.

SDS is confident that most providers will be able to become settings-compliant by December, 2018. As FY18 draws to a close, SDS will be able to identify the number of recipients likely to need a transition plan due to anticipated non-compliance with settings rules. Transition steps to take place between July 2018 and January 2019 will include providing advance notice of settings noncompliance to affected recipients, their care coordinators, and all other interested parties; providing information on the other service options available to help them make an informed decision; identifying the entities that will need to be involved in the transfer to other providers; and ensuring that critical services are in place in advance of the transition.

SDS has the knowledge and experience to initiate and complete transitions at least 60 days before the March 2019 deadline for the few recipients that may be affected by non-settings-compliant providers, using relocation procedures used when SDS takes closure action against a provider. Appropriate SDS program management staff, to include Intellectual and Developmental Disabilities (IDD) and Nursing Facility Level of Care (NFLOC) unit staff, will work on these transitions on a case by case basis. The Division's Adult Protective Service unit staff will be involved with the transition of vulnerable adults at any point that SDS determines the setting to be a health and safety risk.

SDS envisions that Transition Plan Version 4 will be submitted to CMS in December, 2016. This version will contain a more detailed timeline for continuation of remediation activities and transitioning of recipients once the self-assessment is validated, responses have been sorted into compliance categories (fully compliant, emerging compliance, presumed institutional, and non-compliant), and the specifics of settings that require heightened scrutiny are identified.

AMENDMENTS TO REGULATIONS AND CONDITIONS OF PARTICIPATION

Through its internal review of regulations and the providers' voluntary evaluation of home and community-based service settings, SDS determined that amendments to regulations governing the waiver program and to provider standards in the SDS Conditions of Participation will bring SDS into full compliance with federal regulations. SDS also communicated with the Divisions of Health Care Services, Alaska Pioneer Homes, and the Office of Children's Services to ensure the assisted living homes and foster homes, for which they have administrative responsibility, have regulations that support the qualities required of home and community-based settings.

Because the State is focusing its regulatory efforts on achieving compliance with the CMS person-centered planning and conflict-free care coordination requirements by July 1, 2016, the date of reauthorization of Alaska's four waiver programs, SDS plans for the amendments to regulations and Conditions of Participation to achieve settings compliance to follow. Beginning in July, 2016, in collaboration with the Alaska Department of Law, SDS will initiate a project to amend regulations and the Conditions of Participation to address settings compliance, including amendments where the state is "silent" on federal settings requirements. The year-long process will include appropriate internal and required external review, and outreach to stakeholders will include E-Alerts and webinars to solicit public comment. The process will end with regulations that will be effective July 1, 2017.

Regulation changes
• Develop requirements regarding settings for provider certification section of regulations
• Clarify that the care coordinator must document service and settings options presented to the recipient, as well as specific providers considered for those services, during development of the Plan of Care
• Renew emphasis on non-disability specific settings among service options discussed and offered
• Specify that any discussion of residential options must include consideration of the recipient resources for room and board, and whether those resources would cover the cost of a private unit
• Specify that any modifications in a recipient's living conditions in a provider-owned or -controlled residential setting must be supported by a specific assessed need and justified in the Plan of Care

Conditions of Participation: Revisions to provider standards

• Specify that residential services providers must support recipient control of personal resources
• Clarify that the settings where services are to be provided must be physically accessible for the individual recipient

Amendments to Statutes

Language in state statutes, AS 47.33.060 and AS 47.33.300, regarding visitors in assisted living homes, appears to be inconsistent with federal settings requirements; however, these statutes also indicate that an assisted living home may not adopt a house rule that restricts the rights of residents under any other law. SDS has referred the question of whether a statutory change is required to the Department of Law. Should a change be necessary, SDS, in collaboration with the Division of Health Care Services, will develop a technical legislative proposal that will align the statutes with federal regulations. The Department of Health and Social Services will introduce the legislative proposal during the state legislative session that begins in January 2017.

In addition to seeking statutory changes, SDS will collaborate with the Division of Health Care Services to effect changes in assisted living home regulations to remove any language barring residents from having visitors of their choosing at any time. The regulation pertaining to safeguards, 7 AAC 75.220, that would seem to restrict choice if a visitor abuses, neglects or exploits a recipient may need clarification to assure notice of intent to bar a visitor is provided, and informed consent obtained from the recipient.
(Version 3 of Alaska's Transition Plan also contained timelines of activities already completed and to be completed, but those are not included here because the text box does not allow tables to be entered.)

SDS envisions that Transition Plan Version 4 will be submitted to CMS in December, 2016. This version will contain a more detailed timeline for continuation of remediation activities and transitioning of recipients once the self-assessment is validated, responses have been sorted into compliance categories (fully compliant, emerging compliance, presumed institutional, and non-compliant), and the specifics of settings that require heightened scrutiny are identified.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix D-1-b, continued:

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

Criteria used for making determinations for which census areas would be allowed to apply for exceptions to conflict-free care coordination:
(1) The number of conflict-free care coordinators could not meet the capacity for the number of recipients in the census area.

(2) The number of conflict-free care coordinators certified by waiver type could not meet the capacity to serve recipients by waiver type.

(3) Only one conflict-free agency or care coordinator serves the census area, eliminating the recipient's opportunity for choice of care coordinator.

(4) There were no recipients or providers of HCB services or care coordination in a census area.

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

(1) Review of narrative description ensuring administrative separation of HCB services from care coordination:
a. Include a basic description of the duties of the HCB services supervisor(s) and the care coordination supervisor(s).
b. Explain how recipients are given choice of care coordinator.
c. Explain how recipients are given choice of HCB services and other natural supports or services offered in the community.

d. Explain how the agency ensures that the care coordinator is free from influence of direct service providers regarding recipient care plans.

(2) Evidence of administrative separation on organizational chart that includes position titles and names of staff

(3) Attestation by agency owner/administrator of the following:

1.I attest that the agency has and uses a plan/policy/procedure to ensure administrative separation of HCB services from care co ordination. This plan/policy/procedure ensures that:
a. The agency has administrative separation of supervision of care coordination and HCB services.
b. The attached organization chart shows two separate supervisors, one for care coordination and one for HCB services.
c. Care coordination recipients are offered choice for HCB services between and among available service providers.
d. Care coordination recipients are not limited to HCB services provided only by this agency.
e. Care coordination recipients are given choice of care coordinators within the agency.
f. Disputes between care coordination and HCB services units are resolved.

2.I attest that the agency has and uses a plan/policy/procedure to implement dispute resolution. This plan/policy/procedure ensures that:
a. Recipients are free to choose or deny HCB services without influence from the internal agency care coordinator and HCB service staff.
b. Recipients choose how, when, and where to receive their approved HCB services.
c. Recipients are free to communicate grievance(s) regarding care coordination and/or HCB services delivered by the agency.
d. The grievance/complaint procedure is clear and understood by recipients and legal representatives.
e. Grievances/complaints are resolved in a timely manner.

3.I attest that outcomes/evidence of the above methods are or will be made available by report to Senior and Disabilities Services upon request.

4.I attest and understand that the agency must have each individual care coordinator complete a Conflict of Interest Assurance form for each recipient, and maintain this form in the recipient's file.

5.I attest and understand that each individual care coordinator may not have any conflict of interest with recipients they serve.

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

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

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

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

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

Appendix 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.

   The State Medicaid Director performs oversight of these activities through participation in the DHSS Quality Improvement Steering Committee (QISC)." The purpose of the QISC is to provide oversight of SDS's Quality Improvement Strategy, including continuous quality improvement activities, and to report results to the DHSS Commissioner. The QISC approves the SDS CQI Plan and annually reviews and approve SDS's performance measures. Additional activities include quarterly review of reports and recommendations made by the SDS "Quality Improvement Workgroup (QIW) and recommendations for systemic improvement.

   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 the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

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

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

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

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

Children with a severe, chronic physical condition who, absent home and community-based services would receive long-term care in a facility for more than 30 days per year and who have prolonged dependency on medical care or technology to maintain health and well-being and who
• •experience episodes of acute exacerbation of life-threatening conditions;
• •need extraordinary supervision or observation; and
• •need frequent or life-saving administration of specialized treatments or are dependent on mechanical support devices.

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

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

○ **Not applicable. There is no maximum age limit**

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

Specify:

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

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

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

Appendix B: Participant Access and Eligibility

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

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

- (●) **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ( ) **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

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

  - ( ) **A level higher than 100% of the institutional average.**

    Specify the percentage:

  - ( ) **Other**

    Specify:

- ( ) **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ( ) **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

  Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

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

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	296
Year 2	305
Year 3	314
Year 4	324
Year 5	334

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

- ◉ **The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- ○ **The State limits the number of participants that it serves at any point in time during a waiver year.**

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
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.

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

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

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

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - ○ **§1634 State**
   - ◉ **SSI Criteria State**
   - ○ **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - ○ **No**
   - ◉ **Yes**

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

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

- ☐ **Low income families with children as provided in §1931 of the Act**
- ☑ **SSI recipients**
- ☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- ☑ **Optional State supplement recipients**
- ☐ **Optional categorically needy aged and/or disabled individuals who have income at:**

  Select one:

  - ○ **100% of the Federal poverty level (FPL)**
  - ○ **% of FPL, which is lower than 100% of FPL.**

  Specify percentage: [ ]

- ☑ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- ☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- ☐ **Medically needy in 209(b) States (42 CFR §435.330)**
- ☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- ☑ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

  Specify:

  §42 CFR
  §435.110 Parents and other caretaker relatives.
  Sec 1925 Transitional Medical Assistance (TMA)
  §435.115 Extended Medicaid due to increased child support.
  §435.117 Newborn children.
  §435.119 Coverage for individuals age 19 or older and under age 65 at or below 133 percent FPL.
  §435.120 Individuals receiving SSI.

§435.122 Individuals who are ineligible for SSI or optional State supplements because of requirements that do not apply under title XIX of the Act.
§435.130 Individuals receiving mandatory State supplements.
§435.131 Individuals eligible as essential spouses in December 1973
§435.133 Blind and disabled individuals eligible in December 1973.
§435.134 Individuals who would be eligible except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972).
§435.135 Individuals who become ineligible for cash assistance as a result of OASDI cost-of-living increases received after April 1977.
§435.137 Disabled widows and widowers who would be eligible for SSI except for the increase in disability benefits resulting from elimination of the reduction factor under Pub. L. 98-21.
§435.138 Disabled widows and widowers aged 60 through 64 who would be eligible for SSI except for early receipt of social security benefits.
§435.170 Pregnant women eligible for extended coverage.
§435.210 Individuals who meet the income and resource requirements of the cash assistance programs.
§435.232 Individuals receiving only optional State supplements.

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

- ☑ **A special income level equal to:**

Select one:

- ◉ **300% of the SSI Federal Benefit Rate (FBR)**
- ○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage: [ ]

- ○ **A dollar amount which is lower than 300%.**

Specify dollar amount: [ ]

- ☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- ☐ **Medically needy without 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 7)

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

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

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☑ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act.** *Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.*

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

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

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

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

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

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

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

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

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

○ **The following standard included under the State plan**

Select one:

○ **SSI standard**
○ **Optional State supplement standard**
○ **Medically needy income standard**
○ **The special income level for institutionalized persons**

(*select one*):

○ **300% of the SSI Federal Benefit Rate (FBR)**
○ **A percentage of the FBR, which is less than 300%**

Specify the percentage:

○ **A dollar amount which is less than 300%.**

Specify dollar amount:

○ **A percentage of the Federal poverty level**

Specify percentage:

○ **Other standard included under the State Plan**

Specify:

○ **The following dollar amount**

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

◉ **The following formula is used to determine the needs allowance:**

Specify:

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

○ **Other**

Specify:

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

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

Specify:

Specify the amount of the allowance (*select one*):

- ○ **SSI standard**
- ○ **Optional State supplement standard**
- ○ **Medically needy income standard**
- ○ **The following dollar amount:**

  Specify dollar amount: [ ] If this amount changes, this item will be revised.
- ○ **The amount is determined using the following formula:**

  Specify:

iii. Allowance for the family (*select one*):

- ○ **Not Applicable (see instructions)**
- ◉ **AFDC need standard**
- ○ **Medically needy income standard**
- ○ **The following dollar amount:**

  Specify dollar amount: [ ] The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
- ○ **The amount is determined using the following formula:**

  Specify:
- ○ **Other**

  Specify:

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

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

Select one:

- ○ **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- ◉ **The State does not establish reasonable limits.**
- ○ **The State establishes the following reasonable limits**

  Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ○ **SSI standard**
- ○ **Optional State supplement standard**
- ○ **Medically needy income standard**
- ○ **The special income level for institutionalized persons**
- ○ **A percentage of the Federal poverty level**

  Specify percentage:

- ○ **The following dollar amount:**

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

- ○ **The following formula is used to determine the needs allowance:**

  Specify formula:

- ◉ **Other**

  Specify:

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

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

Select one:

- (●) **Allowance is the same**
- ( ) **Allowance is different.**

Explanation of difference:

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

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

Select one:

- ( ) **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- (●) **The State does not establish reasonable limits.**
- ( ) **The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

a. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

   i. **Minimum number of services.**

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

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

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

This waiver employs the nursing facility level of care (NFLOC) standard to evaluate and reevaluate the need for waiver services. The assessment tool is the State of Alaska Nursing Facility Assessment Form for Children, approved July 1, 2004. Criteria considered include the applicant or participant''s health condition as indicated by the

primary and secondary diagnoses, the appropriateness of weight and height to age and development, the performance of activities of daily living and the need for assistive devices. Also considered are services that, absent home and community-based services, would require institutionalization including dependence on technology (i.e., ventilator or feeding tube) or the need for 24-hour support or monitoring. Additional criteria considered include the applicant or participant's cognitive status including decision making skills, orientation, and memory. Information on socially inappropriate or dangerous behaviors is collected including verbal or physical abusive or self abuse.

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

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

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

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

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

Applicants submit required information about medical needs and functional abilities for an initial screening. The screening is done by a nurse employed by a provider agency who then submits the screening to SDS with supporting medical documentation. 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. All assessments and determinations are made by qualified SDS assessors who do not provide any other home and community-based services.

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

The State has developed telehealth policy for conducting assessments and reassessments. These assessments will occur where signed agreements with rural health care providers exist. The agreements outline the procedures and secure technology requirements for all parties. Recipients must be able to travel to the health care provider clinic to be assessed or reassessed using telehealth. The State intends to conduct assessments and reassessments in the recipient's own home using telehealth once secure technology and connectivity is in place.

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

The assessor making the finding of material improvement begins The MIRP with a review of existing documentation of the recipient's condition during the 12 months prior to the finding. In addition, the assessor contacts the recipient and/or their representative requesting any additional documentation the recipient believes may contribute to an understanding of their current condition. Next, the assessor's supervisor, an RN, conducts a quality control review (QC) of the reassessment tool for scoring validity as well as consistency and completeness, and reviews any newly received documentation of the recipient's condition. The supervisor seeks additional clarifying information if needed, including a review of service utilization to determine if the individual is able to demonstrate the ability to

function in a home setting with the need for waiver services.

After the QC review, an SDS RN, who is not the assessor or their supervisor, conducts a comprehensive comparison of the "qualifying assessment," the most recent assessment or related fair hearing, additional supporting information, or a Qualis finding of material improvement that found the recipient eligible, and the "denial assessment," the subsequent assessment that found material improvement. In preparation for this analysis, SDS sends a formal notice to the recipient and/or their representative informing them that notwithstanding the finding of material improvement, before a final eligibility determination, SDS will review any additional documentation that may contradict that finding. SDS also sends the "Level of Care Verification" form to the primary physician for an opinion on the recipient's condition. The RN then uses the "Material Improvement Reporting for CCMC Waivers" form, adopted by reference into State regulations at 7 AAC 130.219, focusing on the specific ways in which the recipient's condition has changed since their qualifying assessment. The RN analyzes all existing and new information, and develops a detailed narrative explanation of how the recipient's physical condition has improved to the point of material improvement.

The final step in the MIRP is submission of the written analysis and supporting documents to the State's contractor for a "third party review" of eligibility. The contractor employs physicians and nurses who independently review the qualifying and denial assessments and all accompanying documentation. The contractor either upholds or overturns the SDS decision, which is the final level of care determination.

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 Unit Manager's duties. Though SDS does not report on this measure to CMS, timeliness is evaluated and measured by the State to ensure adherence to eligibility processes.

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

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**

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. **Sub-Assurances:**

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

Performance Measures

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

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

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

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(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 =

		95%, +/- 5% and 50% distribution
☐ **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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

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

Performance Measures

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

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

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

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(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 = 95%, +/- 5% and 50% distribution
☐ **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:
LOC 3: # and % of initial LOC determination criteria applied correctly. Numerator: # of initial and annual LOC determination criterion applied correctly. Denominator: # of participants who were included in the case review sample.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%, +/- 5% and 50% distribution
☐ **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 comprises Managers of the IDD Waiver Unit and NFLOC Unit (cochairs), Research and Analysis Team, Quality Assurance Unit, Policy and Program Development Unit and the Personal Care Assistance Unit. These managers are the first line of discovery and are charged with identification of Level Of Care problems within the waiver program through monitoring and evaluation of established performance measure data.

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

The Level of Care Committee prepares standardized monthly reports for the Quality Improvement Workgroup (QIW) based on the Level of Care measures approved by the Department of Health and Social Service Quality Improvement Steering Committee (QISC). QIW reports include at minimum:
• Monthly, quarterly and annual cumulative aggregated data of findings and corrective actions taken at the program/ unit levels as identified through the task committee review activities;

• Historical data for use in comparing similar reporting periods;
• A summary of findings and recommended action, including preliminary trends identified by the task committee.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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 Nursing Facility Level of Care Unit and the IDD Unit are responsible for initiating remediation activities.

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

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

ii. Remediation Data Aggregation

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

Responsible Party*(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 the recipient's legal representative, along with the participant''s care coordinator, completes a waiver Plan of Care (POC) of feasible service alternatives under the waiver. Section IV of the POC "Participant Choice of Services" requires the participant or legal representative to initial a series of statements indicating that they understand the choices available – either receiving Medicaid-funded care in an institution, through Medicaid home and community-based services, only non-Medicaid services, or receiving no services at all. The section also outlines the assistance SDS and/or the 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.

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

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

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

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
People who have limited English proficiency, vision, hearing or other impairments seeking waiver services have equal access to both financial and functional eligibility determinations.

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

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

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

When working with blind or deaf participants, SDS and care coordinators often rely on family members who act as interpreters for their children. Those regions with ADRCs or Independent Living Centers (ILC) are sources of assistance with ASL interpreters and other accommodations. SDS and care coordinators also use the "Alaska Relay" service for telephone communications.
All applicants for Medicaid services are notified of the opportunity for reasonable accommodations in the Medicaid application, during the eligibility processes, and waiver determination of level of care process.

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:
Statutory Service

Service:
Case Management

Alternate Service Title (if any):
Care Coordination

HCBS Taxonomy:

Category 1: 01 Case Management

Sub-Category 1: 0101010 case management

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4: **Sub-Category 4:**

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, unless the care coordinator receives SDS approval for quarterly face to face visits due to the rural or remote location of a recipient, in which case the care coordinator conducts twice-monthly contacts via telephone. Care coordination services also assist with case terminations to ensure participants transitioning off a waiver have adequate community services and supports.
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.

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 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 to regulations at 7 AAC 105.410, Sanctions, administrative actions pursuant to regulations at 7AAC 130.225, Provider disenrollment and decertification, and overpayment recovery pursuant to regulations at 7AAC 105.260, Recouping an overpayment.

These standards apply to all providers of care coordination Medicaid wavier home and community-based services certified under regulations at 7AAC 130.214, Provider certification and enrollment.

The following general standards apply to all care coordination agencies. The provider agency shall:
a. Cooperate with the Department certification and oversight process including requests for information and access to any service location or proposed service location.
b. Implement and carry out the agency policies and procedures submitted with an application for certification.
c. Attend all training required by the Department as part of the application process and ongoing certification requirements.
d. Comply with regulations at 7 AAC 105 - Medicaid provider and recipient participation.
e. Comply with Alaska statute at AS 47.05. 300 – 390 - Criminal history and regulations at 7 AAC 10.010-10.990 Barrier crimes, criminal history checks and centralized registry.
f. Ensure that, pursuant to regulations at 7 AAC 105.420-430 or similar authority in other states, no owners, administrators, employees or contractors are hired or retained who have been convicted of medical assistance fraud, sanctioned by, suspended or terminated from the Medicaid program due to program abuse or abuse of a participant, or convicted of a crime the Department considers a risk to the health and safety of a participant. In addition, the provider agency shall comply with 7 AAC 105.420(c) by checking the Office Inspector General List of Excluded Individuals at http://oig.gov/fraud/exclusions.asp and the Excluded Parties List System found at https://www.epls.gov.
g. Charge waiver participants fees no higher than are charged to private pay recipients for comparable services.
h. Cooperate with Department regulations at 7 AAC 105.220 by providing copies of records, access to records, access to service location for onsite inspection, and access to agency personnel.
i. Report suspected Medicaid health care fraud to the Medicaid Fraud Control Unit by calling 1-907-269-6279 or faxing 1-907-269-6202.
j. Notify SDS, in writing within 24 hours or one business day, of an owner, administrator, employee, volunteer or agent of the agency charged or convicted of criminal offense or issued, as a respondent, a protective or restraining order.
k. Maintain a formal governing body with full legal authority and responsibility for operation of the agency with all board meetings are open to the public if the provider agency is a governmental or nonprofit agency.
l. Comply with all applicable federal, state and local laws and cooperate fully with all federal, state and municipal oversight agencies to assure the health, welfare and safety of participants.
m. Maintain confidentially of participant records and information and shall comply with the requirements of the Health Information Protection and Portability Act (HIPPA).

Provider Qualifications
Every care coordination provider agency shall appoint a qualified Program Administrator to manage the day to day operations of the agency's services. The Program Administrator shall:
a. Be at least 21 years of age;
b. Have two years of full-time paid experience working with individuals in a human service setting and one year (which may be concurrent) of full time paid experience as a supervisor of two or more

staff who worked in a human service setting. The one year of work experience must also include responsibility for program planning, development and evaluation, management or operation of programs or service delivery, fiscal management, needs assessment and other similar tasks;
c. Have education and/or experience as follows:
i. BA or BS degree in social work, psychology, rehabilitation, nursing or closely related human service field from an accredited university or;
ii. AA degree in human services, psychology, rehabilitation, nursing or closely related human service field from an accredited university and two year of full time work experience in a human services field, or;
iii. Four years of full time paid work experience in a related human service field or setting, or;
iv. Certification as a rural community health aide or practitioner and one year of full time paid work experience providing home health or other similar services.

A Program Administrator for a Care Coordination agency may not act as or be appointed as a Program Administrator for any other types of home and community-based waiver services. Notwithstanding this prohibition, a Program Administrator may be appointed to manage more than one service if appropriate to the service location and if on site management requirements of the service are met.

Individual care coordinators and care coordination provider agencies must be certified by SDS prior to enrollment as a Medicaid provider.
a. Independent care coordinators or sole practitioners must be certified and enrolled as provider agencies in accordance with regulations at 7 AAC 130.220.
b. Care coordinators who are self-employed as independent or sole practitioners must meet the standards for a Care Coordination Services Program Administrator to qualify for certification and enrollment.
c. An individual who applies for certification as a care coordinator must complete the SDS basic Care Coordination training course, and demonstrate comprehension of course content prior to certification. Training may be completed up to two years prior to application.
d. To maintain or renew certification, a care coordinator must attend SDS Care Coordination training every two years.

In order to meet certification requirements a care coordinator applicant must:
a. Be at least 18 years of age;
b. Have one of the following combinations of education or experience:
i. BA, BS or AA degree from an accredited college or university in social work, psychology, rehabilitation, nursing or a closely related human services field, and one year of full-time, paid experience working with human services participants; or
ii. Two years of course credits from an accredited college or university in social work, psychology, rehabilitation, nursing or a closely related human services field, and one year of full-time, paid experience working with human services participants; or
iii. Three years of full-time paid experience working with human services participants in social work, psychology, rehabilitation, nursing, or a closely related human services field or setting; or
iv. Certification as a rural community health aide or practitioner and one year of full-time, paid experience working with human services participants.

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 to regulations at 7 AAC 105.410, Sanctions, administrative actions pursuant to regulations at 7AAC 130.225, Provider disenrollment and decertification, and overpayment recovery pursuant to regulations at 7AAC 105.260, Recouping an overpayment.

These standards apply to all providers of care coordination Medicaid wavier home and community-based services certified under regulations at 7AAC 130.214, Provider certification and enrollment.

The following general standards apply to all care coordination agencies. The provider agency shall:
a. Cooperate with the Department certification and oversight process including requests for information and access to any service location or proposed service location.
b. Implement and carry out the agency policies and procedures submitted with an application for certification.
c. Attend all training required by the Department as part of the application process and ongoing certification requirements.
d. Comply with regulations at 7 AAC 105 - Medicaid provider and recipient participation.
e. Comply with Alaska statute at AS 47.05. 300 – 390 - Criminal history and regulations at 7 AAC 10.010-10.990 Barrier crimes, criminal history checks and centralized registry.
f. Ensure that, pursuant to regulations at 7 AAC 105.420-430 or similar authority in other states, no owners, administrators, employees or contractors are hired or retained who have been convicted of medical assistance fraud, sanctioned by, suspended or terminated from the Medicaid program due to program abuse or abuse of a participant, or convicted of a crime the Department considers a risk to the health and safety of a participant. In addition, the provider agency shall comply with 7 AAC 105.420(c) by checking the Office Inspector General List of Excluded Individuals at http://oig.gov/fraud/exclusions.asp and the Excluded Parties List System found at https://www.epls.gov.
g. Charge waiver participants fees no higher than are charged to private pay recipients for comparable services.
h. Cooperate with Department regulations at 7 AAC 105.220 by providing copies of records, access to records, access to service location for onsite inspection, and access to agency personnel.
i. Report suspected Medicaid health care fraud to the Medicaid Fraud Control Unit by calling 1-907-269-6279 or faxing 1-907-269-6202.
j. Notify SDS, in writing within 24 hours or one business day, of an owner, administrator, employee, volunteer or agent of the agency charged or convicted of criminal offense or issued, as a respondent, a protective or restraining order.
k. Maintain a formal governing body with full legal authority and responsibility for operation of the agency with all board meetings are open to the public if the provider agency is a governmental or nonprofit agency.
l. Comply with all applicable federal, state and local laws and cooperate fully with all federal, state and municipal oversight agencies to assure the health, welfare and safety of participants.
m. Maintain confidentially of participant records and information and shall comply with the requirements of the Health Information Protection and Portability Act (HIPPA).

Provider Qualifications
Every care coordination provider agency shall appoint a qualified Program Administrator to manage the day to day operations of the agency's services. The Program Administrator shall:
a. Be at least 21 years of age;
b. Have two years of full-time paid experience working with individuals in a human service setting and one year (which may be concurrent) of full time paid experience as a supervisor of two or more staff who worked in a human service setting. The one year of work experience must also include responsibility for program planning, development and evaluation, management or operation of programs or service delivery, fiscal management, needs assessment and other similar tasks;
c. Have education and/or experience as follows:
i. BA or BS degree in social work, psychology, rehabilitation, nursing or closely related human service field from an accredited university or;
ii. AA degree in human services, psychology, rehabilitation, nursing or closely related human service field from an accredited university and two year of full time work experience in a human services field, or;
iii. Four years of full time paid work experience in a related human service field or setting, or;
iv. Certification as a rural community health aide or practitioner and one year of full time paid work experience providing home health or other similar services.

A Program Administrator for a Care Coordination agency may not act as or be appointed as a Program Administrator for any other types of home and community-based waiver services. Notwithstanding this prohibition, a Program Administrator may be appointed to manage more than one service if appropriate to the service location and if on site management requirements of the service are met.

Individual care coordinators and care coordination provider agencies must be certified by SDS prior to enrollment as a Medicaid provider.
a. Independent care coordinators or sole practitioners must be certified and enrolled as provider agencies in accordance with regulations at 7 AAC 130.220.
b. Care coordinators who are self-employed as independent or sole practitioners must meet the standards for a Care Coordination Services Program Administrator to qualify for certification and enrollment.
c. An individual who applies for certification as a care coordinator must complete the SDS basic Care Coordination training course, and demonstrate comprehension of course content prior to certification. Training may be completed up to two years prior to application.
d. To maintain or renew certification, a care coordinator must attend SDS Care Coordination training every two years.

In order to meet certification requirements a care coordinator applicant must:
a. Be at least 18 years of age;
b. Have one of the following combinations of education or experience:
i. BA, BS or AA degree from an accredited college or university in social work, psychology, rehabilitation, nursing or a closely related human services field, and one year of full-time, paid experience working with human services participants; or
ii. Two years of course credits from an accredited college or university in social work, psychology, rehabilitation, nursing or a closely related human services field, and one year of full-time, paid experience working with human services participants; or
iii. Three years of full-time paid experience working with human services participants in social work, psychology, rehabilitation, nursing, or a closely related human services field or setting; or
iv. Certification as a rural community health aide or practitioner and one year of full-time, paid experience working with human services participants.

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):

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope)*:

Day habilitation services assist participants who are at least three years of age with acquisition, retention or improvement of self-help, socialization, and adaptive skills that take 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, and may be provided individually or in a group.

All day habilitation services must be prior authorized and do not include vocational 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**
☑ **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 to regulations at 7 AAC 105.410, Sanctions, administrative actions pursuant to regulations at 7AAC 130.225, Provider disenrollment and decertification, and overpayment recovery pursuant to regulations at 7AAC 105.260, Recouping an overpayment.

These standards apply to all providers of day habilitation Medicaid wavier home and community-based services certified under regulations at 7AAC 130.220, Provider certification and enrollment.

The following general standards apply to all day habilitation agencies. The provider agency shall:
a. Cooperate with the Department certification and oversight process including requests for information and access to any service location or proposed service location.
b. Implement and carry out the agency policies and procedures submitted with an application for certification.
c. Attend all training required by the Department as part of the application process and ongoing certification requirements.
d. Comply with regulations at 7 AAC 105 - Medicaid provider and recipient participation.
e. Comply with Alaska statute at AS 47.05. 300 – 390 - Criminal history and regulations at 7 AAC 10.010-10.990 Barrier crimes, criminal history checks and centralized registry.
f. Ensure that, pursuant to regulations at 7 AAC 105.420-430 or similar authority in other states, no owners, administrators, employees or contractors are hired or retained who have been convicted of medical assistance fraud, sanctioned by, suspended or terminated from the Medicaid program due to program abuse or abuse of a participant, or convicted of a crime the Department considers a risk to the health and safety of a participant. In addition, the provider agency shall comply with 7 AAC 105.420(c) by checking the Office Inspector General List of Excluded Individuals at http://oig.gov/fraud/exclusions.asp and the Excluded Parties List System found at

https://www.epls.gov.
g. Charge waiver participants fees no higher than are charged to private pay recipients for comparable services.
h. Cooperate with Department regulations at 7 AAC 105.220 by providing copies of records, access to records, access to service location for onsite inspection, and access to agency personnel.
i. Report suspected Medicaid health care fraud to the Medicaid Fraud Control Unit by calling 1-907-269-6279 or faxing 1-907-269-6202.
j. Notify SDS, in writing within 24 hours or one business day, of an owner, administrator, employee, volunteer or agent of the agency charged or convicted of criminal offense or issued, as a respondent, a protective or restraining order.
k. Maintain a formal governing body with full legal authority and responsibility for operation of the agency with all board meetings are open to the public if the provider agency is a governmental or nonprofit agency.
l. Comply with all applicable federal, state and local laws and cooperate fully with all federal, state and municipal oversight agencies to assure the health, welfare and safety of participants.
m. Maintain confidentially of participant records and information and shall comply with the requirements of the Health Information Protection and Portability Act (HIPPA).

Provider Qualifications
Every day habilitation provider agency shall appoint a qualified Program Administrator to manage the day to day operations of the agency's services. The Program Administrator shall:
a. Be at least 21 years of age;
b. Have two years of full-time paid experience working with individuals in a human service setting and one year (which may be concurrent) of full time paid experience as a supervisor of two or more staff who worked in a human service setting. The one year of work experience must also include responsibility for program planning, development and evaluation, management or operation of programs or service delivery, fiscal management, needs assessment and other similar tasks;
c. Have education and/or experience as follows:
i. BA or BS degree in social work, psychology, rehabilitation, nursing or closely related human service field from an accredited university or;
ii. AA degree in human services, psychology, rehabilitation, nursing or closely related human service field from an accredited university and two year of full time work experience in a human services field, or;
iii. Four years of full time paid work experience in a related human service field or setting, or;
iv. Certification as a rural community health aide or practitioner and one year of full time paid work experience providing home health or other similar services.

Day Habilitation Provider Qualifications (to correct direct service workers section is wrong in the IDD/CCMC/APDD waivers)

SDS "Standards for Day Habilitation Services" " under 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 to regulations at 7 AAC 105.410, Sanctions, administrative actions pursuant to regulations at 7AAC 130.225, Provider disenrollment and decertification, and overpayment recovery pursuant to regulations at 7AAC 105.260, Recouping an overpayment.

These standards apply to all providers of day habilitation Medicaid waiver home and community-based services certified under regulations at 7AAC 130.220, Provider certification and enrollment.

The following general standards apply to all day habilitation agencies. The provider agency shall:
a. Cooperate with the Department certification and oversight process including requests for information and access to any service location or proposed service location.
b. Implement and carry out the agency policies and procedures submitted with an application for

certification.
c. Attend all training required by the Department as part of the application process and ongoing certification requirements.
d. Comply with regulations at 7 AAC 105 - Medicaid provider and recipient participation.
e. Comply with Alaska statute at AS 47.05. 300 – 390 - Criminal history and regulations at 7 AAC 10.010-10.990 Barrier crimes, criminal history checks and centralized registry.
f. Ensure that, pursuant to regulations at 7 AAC 105.420-430 or similar authority in other states, no owners, administrators, employees or contractors are hired or retained who have been convicted of medical assistance fraud, sanctioned by, suspended or terminated from the Medicaid program due to program abuse or abuse of a participant, or convicted of a crime the Department considers a risk to the health and safety of a participant. In addition, the provider agency shall comply with 7 AAC 105.420(c) by checking the Office Inspector General List of Excluded Individuals at http://oig.gov/fraud/exclusions.asp and the Excluded Parties List System found at https://www.epls.gov.
g. Charge waiver participants fees no higher than are charged to private pay recipients for comparable services.
h. Cooperate with Department regulations at 7 AAC 105.220 by providing copies of records, access to records, access to service location for onsite inspection, and access to agency personnel.
i. Report suspected Medicaid health care fraud to the Medicaid Fraud Control Unit by calling 1-907-269-6279 or faxing 1-907-269-6202.
j. Notify SDS, in writing within 24 hours or one business day, of an owner, administrator, employee, volunteer or agent of the agency charged or convicted of criminal offense or issued, as a respondent, a protective or restraining order.
k. Maintain a formal governing body with full legal authority and responsibility for operation of the agency with all board meetings are open to the public if the provider agency is a governmental or nonprofit agency.
l. Comply with all applicable federal, state and local laws and cooperate fully with all federal, state and municipal oversight agencies to assure the health, welfare and safety of participants.
m. Maintain confidentially of participant records and information and shall comply with the requirements of the Health Information Protection and Portability Act (HIPPA).

Provider Qualifications
Every day habilitation provider agency shall appoint a qualified Program Administrator to manage the day to day operations of the agency's services. The Program Administrator shall:
a. Be at least 21 years of age;
b. Have two years of full-time paid experience working with individuals in a human service setting and one year (which may be concurrent) of full time paid experience as a supervisor of two or more staff who worked in a human service setting. The one year of work experience must also include responsibility for program planning, development and evaluation, management or operation of programs or service delivery, fiscal management, needs assessment and other similar tasks;
c. Have education and/or experience as follows:
i. BA or BS degree in social work, psychology, rehabilitation, nursing or closely related human service field from an accredited university or;
ii. AA degree in human services, psychology, rehabilitation, nursing or closely related human service field from an accredited university and two year of full time work experience in a human services field, or;
iii. Four years of full time paid work experience in a related human service field or setting, or;
iv. Certification as a rural community health aide or practitioner and one year of full time paid work experience providing home health or other similar services.

Day habilitation services direct service workers:
a. Day habilitation direct service workers must be at least 18 years of age; qualified through education or experience; and possess, or develop before providing services, the skills necessary to meet the needs of the recipient population.
b. Required education and alternatives to formal education:
i. High school or general education development (GED) diploma; or
ii. Demonstration to the program administrator of the ability to read written instructions and to make appropriate entries regarding services in the recipient record or file.
c. Required skill set:

i. the ability to communicate with his/her supervisor, the recipient, and the primary caregiver;
ii. the ability to understand the needs of, and to work with, the recipient population;
iii. the ability to be guided by the plan of care; and
iv. the ability to handle household and medical emergencies.

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):

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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.

Payments made for residential habilitation are not made for room and board or the cost of facility maintenance, except the cost of life safety code modifications and other necessary accessibility modifications that ensure the health, safety and welfare of participants. In addition, payments will not be made directly or indirectly to members of the participant's immediate family, nor for the routine care and supervision that would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid.

All residential habilitation services must be prior authorized.
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**
- ☑ **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	Assisted Living Home
Individual	Foster Home

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 to regulations at 7 AAC 105.410, Sanctions, administrative actions pursuant to regulations at 7AAC 130.225, Provider disenrollment and decertification, and overpayment recovery pursuant to regulations at 7AAC 105.260, Recouping an overpayment.

These standards apply to all providers of residential habilitation Medicaid wavier home and

community-based services certified under regulations at 7AAC 130.220, Provider certification and enrollment.

The following general standards apply to all residential habilitation agencies. The provider agency shall:
a. Cooperate with the Department certification and oversight process including requests for information and access to any service location or proposed service location.
b. Implement and carry out the agency policies and procedures submitted with an application for certification.
c. Attend all training required by the Department as part of the application process and ongoing certification requirements.
d. Comply with regulations at 7 AAC 105 - Medicaid provider and recipient participation.
e. Comply with Alaska statute at AS 47.05. 300 – 390 - Criminal history and regulations at 7 AAC 10.010-10.990 Barrier crimes, criminal history checks and centralized registry.
f. Ensure that, pursuant to regulations at 7 AAC 105.420-430 or similar authority in other states, no owners, administrators, employees or contractors are hired or retained who have been convicted of medical assistance fraud, sanctioned by, suspended or terminated from the Medicaid program due to program abuse or abuse of a participant, or convicted of a crime the Department considers a risk to the health and safety of a participant. In addition, the provider agency shall comply with 7 AAC 105.420(c) by checking the Office Inspector General List of Excluded Individuals at http://oig.gov/fraud/exclusions.asp and the Excluded Parties List System found at https://www.epls.gov.
g. Charge waiver participants fees no higher than are charged to private pay recipients for comparable services.
h. Cooperate with Department regulations at 7 AAC 105.220 by providing copies of records, access to records, access to service location for onsite inspection, and access to agency personnel.
i. Report suspected Medicaid health care fraud to the Medicaid Fraud Control Unit by calling 1-907-269-6279 or faxing 1-907-269-6202.
j. Notify SDS, in writing within 24 hours or one business day, of an owner, administrator, employee, volunteer or agent of the agency charged or convicted of criminal offense or issued, as a respondent, a protective or restraining order.
k. Maintain a formal governing body with full legal authority and responsibility for operation of the agency with all board meetings are open to the public if the provider agency is a governmental or nonprofit agency.
l. Comply with all applicable federal, state and local laws and cooperate fully with all federal, state and municipal oversight agencies to assure the health, welfare and safety of participants.
m. Maintain confidentially of participant records and information and shall comply with the requirements of the Health Information Protection and Portability Act (HIPPA).

Provider Qualifications

Every residential habilitation provider agency shall appoint a qualified Program Administrator to manage the day to day operations of the agency's services. The Program Administrator shall:
a. Be at least 21 years of age;
b. Have two years of full-time paid experience working with individuals in a human service setting and one year (which may be concurrent) of full time paid experience as a supervisor of two or more staff who worked in a human service setting. The one year of work experience must also include responsibility for program planning, development and evaluation, management or operation of programs or service delivery, fiscal management, needs assessment and other similar tasks;
c. Have education and/or experience as follows:
i. BA or BS degree in social work, psychology, rehabilitation, nursing or closely related human service field from an accredited university or;
ii. AA degree in human services, psychology, rehabilitation, nursing or closely related human service field from an accredited university and two year of full time work experience in a human services field, or;
iii. Four years of full time paid work experience in a related human service field or setting, or;
iv. Certification as a rural community health aide or practitioner and one year of full time paid work experience providing home health or other similar services.

Residential habilitation direct care workers must meet the minimum qualifications
Agency direct care workers must:
a. Be at least 18 years old;
b. Have a high school diploma or GED or, have the ability to read written instructions and write required service notes in English;
c. Be able to communicate with the participant and if applicable, the primary caregiver;
d. Understand the needs of the participant population and the services to be provided as described in the service plan;
e. Provide three character references indicating that the direct care worker possesses sound judgment and is a reliable individual;
f. Pass a criminal background check required by Alaska statute at AS 47.05.300 and regulations at 7 AAC 10. 900;
g. Have documentation of current First Aid and CPR training, except as provided in regulations at 7 AAC 75.210 (d) for licensed assisted living homes.

The provider agency shall ensure all direct care worker training includes the SDS Service Principles and the reporting requirements for suspected abuse, neglect, or exploitation of vulnerable adults or children as well as the reporting requirements found in regulations at 7AAC 130. 215, Recipient Safeguards.

In addition to training required for licensure as described in regulations at 7AAC 75.210-340, Operation of Assisted Living Homes and the SDS service principles, the provider agency shall provide training to residential habilitation direct care workers that shall include but is not limited to:
a. Reporting requirements for suspected abuse, neglect, self neglect or exploitation of vulnerable adults and critical incidents;
b. Nutritional, hydration and special diet needs of the CCMC waiver population
c. Fall Prevention;
d. Risk factors and monitoring for skin integrity;
e. Risk factors and monitoring for urinary tract infections;
f. Prohibited uses of restriction intervention or restraint;
g. Safety and monitoring of participant self- administered or worker assisted administration of medication.

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: 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 to regulations at 7 AAC 105.410, Sanctions, administrative actions pursuant to regulations at 7AAC 130.225, Provider disenrollment and decertification, and overpayment recovery pursuant to regulations at 7AAC 105.260, Recouping an overpayment.

These standards apply to all providers of residential habilitation Medicaid wavier home and community-based services certified under regulations at 7AAC 130.220, Provider certification and enrollment.

The following general standards apply to all residential habilitation agencies. The provider agency shall:
a. Cooperate with the Department certification and oversight process including requests for information and access to any service location or proposed service location.
b. Implement and carry out the agency policies and procedures submitted with an application for certification.
c. Attend all training required by the Department as part of the application process and ongoing certification requirements.
d. Comply with regulations at 7 AAC 105 - Medicaid provider and recipient participation.
e. Comply with Alaska statute at AS 47.05. 300 – 390 - Criminal history and regulations at 7 AAC 10.010-10.990 Barrier crimes, criminal history checks and centralized registry.
f. Ensure that, pursuant to regulations at 7 AAC 105.420-430 or similar authority in other states, no owners, administrators, employees or contractors are hired or retained who have been convicted of medical assistance fraud, sanctioned by, suspended or terminated from the Medicaid program due to program abuse or abuse of a participant, or convicted of a crime the Department considers a risk to the health and safety of a participant. In addition, the provider agency shall comply with 7 AAC 105.420(c) by checking the Office Inspector General List of Excluded Individuals at http://oig.gov/fraud/exclusions.asp and the Excluded Parties List System found at https://www.epls.gov.
g. Charge waiver participants fees no higher than are charged to private pay recipients for comparable services.
h. Cooperate with Department regulations at 7 AAC 105.220 by providing copies of records, access to records, access to service location for onsite inspection, and access to agency personnel.
i. Report suspected Medicaid health care fraud to the Medicaid Fraud Control Unit by calling 1-907-269-6279 or faxing 1-907-269-6202.
j. Notify SDS, in writing within 24 hours or one business day, of an owner, administrator, employee, volunteer or agent of the agency charged or convicted of criminal offense or issued, as a respondent, a protective or restraining order.
k. Maintain a formal governing body with full legal authority and responsibility for operation of the agency with all board meetings are open to the public if the provider agency is a governmental or nonprofit agency.
l. Comply with all applicable federal, state and local laws and cooperate fully with all federal, state and municipal oversight agencies to assure the health, welfare and safety of participants.
m. Maintain confidentially of participant records and information and shall comply with the requirements of the Health Information Protection and Portability Act (HIPPA).

Provider Qualifications

Every residential habilitation provider agency shall appoint a qualified Program Administrator to manage the day to day operations of the agency's services. The Program Administrator shall:
a. Be at least 21 years of age;
b. Have two years of full-time paid experience working with individuals in a human service setting and one year (which may be concurrent) of full time paid experience as a supervisor of two or more

staff who worked in a human service setting. The one year of work experience must also include responsibility for program planning, development and evaluation, management or operation of programs or service delivery, fiscal management, needs assessment and other similar tasks;
c. Have education and/or experience as follows:
i. BA or BS degree in social work, psychology, rehabilitation, nursing or closely related human service field from an accredited university or;
ii. AA degree in human services, psychology, rehabilitation, nursing or closely related human service field from an accredited university and two year of full time work experience in a human services field, or;
iii. Four years of full time paid work experience in a related human service field or setting, or;
iv. Certification as a rural community health aide or practitioner and one year of full time paid work experience providing home health or other similar services.

Residential habilitation direct care workers must meet the minimum qualifications
Agency direct care workers must:
a. Be at least 18 years old;
b. Have a high school diploma or GED or, have the ability to read written instructions and write required service notes in English;
c. Be able to communicate with the participant and if applicable, the primary caregiver;
d. Understand the needs of the participant population and the services to be provided as described in the service plan;
e. Provide three character references indicating that the direct care worker possesses sound judgment and is a reliable individual;
f. Pass a criminal background check required by Alaska statute at AS 47.05.300 and regulations at 7 AAC 10. 900;
g. Have documentation of current First Aid and CPR training, except as provided in regulations at 7 AAC 75.210 (d) for licensed assisted living homes.

The provider agency shall ensure all direct care worker training includes the SDS Service Principles and the reporting requirements for suspected abuse, neglect, or exploitation of vulnerable adults or children as well as the reporting requirements found in regulations at 7AAC 130. 215, Recipient Safeguards.

In addition to training required for licensure as described in regulations at 7AAC 75.210-340, Operation of Assisted Living Homes and the SDS service principles, the provider agency shall provide training to residential habilitation direct care workers that shall include but is not limited to:
a. Reporting requirements for suspected abuse, neglect, self neglect or exploitation of vulnerable adults and critical incidents;
b. Nutritional, hydration and special diet needs of the CCMC waiver population
c. Fall Prevention;
d. Risk factors and monitoring for skin integrity;
e. Risk factors and monitoring for urinary tract infections;
f. Prohibited uses of restriction intervention or restraint;
g. Safety and monitoring of participant self- administered or worker assisted administration of medication.

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: 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):

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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.

All respite services must be prior authorized.

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**
☑ **Legal Guardian**

Provider Specifications:

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

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 to regulations at 7 AAC 105.410, Sanctions, administrative actions pursuant to regulations at 7AAC 130.225, Provider disenrollment and decertification, and overpayment recovery pursuant to regulations at 7AAC 105.260, Recouping an overpayment.

These standards apply to all providers of respite Medicaid wavier home and community-based services certified under regulations at 7AAC 130.220, Provider certification and enrollment.

The following general standards apply to all respite agencies. The provider agency shall:
a. Cooperate with the Department certification and oversight process including requests for information and access to any service location or proposed service location.
b. Implement and carry out the agency policies and procedures submitted with an application for certification.
c. Attend all training required by the Department as part of the application process and ongoing certification requirements.
d. Comply with regulations at 7 AAC 105 - Medicaid provider and recipient participation.
e. Comply with Alaska statute at AS 47.05. 300 – 390 - Criminal history and regulations at 7 AAC 10.010-10.990 Barrier crimes, criminal history checks and centralized registry.
f. Ensure that, pursuant to regulations at 7 AAC 105.420-430 or similar authority in other states, no owners, administrators, employees or contractors are hired or retained who have been convicted of medical assistance fraud, sanctioned by, suspended or terminated from the Medicaid program due to program abuse or abuse of a participant, or convicted of a crime the Department considers a risk to the health and safety of a participant. In addition, the provider agency shall comply with 7 AAC

105.420(c) by checking the Office Inspector General List of Excluded Individuals at http://oig.gov/fraud/exclusions.asp and the Excluded Parties List System found at https://www.epls.gov.
g. Charge waiver participants fees no higher than are charged to private pay recipients for comparable services.
h. Cooperate with Department regulations at 7 AAC 105.220 by providing copies of records, access to records, access to service location for onsite inspection, and access to agency personnel.
i. Report suspected Medicaid health care fraud to the Medicaid Fraud Control Unit by calling 1-907-269-6279 or faxing 1-907-269-6202.
j. Notify SDS, in writing within 24 hours or one business day, of an owner, administrator, employee, volunteer or agent of the agency charged or convicted of criminal offense or issued, as a respondent, a protective or restraining order.
k. Maintain a formal governing body with full legal authority and responsibility for operation of the agency with all board meetings are open to the public if the provider agency is a governmental or nonprofit agency.
l. Comply with all applicable federal, state and local laws and cooperate fully with all federal, state and municipal oversight agencies to assure the health, welfare and safety of participants.
m. Maintain confidentially of participant records and information and shall comply with the requirements of the Health Information Protection and Portability Act (HIPPA).

Provider Qualifications

Every respite provider agency shall appoint a qualified Program Administrator to manage the day to day operations of the agency's services. The Program Administrator shall:
a. Be at least 21 years of age;
b. Have two years of full-time paid experience working with individuals in a human service setting and one year (which may be concurrent) of full time paid experience as a supervisor of two or more staff who worked in a human service setting. The one year of work experience must also include responsibility for program planning, development and evaluation, management or operation of programs or service delivery, fiscal management, needs assessment and other similar tasks;
c. Have education and/or experience as follows:
i. BA or BS degree in social work, psychology, rehabilitation, nursing or closely related human service field from an accredited university or;
ii. AA degree in human services, psychology, rehabilitation, nursing or closely related human service field from an accredited university and two year of full time work experience in a human services field, or;
iii. Four years of full time paid work experience in a related human service field or setting, or;
iv. Certification as a rural community health aide or practitioner and one year of full time paid work experience providing home health or other similar services.

Respite direct care workers must meet the minimum qualifications
Agency direct care workers must:
a. Be at least 18 years old;
b. Have a high school diploma or GED or, have the ability to read written instructions and write required service notes in English;
c. Be able to communicate with the participant and if applicable, the primary caregiver;
d. Understand the needs of the participant population and the services to be provided as described in the service plan;
e. Provide three character references indicating that the direct care worker possesses sound judgment and is a reliable individual;
f. Pass a criminal background check required by Alaska statute at AS 47.05.300 and regulations at 7 AAC 10. 900;
g. Have documentation of current First Aid and CPR training, except as provided in regulations at 7 AAC 75.210 (d) for licensed assisted living homes.

The provider agency shall ensure all direct care worker training includes the SDS Service Principles and the reporting requirements for suspected abuse, neglect, or exploitation of vulnerable adults or children as well as the reporting requirements found in regulations at 7AAC 130. 215, Recipient Safeguards.

In addition to training required for licensure as described in regulations at 7AAC 75.210-340, Operation of Assisted Living Homes and the SDS service principles, the provider agency shall provide training to respite direct care workers that shall include but is not limited to:
a. Reporting requirements for suspected abuse, neglect, self neglect or exploitation of vulnerable adults and critical incidents;
b. Nutritional, hydration and special diet needs of the CCMC waiver population
c. Fall Prevention;
d. Risk factors and monitoring for skin integrity;
e. Risk factors and monitoring for urinary tract infections;
f. Prohibited uses of restriction intervention or restraint;
g. Safety and monitoring of participant self- administered or worker assisted administration of medication.

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: 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:
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 to regulations at 7 AAC 105.410, Sanctions, administrative actions pursuant to regulations at 7AAC 130.225, Provider disenrollment and decertification, and overpayment recovery pursuant to regulations at 7AAC 105.260, Recouping an overpayment.

These standards apply to all providers of respite Medicaid wavier home and community-based services certified under regulations at 7AAC 130.220, Provider certification and enrollment.

The following general standards apply to all respite agencies. The provider agency shall:
a. Cooperate with the Department certification and oversight process including requests for information and access to any service location or proposed service location.
b. Implement and carry out the agency policies and procedures submitted with an application for certification.
c. Attend all training required by the Department as part of the application process and ongoing certification requirements.
d. Comply with regulations at 7 AAC 105 - Medicaid provider and recipient participation.
e. Comply with Alaska statute at AS 47.05. 300 – 390 - Criminal history and regulations at 7 AAC 10.010-10.990 Barrier crimes, criminal history checks and centralized registry.
f. Ensure that, pursuant to regulations at 7 AAC 105.420-430 or similar authority in other states, no owners, administrators, employees or contractors are hired or retained who have been convicted of medical assistance fraud, sanctioned by, suspended or terminated from the Medicaid program due to program abuse or abuse of a participant, or convicted of a crime the Department considers a risk to the health and safety of a participant. In addition, the provider agency shall comply with 7 AAC 105.420(c) by checking the Office Inspector General List of Excluded Individuals at http://oig.gov/fraud/exclusions.asp and the Excluded Parties List System found at https://www.epls.gov.
g. Charge waiver participants fees no higher than are charged to private pay recipients for comparable services.
h. Cooperate with Department regulations at 7 AAC 105.220 by providing copies of records, access to records, access to service location for onsite inspection, and access to agency personnel.
i. Report suspected Medicaid health care fraud to the Medicaid Fraud Control Unit by calling 1-907-269-6279 or faxing 1-907-269-6202.
j. Notify SDS, in writing within 24 hours or one business day, of an owner, administrator, employee, volunteer or agent of the agency charged or convicted of criminal offense or issued, as a respondent, a protective or restraining order.
k. Maintain a formal governing body with full legal authority and responsibility for operation of the agency with all board meetings are open to the public if the provider agency is a governmental or nonprofit agency.
l. Comply with all applicable federal, state and local laws and cooperate fully with all federal, state and municipal oversight agencies to assure the health, welfare and safety of participants.
m. Maintain confidentially of participant records and information and shall comply with the requirements of the Health Information Protection and Portability Act (HIPPA).

Provider Qualifications

Every respite provider agency shall appoint a qualified Program Administrator to manage the day to day operations of the agency's services. The Program Administrator shall:
a. Be at least 21 years of age;
b. Have two years of full-time paid experience working with individuals in a human service setting

and one year (which may be concurrent) of full time paid experience as a supervisor of two or more staff who worked in a human service setting. The one year of work experience must also include responsibility for program planning, development and evaluation, management or operation of programs or service delivery, fiscal management, needs assessment and other similar tasks;
c. Have education and/or experience as follows:
i. BA or BS degree in social work, psychology, rehabilitation, nursing or closely related human service field from an accredited university or;
ii. AA degree in human services, psychology, rehabilitation, nursing or closely related human service field from an accredited university and two year of full time work experience in a human services field, or;
iii. Four years of full time paid work experience in a related human service field or setting, or;
iv. Certification as a rural community health aide or practitioner and one year of full time paid work experience providing home health or other similar services.

Respite direct care workers must meet the minimum qualifications
Agency direct care workers must:
a. Be at least 18 years old;
b. Have a high school diploma or GED or, have the ability to read written instructions and write required service notes in English;
c. Be able to communicate with the participant and if applicable, the primary caregiver;
d. Understand the needs of the participant population and the services to be provided as described in the service plan;
e. Provide three character references indicating that the direct care worker possesses sound judgment and is a reliable individual;
f. Pass a criminal background check required by Alaska statute at AS 47.05.300 and regulations at 7 AAC 10. 900;
g. Have documentation of current First Aid and CPR training, except as provided in regulations at 7 AAC 75.210 (d) for licensed assisted living homes.

The provider agency shall ensure all direct care worker training includes the SDS Service Principles and the reporting requirements for suspected abuse, neglect, or exploitation of vulnerable adults or children as well as the reporting requirements found in regulations at 7AAC 130. 215, Recipient Safeguards.

In addition to training required for licensure as described in regulations at 7AAC 75.210-340, Operation of Assisted Living Homes and the SDS service principles, the provider agency shall provide training to respite direct care workers that shall include but is not limited to:
a. Reporting requirements for suspected abuse, neglect, self neglect or exploitation of vulnerable adults and critical incidents;
b. Nutritional, hydration and special diet needs of the CCMC waiver population
c. Fall Prevention;
d. Risk factors and monitoring for skin integrity;
e. Risk factors and monitoring for urinary tract infections;
f. Prohibited uses of restriction intervention or restraint;
g. Safety and monitoring of participant self- administered or worker assisted administration of medication.

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:
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 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 to regulations at 7 AAC 105.410, Sanctions, administrative actions pursuant to regulations at 7AAC 130.225, Provider disenrollment and decertification, and overpayment recovery pursuant to regulations at 7AAC 105.260, Recouping an overpayment.

These standards apply to all providers of respite Medicaid wavier home and community-based services certified under regulations at 7AAC 130.220, Provider certification and enrollment.

The following general standards apply to all respite agencies. The provider agency shall:
a. Cooperate with the Department certification and oversight process including requests for information and access to any service location or proposed service location.
b. Implement and carry out the agency policies and procedures submitted with an application for certification.
c. Attend all training required by the Department as part of the application process and ongoing certification requirements.
d. Comply with regulations at 7 AAC 105 - Medicaid provider and recipient participation.
e. Comply with Alaska statute at AS 47.05. 300 – 390 - Criminal history and regulations at 7 AAC 10.010-10.990 Barrier crimes, criminal history checks and centralized registry.
f. Ensure that, pursuant to regulations at 7 AAC 105.420-430 or similar authority in other states, no owners, administrators, employees or contractors are hired or retained who have been convicted of medical assistance fraud, sanctioned by, suspended or terminated from the Medicaid program due to program abuse or abuse of a participant, or convicted of a crime the Department considers a risk to the health and safety of a participant. In addition, the provider agency shall comply with 7 AAC 105.420(c) by checking the Office Inspector General List of Excluded Individuals at http://oig.gov/fraud/exclusions.asp and the Excluded Parties List System found at https://www.epls.gov.
g. Charge waiver participants fees no higher than are charged to private pay recipients for comparable services.
h. Cooperate with Department regulations at 7 AAC 105.220 by providing copies of records, access to records, access to service location for onsite inspection, and access to agency personnel.
i. Report suspected Medicaid health care fraud to the Medicaid Fraud Control Unit by calling 1-907-269-6279 or faxing 1-907-269-6202.
j. Notify SDS, in writing within 24 hours or one business day, of an owner, administrator, employee, volunteer or agent of the agency charged or convicted of criminal offense or issued, as a respondent, a protective or restraining order.
k. Maintain a formal governing body with full legal authority and responsibility for operation of the agency with all board meetings are open to the public if the provider agency is a governmental or nonprofit agency.
l. Comply with all applicable federal, state and local laws and cooperate fully with all federal, state and municipal oversight agencies to assure the health, welfare and safety of participants.
m. Maintain confidentially of participant records and information and shall comply with the requirements of the Health Information Protection and Portability Act (HIPPA).

Provider Qualifications

Every respite provider agency shall appoint a qualified Program Administrator to manage the day to day operations of the agency's services. The Program Administrator shall:
a. Be at least 21 years of age;
b. Have two years of full-time paid experience working with individuals in a human service setting and one year (which may be concurrent) of full time paid experience as a supervisor of two or more staff who worked in a human service setting. The one year of work experience must also include responsibility for program planning, development and evaluation, management or operation of programs or service delivery, fiscal management, needs assessment and other similar tasks;
c. Have education and/or experience as follows:
i. BA or BS degree in social work, psychology, rehabilitation, nursing or closely related human service field from an accredited university or;
ii. AA degree in human services, psychology, rehabilitation, nursing or closely related human service field from an accredited university and two year of full time work experience in a human services field, or;
iii. Four years of full time paid work experience in a related human service field or setting, or;
iv. Certification as a rural community health aide or practitioner and one year of full time paid work experience providing home health or other similar services.

Respite direct care workers must meet the minimum qualifications
Agency direct care workers must:
a. Be at least 18 years old;
b. Have a high school diploma or GED or, have the ability to read written instructions and write required service notes in English;
c. Be able to communicate with the participant and if applicable, the primary caregiver;
d. Understand the needs of the participant population and the services to be provided as described in the service plan;
e. Provide three character references indicating that the direct care worker possesses sound judgment and is a reliable individual;
f. Pass a criminal background check required by Alaska statute at AS 47.05.300 and regulations at 7 AAC 10. 900;
g. Have documentation of current First Aid and CPR training, except as provided in regulations at 7 AAC 75.210 (d) for licensed assisted living homes.

The provider agency shall ensure all direct care worker training includes the SDS Service Principles and the reporting requirements for suspected abuse, neglect, or exploitation of vulnerable adults or children as well as the reporting requirements found in regulations at 7AAC 130. 215, Recipient Safeguards.

In addition to training required for licensure as described in regulations at 7AAC 75.210-340, Operation of Assisted Living Homes and the SDS service principles, the provider agency shall provide training to respite direct care workers that shall include but is not limited to:
a. Reporting requirements for suspected abuse, neglect, self neglect or exploitation of vulnerable adults and critical incidents;
b. Nutritional, hydration and special diet needs of the CCMC waiver population
c. Fall Prevention;
d. Risk factors and monitoring for skin integrity;
e. Risk factors and monitoring for urinary tract infections;
f. Prohibited uses of restriction intervention or restraint;
g. Safety and monitoring of participant self- administered or worker assisted administration of medication.

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:
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: 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):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03021 ongoing supported employment, individual

Category 2:	Sub-Category 2:
03 Supported Employment	03022 ongoing supported employment, group

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope)*:
Supported employment services assist recipients to acquire and maintain the work-related skills necessary for employment or to become self-employed. These services focus on activities that will lead to an appropriate job match for the recipient and the employer, and include vocational or job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, and career advancement activities. In addition, the services may include benefits support, training, planning, and asset development. Following job placement, the provider may offer intensive, ongoing supports, including supervision, job coaching, and additional training, to enable recipient to perform in the workplace.

Supported employment services may be offered in a variety of settings, but, because independence and community integration are significant goals for these services, they may not be provided in sheltered workshops or other similar specialized vocational facilities.

Supported Employment –(Individual/one with one) includes ongoing supports usually in the form of job coaching to participants who, because of their disabilities, need intensive on-going support to obtain and maintain a job in competitive, customized, or self-employment, integrated work setting. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.

Supported Employment (Group) includes employment support/ services and training activities provided in settings for groups of workers usually with disabilities. Examples include mobile crews and other business-based work settings employing small groups of workers with and without disabilities in an integrated employment setting in their community. The outcome of this service is sustained paid employment and work experience leading to further career development and increasing independent community-based employment for which an individual is compensated at or above the minimum wage.

Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

All supported employment services must be prior authorized.
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**
- ☑ **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: 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):*
Other Standard:
Standards include adherence to applicable general agency standards which include but are not limited to participant's rights, Program Administration, background check requirements, record keeping, direct service worker qualifications; monitoring for participant health and welfare and reporting requirements.

Program Administration

A. Personnel.
1. Supported Employment program administrator.
a. The provider agency must designate a Supported Employment program administrator who is responsible for day-to-day management of the program.

b. The provider may use a term other than program administrator for this position, e.g., program director, program manager, or program supervisor.

c. The program administrator must be at least 30 years of age, and qualified through experience and education in a human services field or setting.

i. Required experience
(A) Three years of full-time or equivalent part-time experience working with human service recipients and their families; and
(B) one year (which may be concurrent) of full-time or equivalent part-time experience as a supervisor of two or more staff who worked full-time or equivalent part-time in a human services field or setting, in a position with responsibility for planning, development, and management or operation of programs involving service deliver, fiscal management, needs assessment, program evaluation and similar tasks
ii. Required education and additional experience or alternatives to formal education:
(A) Bachelor of Arts or Bachelor of Science degree from an accredited college or university in social work, psychology, rehabilitation, nursing or a closely related human services field, in addition to the required one year of experience as a supervisor; or
(B) Associate of Arts degree from an accredited college or university in psychology, rehabilitation, nursing or a closely related human services field, and two years of full-time, or equivalent part-time experience working with human services recipients, in addition to the required one year of experience as a supervisor; or
(C) five years of full-time or equivalent part-time experience working with human services recipients in social work, psychology, rehabilitation, nursing, or a closely related human services field or setting, in addition to the required one year of experience as a supervisor; or
(D) certification as a rural community health aide or practitioner and one year of full-time, or

equivalent part-time experience working with human services recipients, in addition to the required one year of experience as a supervisor.

d. In addition to meeting education and experience requirements, the administrator must possess, or develop before providing program services, the knowledge base and skills necessary to carry out the Supported Employment program.

i. The administrator knowledge base must include:

(A) the medical, behavioral, and habilitative conditions and requirements of the population to be served;
(B) employment-first philosophy, state regulations and emerging service delivery techniques;
(C) the applicable laws, regulations and policies related to governing services for individuals with disabilities.

ii. The administrator skill set must include:

(A) the ability to evaluate, and to foster the development of a plan to meet the needs of the population to be served;
(B) the ability to supervise and support Supported Employment workers; and
(C) ability to conduct pre-employment assessments

2. Supported Employment direct care workers.
a. Direct care workers must be at least 21 years of age, qualified through education or experience, and possess, or develops before providing services, the skills necessary to perform the tasks included in the Supported Employment services plan.
b. Required education: high school or general education development (GED) diploma.
c. Required skill set:
i. vocational exploration and discovery for individuals with disabilities; needs help
ii. benefits counseling, including the impact of wages on state and federal disability benefits;
iii. researching employment opportunities;
iv. job development and job matching;
v. identifying and teaching required employment-related skills; and
vi. job coaching and support.

B. Training.
1. The provider must provide orientation and training for direct care workers to ensure they are qualified to perform, and to maintain a safe environment while providing, Supported Employment services.
2. The provider must provide training for direct care workers in regards to the following:
a. state policy and regulations governing the provision of Supported Employment services;
b. understanding the needs of the population to be served;
c. universal precautions and basic infection control procedures;
d. cardiopulmonary resuscitation (CPR) and first aid; and
e. personal care skills for those recipients who require assistance while receiving Supported Employment services.

C. Monitoring services.
The provider agency must monitor the delivery of Supported Employment services as frequently as necessary to evaluate whether the following conditions are met:
1. The services are furnished in accordance with the plan of care and in a timely manner.
2. The services do not include payment for the supervisory activities rendered as a normal part of the business setting.
3. The services are delivered in a manner that protects the recipient's health, safety, and welfare

II. Billing for services.
The provider agency may not claim reimbursement for

1. incentive payments made to an employer to encourage or subsidize the employer's participation in a Supported Employment services program;
2. payments that are passed through to users of Supported Employment services programs; or
3. payments for any training that is not directly related to the recipient's Supported Employment services program.
III. Supported Employment services plan
A. Development.
1. The provider must collaborate with the recipient's care coordinator
a. to determine the recipient's need for Supported Employment services, and
b. to identify the goals the recipient might achieve through the services.
2. The provider must specify in a Supported Employment services plan (assessment)
a. the activities that will lead the recipient to secure competitive, community-based employment and services to retain employment or self-employment, and
b. the amount, frequency and duration of each activity.
3. The Supported Employment services plan must be retained in the recipient's file, and be made available to Senior and Disabilities Services upon request.
B. Implementation.
1. The provider must ensure the safety of the recipient at all times in the provision of services.
2. The provider must provide services in a manner that results in the intended goals of service provision including:
a. work skills needed to perform on the job and obtain or maintain job stability;
b. maximum integration of the recipient in the work setting and the community;
c. development of a system of natural supports in the workplace and community; and
d. employment that leads to increased earnings and work-related benefits

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

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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 landlord under the lease or applicable law. In addition, the state will not authorize chore services if the certified chore provider resides in the same residence as the recipient of chore services.

All chore services must be prior authorized.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Alaska regulations at 7 AAC 130.245 limit chore services to five hours per week, up to a maximum of 260 hours for a one-year plan of care for individuals on the CCMC waiver, however, if a CCMC recipient has a documented history of respiratory illness, the department will pay for chore services not to exceed 10 hours each week during the period that a plan of care is in effect, up to a maximum of 520 hours for a one-year plan of care.

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 to regulations at 7 AAC 105.410, Sanctions, administrative actions pursuant to regulations at 7AAC 130.225, Provider disenrollment and decertification, and overpayment recovery pursuant to regulations at 7AAC 105.260, Recouping an overpayment.

These standards apply to all providers of chore Medicaid wavier home and community-based services certified under regulations at 7AAC 130.220, Provider certification and enrollment.

The following general standards apply to all chore agencies. The provider agency shall:
a. Cooperate with the Department certification and oversight process including requests for information and access to any service location or proposed service location.
b. Implement and carry out the agency policies and procedures submitted with an application for certification.
c. Attend all training required by the Department as part of the application process and ongoing certification requirements.
d. Comply with regulations at 7 AAC 105 - Medicaid provider and recipient participation.
e. Comply with Alaska statute at AS 47.05. 300 – 390 - Criminal history and regulations at 7 AAC 10.010-10.990 Barrier crimes, criminal history checks and centralized registry.
f. Ensure that, pursuant to regulations at 7 AAC 105.420-430 or similar authority in other states, no owners, administrators, employees or contractors are hired or retained who have been convicted of medical assistance fraud, sanctioned by, suspended or terminated from the Medicaid program due to program abuse or abuse of a participant, or convicted of a crime the Department considers a risk to the health and safety of a participant. In addition, the provider agency shall comply with 7 AAC 105.420(c) by checking the Office Inspector General List of Excluded Individuals at http://oig.gov/fraud/exclusions.asp and the Excluded Parties List System found at https://www.epls.gov.
g. Charge waiver participants fees no higher than are charged to private pay recipients for comparable services.
h. Cooperate with Department regulations at 7 AAC 105.220 by providing copies of records, access to records, access to service location for onsite inspection, and access to agency personnel.
i. Report suspected Medicaid health care fraud to the Medicaid Fraud Control Unit by calling 1-907-269-6279 or faxing 1-907-269-6202.
j. Notify SDS, in writing within 24 hours or one business day, of an owner, administrator, employee, volunteer or agent of the agency charged or convicted of criminal offense or issued, as a respondent, a protective or restraining order.
k. Maintain a formal governing body with full legal authority and responsibility for operation of the agency with all board meetings are open to the public if the provider agency is a governmental or nonprofit agency.
l. Comply with all applicable federal, state and local laws and cooperate fully with all federal, state and municipal oversight agencies to assure the health, welfare and safety of participants.
m. Maintain confidentially of participant records and information and shall comply with the requirements of the Health Information Protection and Portability Act (HIPPA).

Provider Qualifications

Every chore provider agency shall appoint a qualified Program Administrator to manage the day to day operations of the agency's services. The Program Administrator shall:

a. Be at least 21 years of age;
b. Have two years of full-time paid experience working with individuals in a human service setting and one year (which may be concurrent) of full time paid experience as a supervisor of two or more staff who worked in a human service setting. The one year of work experience must also include responsibility for program planning, development and evaluation, management or operation of programs or service delivery, fiscal management, needs assessment and other similar tasks;
c. Have education and/or experience as follows:
i. BA or BS degree in social work, psychology, rehabilitation, nursing or closely related human service field from an accredited university or;
ii. AA degree in human services, psychology, rehabilitation, nursing or closely related human service field from an accredited university and two year of full time work experience in a human services field, or;
iii. Four years of full time paid work experience in a related human service field or setting, or;
iv. Certification as a rural community health aide or practitioner and one year of full time paid work experience providing home health or other similar services.

Chore direct care workers must meet the minimum qualifications
Agency direct care workers must:
a. Be at least 18 years old;
b. Have a high school diploma or GED or, have the ability to read written instructions and write required service notes in English;
c. Be able to communicate with the participant and if applicable, the primary caregiver;
d. Understand the needs of the participant population and the services to be provided as described in the service plan;
e. Provide three character references indicating that the direct care worker possesses sound judgment and is a reliable individual;
f. Pass a criminal background check required by Alaska statute at AS 47.05.300 and regulations at 7 AAC 10. 900;
g. Have documentation of current First Aid and CPR training, except as provided in regulations at 7 AAC 75.210 (d) for licensed assisted living homes.

The provider agency shall ensure all chore direct care worker training includes the SDS Service Principles and the reporting requirements for suspected abuse, neglect, or exploitation of vulnerable adults or children as well as the reporting requirements found in regulations at 7AAC 130. 215, Recipient Safeguards.

The provider agency shall provide the following orientation and training for chore service workers to ensure they are able to perform tasks and to maintain a safe environment for the participant.
a. safety in the workplace, and proper use of tools/equipment;
b. maintenance of clean, safe and healthy home environment;
c. universal precautions and basic infection control procedures;
d. understanding the needs of the population to be served;
e. safe food handling and storage, and nutritious meal preparation;
f. circumstances that could result in emergency, appropriate responses to such emergencies.

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

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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.

The state will not pay for environmental modifications that increase the square footage of an existing residence, are part of a larger renovation to an existing residence, are included in the construction of a new residence or are general utility adaptations, modifications or improvements to the existing residence, unless necessary to reduce the risk of injury or illness to the participant when other practical modification s are not available. In addition, the state will not pay for environmental modifications to the exterior of the dwelling, outbuildings, yards, driveways and fences, except when those modifications are necessary for participant access. Finally, the state will not pay for duplicate modifications to the same residence, or elevator installation, repair or maintenance.

All environmental modification services must be prior authorized.

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

The State will pay for environmental modifications up to $18,500 per participant $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 'recipient'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:

Meals

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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.

The provider distributes a nutrition risk screening form, approved by SDS, to each program participant annually. SDS uses the National "DETERMINE Your Nutritional Health Checklist" that was developed by the federal Nutrition Screening Initiative. The Checklist identifies and explains the warning signs of poor nutritional health to determine participant risk. Use of the Checklist does not result in the diagnosis of a condition, but provides a nutritional score; a score of 3-5 indicates a moderate nutritional risk and a score of 6 or more a high nutritional risk. Providers record the score and encourage participants to take the Checklist to appointments with health or social services professionals to obtain further assistance in reducing nutritional risk.
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**
- ☑ **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

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 to regulations at 7 AAC 105.410, Sanctions, administrative actions pursuant to regulations at 7AAC 130.225, Provider disenrollment and decertification, and overpayment recovery pursuant to regulations at 7AAC 105.260, Recouping an overpayment.

These standards apply to all providers of meal Medicaid wavier home and community-based services certified under regulations at 7AAC 130.220, Provider certification and enrollment.

The following general standards apply to all meal agencies. The provider agency shall:
a. Cooperate with the Department certification and oversight process including requests for information and access to any service location or proposed service location.
b. Implement and carry out the agency policies and procedures submitted with an application for certification.
c. Attend all training required by the Department as part of the application process and ongoing certification requirements.
d. Comply with regulations at 7 AAC 105 - Medicaid provider and recipient participation.
e. Comply with Alaska statute at AS 47.05. 300 – 390 - Criminal history and regulations at 7 AAC 10.010-10.990 Barrier crimes, criminal history checks and centralized registry.
f. Ensure that, pursuant to regulations at 7 AAC 105.420-430 or similar authority in other states, no owners, administrators, employees or contractors are hired or retained who have been convicted of medical assistance fraud, sanctioned by, suspended or terminated from the Medicaid program due to program abuse or abuse of a participant, or convicted of a crime the Department considers a risk to the health and safety of a participant. In addition, the provider agency shall comply with 7 AAC 105.420(c) by checking the Office Inspector General List of Excluded Individuals at http://oig.gov/fraud/exclusions.asp and the Excluded Parties List System found at https://www.epls.gov.
g. Charge waiver participants fees no higher than are charged to private pay recipients for comparable services.
h. Cooperate with Department regulations at 7 AAC 105.220 by providing copies of records, access to records, access to service location for onsite inspection, and access to agency personnel.
i. Report suspected Medicaid health care fraud to the Medicaid Fraud Control Unit by calling 1-907-269-6279 or faxing 1-907-269-6202.
j. Notify SDS, in writing within 24 hours or one business day, of an owner, administrator, employee, volunteer or agent of the agency charged or convicted of criminal offense or issued, as a respondent, a protective or restraining order.
k. Maintain a formal governing body with full legal authority and responsibility for operation of the agency with all board meetings are open to the public if the provider agency is a governmental or nonprofit agency.
l. Comply with all applicable federal, state and local laws and cooperate fully with all federal, state and municipal oversight agencies to assure the health, welfare and safety of participants.
m. Maintain confidentially of participant records and information and shall comply with the requirements of the Health Information Protection and Portability Act (HIPPA).

Provider Qualifications

Every meal provider agency shall appoint a qualified Program Administrator to manage the day to day operations of the agency's services. The Program Administrator shall:
a. Be at least 21 years of age;
b. Have two years of full-time paid experience working with individuals in a human service setting

and one year (which may be concurrent) of full time paid experience as a supervisor of two or more staff who worked in a human service setting. The one year of work experience must also include responsibility for program planning, development and evaluation, management or operation of programs or service delivery, fiscal management, needs assessment and other similar tasks;
c. Have education and/or experience as follows:
i. BA or BS degree in social work, psychology, rehabilitation, nursing or closely related human service field from an accredited university or;
ii. AA degree in human services, psychology, rehabilitation, nursing or closely related human service field from an accredited university and two year of full time work experience in a human services field, or;
iii. Four years of full time paid work experience in a related human service field or setting, or;
iv. Certification as a rural community health aide or practitioner and one year of full time paid work experience providing home health or other similar services.

The meal provider agency shall appoint a Program Manager who is responsible for conducting the day- to-day management of the program. The manager must be at least 21 years of age, and have at least one year experience in nutritional planning, coordinating a foodservice, or foodservice management.

The meal provider agency shall employ or contract with a dietary consultant who shall assist in the development of menus, conduct nutrient analyses, and advise the provider agency regarding food quality and service. The dietary consult must possess one of the following qualifications: Registered Dietician or Licensed Nutritionist who meets the requirements of AS 08.38.010 – AS 08.38.130; Independent Registered Dietitian (RD); Licensed Nutritionist (LN); or another Individual with Comparable Expertise (ICE).

The provider agency ensures that meal direct care workers who handle unpackaged food or food contact surfaces have a Food Worker Card as specified in the applicable food code.
The provider ensures that all meal program volunteers who handle unpackaged food or food contact surfaces are training in regard to food safety requirements.
The provider agency shall ensure all meal direct care worker training includes the SDS Service Principles and the reporting requirements for suspected abuse, neglect, or exploitation of vulnerable adults or children as well as the reporting requirements found in regulations at 7AAC 130. 215, Recipient Safeguards.

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

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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 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.

NOCM services under the waiver differ from Private Duty Nursing available for children under the State plan from in the nature and provider type. State Plan coverage provides only for direct nursing services while NOCM allows a nurse to train and supervise family or service providers, delegate nursing tasks to those providers, and monitor the provision of those services.

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**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Private Duty Nursing Agency
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: 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: 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: 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

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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.

Requests for SME services must be supported by a written cost estimate, as well as written, contemporaneous documentation from a licensed physician, licensed physician's assistant, nurse practitioner, occupational therapist, physical therapist, speech therapist or pathologist, or psychiatrist showing that the specific item requested is appropriate for the participant, consistent with the plan of care, and necessary to prevent institutionalization.

The state will not pay as a home and community-based waiver service the cost of any SME payable under 7 AAC 120.200 – 7 AAC 120.299. All SME must be prior authorized.
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**
- ☑ **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	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

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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**
- ☑ **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: 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 to regulations at 7 AAC 105.410, Sanctions, administrative actions pursuant to regulations at 7AAC 130.225, Provider disenrollment and decertification, and overpayment recovery pursuant to regulations at 7AAC 105.260, Recouping an overpayment.

These standards apply to all providers of transportation Medicaid wavier home and community-based services certified under regulations at 7AAC 130.220, Provider certification and enrollment.

The following general standards apply to all transportation agencies. The provider agency shall:
a. Cooperate with the Department certification and oversight process including requests for information and access to any service location or proposed service location.
b. Implement and carry out the agency policies and procedures submitted with an application for certification.
c. Attend all training required by the Department as part of the application process and ongoing certification requirements.
d. Comply with regulations at 7 AAC 105 - Medicaid provider and recipient participation.
e. Comply with Alaska statute at AS 47.05. 300 – 390 - Criminal history and regulations at 7 AAC 10.010-10.990 Barrier crimes, criminal history checks and centralized registry.
f. Ensure that, pursuant to regulations at 7 AAC 105.420-430 or similar authority in other states, no owners, administrators, employees or contractors are hired or retained who have been convicted of medical assistance fraud, sanctioned by, suspended or terminated from the Medicaid program due to program abuse or abuse of a participant, or convicted of a crime the Department considers a risk to the health and safety of a participant. In addition, the provider agency shall comply with 7 AAC 105.420(c) by checking the Office Inspector General List of Excluded Individuals at http://oig.gov/fraud/exclusions.asp and the Excluded Parties List System found at https://www.epls.gov.
g. Charge waiver participants fees no higher than are charged to private pay recipients for comparable services.
h. Cooperate with Department regulations at 7 AAC 105.220 by providing copies of records, access to records, access to service location for onsite inspection, and access to agency personnel.
i. Report suspected Medicaid health care fraud to the Medicaid Fraud Control Unit by calling 1-907-269-6279 or faxing 1-907-269-6202.
j. Notify SDS, in writing within 24 hours or one business day, of an owner, administrator, employee, volunteer or agent of the agency charged or convicted of criminal offense or issued, as a respondent, a protective or restraining order.
k. Maintain a formal governing body with full legal authority and responsibility for operation of the agency with all board meetings are open to the public if the provider agency is a governmental or nonprofit agency.
l. Comply with all applicable federal, state and local laws and cooperate fully with all federal, state and municipal oversight agencies to assure the health, welfare and safety of participants.
m. Maintain confidentially of participant records and information and shall comply with the requirements of the Health Information Protection and Portability Act (HIPPA).

Provider Qualifications

Every transportation provider agency shall appoint a qualified Program Administrator to manage the day to day operations of the agency's services. The Program Administrator shall:
a. Be at least 21 years of age;
b. Have two years of full-time paid experience working with individuals in a human service setting and one year (which may be concurrent) of full time paid experience as a supervisor of two or more staff who worked in a human service setting. The one year of work experience must also include responsibility for program planning, development and evaluation, management or operation of programs or service delivery, fiscal management, needs assessment and other similar tasks;
c. Have education and/or experience as follows:
i. BA or BS degree in social work, psychology, rehabilitation, nursing or closely related human service field from an accredited university or;
ii. AA degree in human services, psychology, rehabilitation, nursing or closely related human service field from an accredited university and two year of full time work experience in a human

services field, or;
iii. Four years of full time paid work experience in a related human service field or setting, or;
iv. Certification as a rural community health aide or practitioner and one year of full time paid work experience providing home health or other similar services.

The transportation provider agency shall appoint a Program Manager who is responsible for conducting the day- to-day management of the program. The manager must be at least 21 years of age, and have at least one year experience in nutritional planning, coordinating a foodservice, or foodservice management.
Drivers for transportation providers must be 18 years of age or older and must have a current Alaska driver license with a class designation appropriate to the type of vehicle operated.

The provider agency shall train staff drivers and volunteers regarding
a. Reporting requirements for suspected abuse, neglect, self neglect or exploitation of vulnerable adults;
b. Reporting of critical incidents;
c. Needs of the participant population;
d. PASS (Passenger Assistance Safety and Securement) course offered by the Community Transportation Association of America, or an equivalent course that provides disability, sensitivity, and assistance training;
e. Safety training including
i. defensive driving;
ii. proper use of safety restraint systems for mobility equipment and individuals, including children;
iii. monitoring the interior conditions and mechanical safety of the vehicle;
iv. incident and accident protocols.

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 an entity.

The Alaska Department of Health and Social Services Licensing and Certification section, Background Check Unit conducts the background check, which includes 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 unsuitable for direct care service employment. Fingerprints are processed by both the Alaska Department of Public Safety and the Federal Bureau of Investigation for a national criminal history record check. Regulations at 7 AAC 10.905 define barrier crimes as a criminal offences inconsistent with the standards of licensure, certification, approval or eligibility to receive [Medicaid] payments, and list those crimes that are permanent, 10, five, three and one year barrier crimes. In addition, state and federal records searched include:
• Alaska Public Safety Information Network (APSIN) - APSIN serves as a central repository for Alaska criminal justice information. This information is also known as an "Interested Persons Report;"
• Alaska Court System/Court View and Name Index - Provides civil and criminal case information and is used to assist in determination of disposition for cases in APSIN;
• Juvenile Offender Management Information System (JOMIS) – JOMIS is the primary repository for juvenile offense history records for the State of Alaska, Division of Juvenile Justice;
• Certified Nurses Aide (CNA) Registry Professional registry listing those individuals certified to perform duties as a CNA;
• National Sex Offender Registry (NSOR)- The NSOR provides centralized access to registries from all 50 states, Guam, Puerto Rico and the District of Columbia; and
• Office of Inspector General (OIG) - a database which provides information relating to parties excluded from participation in the Medicare, Medicaid and all Federal health care programs.
• Any other records/registries the Department deems are applicable.
Applicants for certification and recertification (every two years) as waiver home and community-based service providers must submit a copy of the "Final Authorization" letter issued by the background check unit, or, SDS can independently verify the background check information. In addition, applicants assure SDS by affidavit that their employees and volunteers will comply with the background check requirements.

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).**

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.*

The State defines immediate family members as parents, minor siblings of a recipient under 18 years of age, and the spouse of a recipient. Immediate family members cannot provide services.

The State allows other relatives to provide services if they meet the conditions established through regulation and comport to the qualification of the service type. A legal guardian can provide services to a recipient when the court has deemed it is not a conflict to provide those services.

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. Controls employed to ensure that payments are made only for services rendered include monthly monitoring by care coordinators, documentation by SDS certified agencies of services rendered and who was paid for the services; certified agencies are required to document services, to maintain the records for seven years and are subject to audit requirements.

Payment may be made for any waiver services, subject to the same regulatory limits on individual services as a non-relative/guardian provider, for which the relative/guardian is qualified to furnish, except for further restrictions on care coordination. To protect against conflict of interest, regulations at 7AAC 130.240(g) prohibit the provision of care coordination services by a member of the participant's immediate family, the participant's guardian, a holder of power of attorney for the participant, or the participant's personal care assistant.

The State does not dictate specific circumstances in which relatives who are not immediate family members and legal guardians may furnish services. Providers are able to employ relatives who are not immediate family members and legal guardians authorized by the court to provide all services except for care coordination to recipients and those services that relatives are legally responsible for providing (ex: a spouse can't be employed to provide the chore waiver service to a recipient) as long as the legal guardian or the relative who is not an immediate family member meets all the required minimum employment and training qualifications for the service to be provided. This allows providers the flexibility to employ a person who may have a unique ability to meet a recipient's needs, especially in rural/remote areas of the state. As part of the certification process for all services, the provider agency must be able to provide information on supervision policies, including how the provider assesses the performance of direct care workers to ensure they have the ability to work effectively and to identify skills that need further development.

○ **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**

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by 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 the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
QP 12: # and % of providers who meet state certification or licensure requirements prior to providing waiver services. Numerator: # of providers who meet initial state certification or licensure requirements. Denominator: Sample of currently active waiver service providers who were enrolled in Medicaid during 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 = 95%, +/- 5% and 50% distribution
☐ **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:
QP 13: # and % of providers who continue to meet state certification or licensure requirements while providing waiver services. Numerator: # of providers who continue to meet state re-certification or licensure requirements. Denominator: Sample of currently active providers who are enrolled in Medicaid.

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 = 95%, +/- 5% and 50% distribution
☐ **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 the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-Assurance: The 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 the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
QP 14: # and % of care coordinators in compliance with required SDS training.
Numerator: # of care coordinators that are in compliance with required SDS training, and that are currently certified within the reporting period.
Denominator: Sample of care coordinators that are currently certified 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 = 95%, +/- 5% and 50% distribution
☐ **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:
QP 15: # and % of provider agencies that are in compliance with critical incident report training requirements. Numerator: # of provider agencies that are in compliance with the state's critical incident report training requirements and that are currently certified within the reporting period. Denominator: Sample of provider agencies that are currently certified 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 = 95%, +/- 5% and 50% distribution
☐ **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), Policy and Program Development 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.

Discovery is the responsibility of the Qualified Provider Task Committee Manager who reviews, or direct Unit staff in the review of provider data found in the SDS management information system, DS3, as well as MMIS error reports, Certification Unit records and the SDS Training Database. Additional methods of discovery include review of complaints from providers, participants or their representatives, and other state agencies, as well as provider onsite visits including document reviews and participant and provider staff interviews.

The Qualified Providers Task Committee prepares standardized monthly reports for the Quality Improvement Workgroup (QIW) based on the Qualified Providers performance measures approved by the Department of Health and Social Service Quality Improvement Steering Committee (QISC). QIW reports include at minimum:
* Monthly, quarterly and annual cumulative aggregated data of findings and corrective actions taken at the program/ unit levels as identified through the task committee review activities;
* Historical data for use in comparing similar reporting periods;
* Summary of findings and recommended action, including preliminary trends identified by the task committee.

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.

If a provider not currently certified by SDS bills Medicaid for services to a waiver participant, an MMIS error report compiled by the Division of Health Care Services (DHCS) and reviewed monthly by the Qualified Providers Task Committee is generated 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 certification.

As part of monthly discovery activities, the Provider Quality Assurance Manager reviews the SDS training database against a list of certified providers. For those providers who are out of compliance with SDS training requirements, including Critical Incident Reporting training, the Manager directs staff to issue a "report of findings". The report must include a description of the evidence supporting the finding of non-compliance as well as the specific standard, policy, regulation, or statute that is the basis for the finding. In addition, the report specifies the remediation action required to achieve compliance, the date by which compliance is required and the method of provider confirmation of compliance. SDS may also perform focused studies and conduct agency onsite surveys including document reviews and participant or provider staff interviews. SDS then monitors remediation requirements through review and analysis of provider reports, information provided by participants and reviews of complaints. SDS continues to review progress until the deficiencies are corrected, and reports on the performance of SDS certification and oversight process activities to the departmental Quality Improvement Steering Committee on a quarterly basis.

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 C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

See Attachment #2

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:*

Effective 7/1/16, Senior and Disabilities Services (SDS) has amended State regulations to ensure compliance with federal conflict free care coordination requirements, including allowances for exceptions in rural areas where there is not capacity to meet the needs of individuals residing in an area. SDS has developed and instituted safeguards to protect against conflict of interest and to ensure that service plans are developed in the best interests of the recipients. Each entity must complete a conflict of interest form for each affiliated care coordinator, attesting that each individual care coordinator is conflict-free and will not unduly influence a recipient in their choice of providers of waiver services.

Individual care coordinators, responsible for developing the service plan, may not provide other direct (non-care coordination) waiver services to the recipient. Individual care coordinators may not have an interest in or be employed by a provider (entity) of Home and Community Based services except when the conflicted entity is the only willing and qualified provider. Alaska is a large and sparsely populated state. In rural and remote regions there may be only one or two service providers. This makes it difficult to ensure that recipients in these areas are served by different entities for care coordination and other home and community-based services. Nevertheless, all care coordinators, regardless of location (urban, rural and remote) are always prohibited from providing any other direct (non-care coordination) home and community based service on a recipient's service plan.

For entities granted an exception to the conflict-free requirements, the State has established conflict of interest protections, ensuring that care coordinators employed by that entity remain neutral during the development of the person-centered service plan, and including the requirement that the –entity separate direct care services and care coordination into distinct functions, with separate oversight.

To be certified initially, every care coordinator must complete the State's mandatory care coordinator training; recertification requires completion of bi-annual training. The training curriculum includes the six assurances of the Medicaid Home and Community Based Waiver, person- centered planning, participant choice and conflict of interest. All care coordinators are trained to understand that recipients have choice between waiver services and institutional care and between/among waiver services and providers. The training also includes the State's policies for verification that providers initially and continually meet required licensure and/or certification standards, including conflict free requirements.

Safeguards that address potential and mitigate actual problems:

* The State will not restrict conflict-free care coordinators from entering a census area in which a provider of both care coordination and waiver services during the period of time that the provider has been awarded a conflict-free exception. This will allow recipients additional choice in care coordinators while building capacity during the exception period.

* A recipient can file a complaint or grievance, through the state's Central Intake system, about the state's awarding of an exception to conflict-free care coordination to a particular provider, or about the recipient's experience in attempting to select another care coordinator. Each recipient is informed about the provider's grievance procedures and the state's Central Intake process, and receives copies of the SDS Recipient Rights and Responsibilities and the Notice of Adverse Action and Fair Hearing Rights forms, as part of completing the Appointment for Care Coordination Services form. Each complaint, grievance, and report made to Central Intake is investigated by the appropriate unit within SDS. hen developing the person-centered service care, a care coordinator must disclose to the recipient and the recipient's planning team if he or she works for an agency that provides other home and community-based waiver services. In addition, when the recipient chooses to receive home and community based services from an entity that has been granted an exception to conflict-free requirements, the care coordinator and entity are required to ensure administrative separation of HCB services from care coordination. The entity must also ensure that the care coordination recipient is offered choice for HCB services between and among available service providers, care coordination recipients are not limited to HCB services provided only by the entity, and care coordination recipients are given choice of care coordinators within the entity.

* The application form for an exception to conflict-free care coordination includes assurances, made under penalty of perjury, that the agency has and uses a policy and procedure for dispute resolution that ensures that 1) recipients are free to choose or deny waiver service without influence from the care coordinator or waiver staff, and 2) recipients are free to communicate grievances, that the agency's grievance procedure is clear and understood by the recipient and legal representative, and that grievances/complaints are resolved in a timely manner. The applicant also attests that the outcomes/evidence of recipient choice and grievances are available for SDS review upon request.

(Continued at Main B. Optional/Additional Needed Information)

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.

SDS utilizes a person-centered planning (PCP) approach to POC development, and includes PCP training in mandatory care coordinator training. As such, the participant actively leads development of the POC, and chooses those individuals who will take part in the process.

Prior to POC development, the care coordinator, chosen by the participant from an official list of care coordinators in their geographic area, provides a list of services available through the waiver. The care coordinator then assists the participant to explore the range of services offered, and to make decisions regarding which services meet their needs, preferences and desires.

Participants take the lead in their POC development, may refuse services, and are given information on how to contact SDS for more information or to lodge complaints regarding services, service providers, or any other aspect of waiver participation.

Participants sign the "Recipient Rights" form at time of application, and sign annual service plans and when needed changes are identified, plan amendments.

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, prior to developing the Plan of Care (POC), 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. This meeting is scheduled at a time and location convenient to the participant and those he/she wishes to participant.

As part of the planning process, the participant and the team are given the SDS a brochure entitled "Alaska's Home and Community-Based Medicaid Waivers." The brochure lists all the available services provided through the waiver. In addition, the participant and the team are given a list of providers available to provide services in their area.

The care coordinator takes the lead in developing the POC and includes services that fit with the needs, preferences,

goals and requests of the participant or participant's legal representative and the person-centered team. Services are planned according to the scope, frequency and duration of the participant's need. The plan identifies the provider responsible for delivering each service to the participant.

By SDS policy, the POC must be submitted no later than 60-days after the determination of NFLOC. A new POC must be submitted annually that reflects changes in the participant's health, life plans and goals. The participant is given a list of providers qualified to provide the identified services, and makes the decision as to which provider is used.

The POC must reflect the issues identified in the CAT or TCAT assessment, the preferences of the applicant, the applicant's legal representative and the health concerns of applicant's medical care providers. Any disagreement in the kind of services, frequency, scope or duration of services among participants is noted on the POC prior to submission for the departments' review. After SDS staff review the POC and resolve any conflicts noted, NFLOC staff review the POC prior to issuance of authorizations for billing. In addition, the participant must initial and sign the Senior and Disabilities Services "Program Participant Rights" form that outlines participant's rights including the right to make choices about their care, to participate in the planning of care and to receive a copy of the POC, to change providers at any time, and to submit a complaint through a grievance procedure established by the service provider.

Each provider authenticates participation of the agency they represent, and takes responsibility to provide the service by signing the POC. The care coordinator is responsible for coordination of all the waiver services on the POC, as well as the regular Medicaid services (such as Personal Care Assistance, physical therapy or speech therapy), as well as coordination with State of Alaska grant-funded services and other community resources the family may utilize. Under 7 AAC 125 Personal Care Assistance, a recipient of both HCB Waiver and PCA services will establish coordinated plans of care – using the same plan of care dates, and coordinating services to avoid any duplications.

Monitoring the plan of care is the primary responsibility of the care coordinator. Concerns are discussed with the participant or the participant's legal representative during the minimum monthly face-to-face contact)or, if a care coordinator has received approval to waive monthly visits, during quarterly visits). or by telephone between face to face visits.

The POC is updated annually or when needed to reflect changes in the participant's condition, desires, goals or needs. Annual updates take place after the reassessment and redetermination of the participant's NFLOC. The care coordinator convenes the person-centered planning team, and follows the same process as outlined above for initial POC development. By SDS policy, the care coordinator must submit a new POC within 30 business days of the determination that the participant has met NFLOC level of care. Amendments to the POC are submitted by the care coordinator at any time service changes are needed to ensure the health, safety and welfare of the participant. The care coordinator convenes the person-centered planning team to discuss how best to meet the identified need. The care coordinator submits the SDS "Plan of Care Amendment" form describing the participant's change in condition or circumstances necessitating the change, the goals to be reached with the changes, a justification for requesting the specific change in services and a description of the expected outcomes of the service changes. The amendment form is signed by the participant, members of the planning team, and any providers providing services described on the POC.

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.

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. The SDS assessor administering the State of Alaska Nursing Facility Assessment Form for Children also identifies risks. 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 event of an emergency, and the participant's plan if the agency's back up fails. A copy of the plan of care is filed with the agency, SDS, and at the participant's place of residence.

As part of the requirements for certification, home and community-based waiver providers must develop an "Emergency Response and Recovery Plan" (ERRP). The plan includes a protocol for response when a provider fails to arrive for a scheduled shift, or any other emergency that could present a threat to the health and safety of participants. A copy of the ERRP is filed in each provider's file at SDS.

People who choose to live in remote Alaskan communities are aware of the risks and limited services that are available to them but utilize waivers a means to maintain their independent and remote lifestyles. Individuals are offered support and services necessary to live and age in their chosen community in the least restrictive (developmentally and age appropriate) environment and are free to pursue their life goals. The care coordinator discusses all options for care with every applicant or the applicant's representative, and identifies potential issues with service delivery. These strategies are incorporated into the POC.

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 under an SDS-awarded exception to the CMS requirement that care coordination be conflict-free, the care coordinator is 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 than the care coordinator's 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 POC is reviewed by NFLOC Unit staff 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. SDS staff then approve the POC and prior authorize services.

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.

The state also takes a role in monitoring implementation of the POC through a review of the care coordinator's efforts. After each visit with a participant, the care coordinator completes a provider "record of service" as required by regulations at 7 AAC 105.230 that includes annotated case notes signed and dated by the care coordinator. The SDS Provider Quality Assurance Unit requests the participant contact form when needed in response to a participant complaint, when the State's discovery efforts reveal problems with a participant's care or for safety investigations and/or audit and program integrity reviews. When a care coordinator is identified as deficient in any of these areas, SDS immediately remediates the problem by providing training, technical assistance. If the care coordinator's performance does not improve, SDS will respond with progressive sanctions culminating in loss of provider certification.

Care coordinators must make at least one face to face contact with the participant per month, unless the participant lives in a "remote community" and the state waives the visit under regulations at 7 AAC 130.240. The state will waive the monthly face-to-face visit requirements if the POC documents that the projected cost of travel to visit the participant amounts to or exceeds 50 percent of the payment for all care coordination services for all participants who receive such services from the agency that employs the care coordinator and who reside in the destination community or location for the 12 month period of the request, no local care coordinator is available or, if present, is unwilling (due to a previous violent episode with a participant or their family) or unable to provide services to the participant, and the health, safety and welfare of the participant will not be compromised by infrequent in-person

contacts. If the monthly visit is waived, the care coordinator must meet with the participant face-to-face to monitor service delivery at least once per calendar quarter, in addition to non-face-to-face contact at least twice a month.

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:*

Care coordinators have a responsibility under 7 AAC 43.1030 to monitor POC implementation. Rural exceptions to conflict-free care coordination may allow a care coordinator to work for an agency that provides other direct waiver services to the participant, but may not provide any other home and community-based waiver services to a participant while that care coordinator is providing ongoing care coordination services. However, care coordinators may not work for (or have a close familial relationship with) providers of residential supported living services serving the participant.

Care coordinators must complete mandatory training that addresses their responsibilities to monitor plan of cares, ensure participant health and welfare, and act in the best interest of the participant.

If the care coordinator works for an agency that provides other types of waiver services, they are required to disclose this "conflict of interest" to waiver participants and ensure that participants understand that they retain the right to choose a provider from other than the care coordinators agency.

As part of the waiver application process, each applicant receives the SDS "Participant Rights" form that informs the applicant of their right to choose their providers and to change providers at any time. In addition, the form advises the applicant to consult with SDS on their plan of care, and that SDS staff will investigate complaints regarding plans of care. The applicant initials and signs the form indicating they have been informed.

When the participant's plan of care is being developed, he or she receives a list of all providers certified and enrolled to provide home and community-based waiver services in their location or region.

The state of Alaska has a small population and large geographic area. Every attempt is made to let participants, their representatives or families know of their right to choose providers. However, in some small, geographically isolated communities, there may be very few providers, and in some communities, there may be only one or two. Under these circumstances every attempt is made to accommodate a participant's choice of providers.

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**

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

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

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

Performance Measure:
SP 4: # and % of waiver participants who have services that meet the needs identified through the person centered planning (PCP) process. Numerator: # of participants whose services meet the needs identified during the PCP process. Denominator: # of participants who were included in the case review sample.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%, +/- 5% and 50% distributio
☐ **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:
SP 5: # and % of participants who have documented personal goals identified in the service plan. Numerator: # of participants whose service plans had documented personal goals. Denominator: # of participants who were included in the case review sample.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%, +/- 5% and 50% distribution
☐ **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:
SP 6: # and % of participants who indicate progress made towards goals identified in their service plan. Numerator: # of participants who indicate they made progress towards their goals Denominator: # of participant who were included in the case review sample.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%, +/- 5% and 50% distribution
☐ **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:
SP 7: # and % of waiver participants whose service plans address health and safety risks. Numerator: # of participants whose service plans addressed health and safety risks during the PCP process. Denominator: # of participants who were included in the case review sample.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☑ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%, +/- 5% and 50% distribution
☐ **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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

c. ***Sub-assurance: 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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
SP 8: # and % of renewal service plans or amendments received by SDS prior to the set annual redetermination date. Numerator: # of renewal service plans or amendments received by SDS prior to the set annual redetermination date that are due within the reporting period. Denominator: Sample of renewal service plans due for receipt 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 = 95%, +/- 5% and 50% distribution
☐ **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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
SP 9: # and % of participants who report that they received the type, scope, amount, duration, and frequency requested in their Person Centered Plan (PCP). Numerator: # of participants who report that they received the type, scope, amount, duration, and frequency requested in their PCP. Denominator: # of participants who were included in the case review sample.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%, +/- 5% and 50% distribution
☐ **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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
SP 10: # and % of participant records with appropriately completed freedom of choice form that specified choice was offered among waiver services. Numerator: # of service plans that included evidence that the participant received a choice in waiver services. Denominator: # of participants who were included in the case review sample.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%, +/- 5% and 50% distribution
☐ **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:
SP 11: # and % of participant records with documentation that the participant reviewed a list of qualified providers and was provided a choice of providers Numerator: # of service plans that included evidence that the participant reviewed a list of providers and was provided a choice in providers. Denominator: # of participants who were included in the case review sample

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%, +/- 5% and 50% distribution
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
		☐ **Other**

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

The Service Plan Task Committee prepares standardized monthly reports for the Quality Improvement Workgroup (QIW) based on the Service Plan performance measures approved by the Department of Health and Social Service Quality Improvement Steering Committee (QISC). QIW reports include at minimum:
• Monthly, quarterly and annual cumulative aggregated data of findings and corrective actions taken at the program/ unit levels as identified through the task committee review activities;

• Historical data for use in comparing similar reporting periods;
• A summary of findings and recommended action, including preliminary trends identified by the task committee.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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, 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 the basis for the finding. In addition, the report specifies the remediation action required to achieve compliance, the date by which compliance is required and the method of provider confirmation of compliance.

If POC deficiencies reveal an immediate risk to participant health, safety, or welfare, SDS may act without offering an opportunity for remediation by the care coordinator; actions include, but not limited to suspending or terminating certification, and suspending or withholding payment for services.

SDS monitors remediation requirements until the deficiencies are corrected, maintains written records on the progress of remediation efforts, and reports on the performance of remediation activities to the departmental Quality Improvement Steering Committee on a quarterly basis.

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

E-2: Opportunities for Participant-Direction (5 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 (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 and participants in waiver programs 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 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 applicant receives the "Notice of Adverse Action" by requiring the Senior and Disabilities Services "Program Recipient Rights" form as part of the complete application. The form requires the applicant to read and initial 18 statements attesting to the fact that they understand their rights under the program. The final statement confirms that they have received a copy of the "Notice of Adverse Actions, Hearings and Appeals" information sheet.

All notices of adverse action originate with SDS and are sent by Certified Mail on official Division letterhead. Notices clearly explain the action to be taken, cite the statute or regulation that provides authority for the action, and inform the applicant or recipient of their rights to appeal the action and request a fair hearing. In addition, the notice of adverse action informs the participant that if they continue to satisfy all eligibility criteria other that those at issue in the hearing request, their services will be continued until the date that the final decision is issued, unless the participant informs the state that the participant does not want to receive continuing assistance. A copy of the notice is placed in the applicant or participant's paper file, and uploaded into the SDS computerized client information system where it will remain indefinitely.

A request for a hearing must be made in writing by the applicant or participant, or by their representative, within 30 days of the date on the notice of adverse action. SDS notices direct an applicant or participant to call or write to Xerox, the entity that provides administrative support for fair hearing requests. If an appeal request is received by an SDS employee it must be promptly referred to Xerox for appropriate processing. Individuals who want to file for a fair hearing who are non-English speaking or illiterate are assisted by either their waiver care coordinator or their PCA agency representative who

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

complaint is routed to the appropriate SDS program unit manager within three business days. Deficiencies in SDS operations are addressed with changes in process or policy, clarification of policy or regulations, individual, unit or division-wide training, and in cases of grievous misconduct, referral to Human Resources.

SDS bases its determinations regarding a complaint about provider operations or services on criteria such as consistency with purpose of program, adherence to regulations, standards or the application of agency policy and standards as described in the providers application for SDS certification. SDS investigative staff then reviews provider records, SDS records pertaining to the substance of the complaint, and as necessary, conducts onsite interviews. If the complaint is determined to be without merit, the case is closed and required data is entered into Central Intake tracking system. If the complaint brings a deficiency to light, SDS plans and implements appropriate remediation.

Remediation for providers includes a report of findings issued within 30 days of the investigation disposition and if warranted, remediation measures such as additional training, or sanctions as required by Medicaid regulations at 7 AAC 105.400 – 105.490. A written summary of action taken or a report of findings (if the administrative action is final) is available to a complainant, including a participant, upon request.

All certified provider agencies are required to develop and implement policy and procedures for the handling and resolution of complaints and grievances. Providers are required to describe the methods in which complaints may be filed and processed and how outcomes are recorded. Participants are encouraged, but not required, to utilize the complaint system of their provider agency as described by SDS policy and procedure, but may always file a complaint directly with SDS. Providers also are required to monitor for and address any retaliatory actions that are suspected. To ensure adequate investigation and resolution has taken place, providers must report on the outcomes of participant or other stakeholder complaints and grievances as part of their application to renew certification and upon request if receiving a provider review by SDS. Additionally, providers are required to submit their own quality improvement reports as a part of their recertification application to incorporate the following information: grievances, critical incident reports, medication errors, use of restrictive interventions, consumer satisfaction and internal reviews.

The Research and Analysis Unit reviews and analyzes aggregated complaint data on a monthly basis which is forwarded to the QA Unit. The QA Unit prepares a report for the SDS Quality Improvement Workgroup (QIW), including analysis of complaint data, recommendations for provider or SDS improvements or remediation, development of new or modification of current policy and procedures, and improvements to the complaint process. In turn, the QIW reviews monthly reports of findings and recommendations by the QA Unit, develops a plan to address identified issues, recommends administrative or operational changes if indicated, identifies training and technical assistance needs, tracks and evaluates progress on actions items, and reports on the performance of SDS complaint process activities to the departmental Quality Improvement Steering Committee on a quarterly basis.

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 waiver 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.

Incidents and events that must be reported include:
□ A missing participant when a law enforcement agency is notified;

□ Recipient behavior that results in harm to self or others;

□ Misuse of restrictive interventions;

□ Use of restrictive intervention that resulted in the need for evaluation by or consultation with medical personnel

□ Death of a recipient;

□ Accident, injury, or another unexpected event that affected the recipients health, safety, or welfare to the extant evaluation by or consultation with medical personnel was needed;

□ A medication error resulting in the need for evaluation by or consultation with medical personnel including 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, other than by the prescribed route, not intended for the recipient, intended for the recipient to another person, and other than the correct dosage;

□ An event that involved the recipient and a response from a peace officer.

The SDS Adult Protective Services (APS) Unit acts as the "centralized intake" unit for all reports of physical and sexual abuse, neglect, self-neglect, exploitation, including financial exploitation, and abandonment as well as critical incidents involving waiver participants. Providers, recipients, care coordinators, family members, advocates or any citizen may submit a "report of harm" through the SDS-sponsored "Centralized Reporting" electronic portal accessed through the SDS web at http://dhss.alaska.gov/dsds/Pages/CentralizedReporting.aspx APS reviews all reports of harm and critical incidents within 24 hours of receipt and investigates allegations of abuse neglect or exploitation.

If the report of harm or critical incident involves a participant who resides in a licensed assisted living home, Central Intake refers the case to the Division of Health Care Services Certification and Licensing Unit for investigation. collaborates with Certification and Licensing on shared investigations. All information received from Licensing is recorded in a database shared by Adult Protective Services, SDS Quality Assurance and Assisted Living Home Licensing Unit.

When the Licensing Unit receives a report of abuse or neglect in an assisted living home and plans a site visit, they inform APS in the event that a waiver participant might be displaced from the home. In addition, APS and Licensing perform joint site inspections when immediate risks to the health and safety of the participants are present.

If warranted, QA initiates provider remediation activities. The report remains in the provider file indefinitely, and is considered as part of provider recertification. QA staff enter data from the reports into the SDS critical incident database, which in turn provides data for SDS "health and welfare" performance measures, data trend discovery, and discovery and remediation of individual provider deficiencies and systemic problems.

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.

Reports of harm and critical incident reports (CIR) are received by the Central Intake Unit through the SDS-sponsored "Centralized Reporting" electronic portal. Within 24 hours or one business day of receipt, Central Intake reviews the report of harm or CIR to determine if the report indicates past horm or risk for or suspected abuse, neglect, exploitation that requires APS investigation or referral to the Alaska Office of Children's Services (OCS), the Division of Health Care Services Certification and Licensing Unit, or to law enforcement/emergency services.

The timeline for APS investigations is based on safety risk:

HIGH: when report information indicates a threat to life or a serious imminent threat to physical safety is unresolved by or does not meet the criteria for emergency services, a face-to-face interview of the vulnerable adult is required within 24 hours;

MEDIUM: when the report information indicates indicates a moderate threat to physical safety, but no immediate danger of serious injury or illness, a face-to-face interview of the vulnerable adult is required within five three calendar days;

LOW: when report information indicates indicates a stable safe situation and only minor problems, if any, exist a face-to-face interview of the vulnerable adult is required within seven calendar ten business days.

When the report of harm or critical incident reported does not require APS action, the Manager of the Services QA Unit is responsible to review the provider agency response to the incident to determine whether circumstances to mitigate any risks to health, safety and welfare and to reduce the risk of reoccurrence have been adequately addressed. For an adequate response, SDS takes no further action. For an inadequate response, the SDS Services QA Manager directs staff to contact the provider agency to discuss the areas in which the response was found to be inadequate. If the discussion does not resolve issues raised by the response, staff requests additional information or documents for review, or conducts an agency site visit. During the site visit SDS staff interview agency administrators and staff, and assess agency documents including reports related to the event or circumstances addressed in the SDS Critical Incident Report, agency policies and procedures, and records of staff credentials and training. When the circumstances or event need to be addressed to reduce risks to health, safety, and welfare SDS staff requests that the provider agency develop a Critical Incident Improvement Plan, and notifies the Provider QA Unit that a plan has been requested.

The provider agency, in consultation with the Services QA Unit, develops and submits to SDS a Critical Incident Improvement Plan that outlines the actions which will be taken to prevent reoccurrences, or to improve response in the event of similar incidents, a date by which the actions will be taken, and the provider agency staff responsible for taking the actions. Services QA Unit staff monitor the progress, adequacy and outcomes of the plan until any risks to the health, safety and welfare of participants are corrected.

When SDS refers a case to Certification and Licensing Unit for investigation, record of the action taken is recorded in the shared database. QA staff review the report, and download it into the SDS Critical Incident database. The

information is then a permanent part of the participant's and the provider's files and is used in discovery of trends in provider performance and participant needs.

SDS informs the reporter by mail or secure electronic message of the screening decision after a case has been screened by APS and outlines confidentiality requirements as prescribed in AS 47.24.505. At the conclusion of an APS investigation the investigator sends a second letter to the reporter and participant or guardian which states the outcome of the investigation. Due to confidentiality, the letter does not describe details from the report received or details of the investigation.

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 Provider 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 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.

The QA Unit summarizes critical incident data at least monthly for review by the SDS Quality Improvement Workgroup to determine if corrective action is needed and quarterly to the DHSS Quality Improvement Steering Committee for consideration of systemic improvements.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. **Use of Restraints.** *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

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

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

◉ **The use of restraints 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.** 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). 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 may infringe on participant rights or cause physical harm, SDS requires that use be limited, and in compliance with SDS regulations at 7 AAC 130.229, "Use of restrictive intervention," and in the case of licensed assisted living homes, in compliance with 7 AAC 75.295, "Use of intervention and physical restraint."

Prohibited methods of restraint include seclusion, prone restraint, and chemical restraint. Seclusion is defined at 7 AAC 130.229(g)(2) as the involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving. Prone restraint means a physical or mechanical restraint while the participant is in a prone or supine position, or any restraint that limits a participant's ability to avoid pressure to the chest, stomach

or neck, that obstructs circulation or breathing or does not give adequate protection to the head. Also prohibited are methods of restraint that inflict pain such as use of pressure points, hyperextension of joints, and any technique that involves the participant being off balance, taken to the floor or allowed to fall without support. Chemical restraint is defined as the use of medication that was not prescribed or consented to by a participant and limits or restricts a participant's movement or function.

Physical restraint is defined at 7 AAC 75.295 (f), as manual method that restricts body movement, or a physical or mechanical devise that prevents the individual from easily removing it, and that restricts movement or normal access to the body. SDS permits the use of physical restraint when less restrictive interventions have been shown to be ineffective and in two circumstances only: as a response to the risk of imminent danger where the health and safety of the participant or others are at risk, or, as an element of a documented behavioral support plan. Physical restraints may not be used for disciplinary purposes, staff convenience, or as a substitute for adequate staffing.

SDS detects and monitors the use, unauthorized use and prohibited use of restraint and seclusion through provider reports submitted with an application to recertify, ongoing monitoring activities such as provider onsite reviews, service plan and behavioral support plan reviews and reports of harm, critical incidents and complaints received by SDS and other partner agencies. Non-compliance may result in a sanction or enforcement action up to and including termination from the Medicaid program.

To ensure that restraints will not cause harm to the participant, provider agencies must have policy and procedure for its use, training provided to all direct service staff, monitoring that includes quarterly reviews, corrective action and reporting to SDS if restraint is inappropriate, prohibited practices are used, restraint is used in an emergency, or restraint results in the need for medical intervention. The provider must describe their policy and procedure for the use of restraint at application at initial certification and licensure and during recertification and licensing renewal, or when there is a change in the provider's policy and/or procedure. Based on an agency's understanding of the standards for use and the adequacy of the training program to be implemented, SDS will permit the use of restraints.

SDS promotes the use of time limited positive behavioral support plans that use the least restrictive methods needed to manage behavior and eliminate the circumstances in which restraints or seclusion would be necessary. A behavior support plan may be initiated when a participant's challenging or dangerous behavior interferes with home and community-based activities or prevents the participant from participating in activities of their choosing, a participant's behavior is reoccurring and requires the use of restraints two or more times in a six month period or the behavior that required restraint has caused an imminent risk to the participant or others.

A team including the participant, their care coordinator, their family or legal representative, and additional members as needed including health care providers develop the behavioral support plan. The team is led by a professional licensed under AS 08 who has training and experience in the development, implementation and monitoring of behavioral support plans. The team assesses the participant's overall quality life, mental health, neurological or medical conditions that may contribute to the behavior, environment, events or other factors that trigger, increase or decrease the behavior, and the intended function of the behavior. Following the assessment the qualified professional writes a plan that includes strategies for preventing the behavior and for supporting positive behavior, and specific responses including the use of restraints when deemed necessary. The plan also includes a method for measuring and documenting the plan's effectiveness.

The care coordinator, in conjunction with the licensed professional, monitors the behavioral support plan. During the care coordinator's regular visits and through communication with the provider or family, the care coordinator assesses the effectiveness of the plan in eliminating the challenging or dangerous behavior. If the plan does not extinguish the behavior, the care coordinator contacts the licensed professional who may reconvene the planning team, reassess the participant's needs and recommend changes to the plan. If the plan has succeeded in eliminating the behavior, the care coordinator notifies the team and the licensed professional and recommends the restraints be removed from the POC. The licensed professional modifies the plan as needed.

Agency direct care workers who meet the following qualifications and have received the prescribed training may administer restraints. The direct care worker must be at least 18 years old, have a high

school diploma or GED or have the ability to read written instructions and write required service notes in English, understand the needs of the participant population and the services to be provided as described in the service plan, provide three character references indicating that the direct care worker possesses sound judgment and is a reliable individual, pass a criminal background check required by statute at AS 47.05.300 and regulations at 7 AAC 10. 900, and have documentation of current First Aid and CPR training. Direct service workers must be supervised by the Agency Administrator or their designee.

At a minimum, providers must train direct service workers on appropriate safety, de-escalation and crisis management techniques, environmental factors and triggers to challenging behavior, prohibitions on the use of restraints as a convenience for themselves or other staff, the risks of restraint, prohibited practices and the least restrictive methods to manage behavior appropriate to the population served by provider, body mechanics that avoid injury to the participant and staff, proper application of restraint while considering gender, age, physical condition and negative effects, and prohibition on the use of the restraints for which they have been not been trained.

The provider agency must document the use of restraints implemented during the provision of services including the type of restraint used, the environment in which the restraint was used, the event or circumstances necessitating the use of restraint, the outcomes for the participant and direct care worker. Incidents which result in use of restraint must be followed by a debriefing to address the needs of a participant and direct service workers.

Providers must monitor and evaluate the use of restraints through an internal critical incident management process, and must develop specific steps in an individual plan to reduce and eliminate the use of restraint. The evaluation must identify strategies to prevent use of restraint, make appropriate modifications to behavioral support plan, promptly address any corrective action or changes to the service or program to reduce and eliminate further instances of restraint.

Provider agencies, their associates, employees or contracting agents must make a “Critical Incident Report” to the SDS within 24 hours or one business day on the use or suspected use of prohibited practices, use of restraints that were not approved in the participant’s behavioral support plan, any injury requiring medical care which resulted from the use of a restraint, and use of restraint in an emergency situation. Providers must then report the monitoring, evaluation and corrective actions taken in response to evaluations of the use of restraints or seclusion during renewal of certification or at Department request. At least once a quarter per calendar year, the provider must analyze the collected information and take corrective action for identified problem areas. We require through provider standards that all uses of restraint are documented. The documentation must also include other interventions applied or attempted prior to use of any restraint.

A provider must use the following less restrictive interventions prior to the implementation of restraints or time out: prompting by using verbal cues, physical gestures or physical assistance; simple correction by explanation, demonstration, or guidance of a participant; ignoring a behavior that is inappropriate; offering alternatives or non-threatening discussion of possible consequences; use of incentives; teaching and encouraging; canceling an activity for a participant if participant is agitated at the time of the event; controlling access to medications and hazards that may be harmful (laxatives, cleaning products, knives, insecticides); physically blocking without holding a participant for protective purposes; requesting a participant leave an area or room for protection; use of medical alert devices for seizures, falls, wandering, etc.; use of door and window alarm or alert system for participant safety and security; use of a mechanical or therapeutic device that is prescribed by a physician, consented to by participant or their legal representative, and used as prescribed. Devices may include wheel chair safety straps, bed rails, lap trays, leg brace, gait belt, chair cushions; car safety straps or seat belts that are required by law during travel in a vehicle; use of audio monitoring system if the participant and legal representative consent. Monitoring systems may not be used for staff convenience or to invade a participant’s privacy; use of video monitoring systems in common areas and hallways if affected participant(s) and legal representative(s) consent and a health and safety condition exists that requires additional monitoring. Monitoring system may not be used for staff convenience or to invade a participant’s privacy; removal and safeguarding of a participant’s animal if the animal is at risk of abuse or neglect by the participant.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints 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 Â“time outÂ” 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, critical incident reporting management, complaints, referrals, and quality assurance provider reviews.

SDS detects and monitors the use, unauthorized use and prohibited use of restraint and seclusion through provider reports submitted with an application to recertify, ongoing monitoring activities such as provider onsite reviews, service plan and behavioral support plan reviews and reports of harm, critical incidents and complaints received by SDS and partner agencies. Non-compliance may result in sanction or enforcement action up to and including termination from the Medicaid program.

The DHSS Licensing and Certification Unit, responsible for the licensure of assisted living homes, provides orientation related to restraint to providers, conducts annual inspections, and investigates complaints and critical incidents reported to licensing or other partners such as SDS. Reports received are immediately provided to SDS and are incorporated into ongoing SDS provider monitoring activities.

Care coordination services, which must include at least one face to face contact per month, is another way SDS monitors the use and unauthorized use of restraint and time out. Care coordinators are mandated to report any suspected abuse, neglect or exploitation as well as any restraint that is prohibited, inappropriate, used in an emergency or results in the need for medical attention.

During plan of care processing, if the use of restraints or time out is a contingency, the SDS NFLOC Waiver Unit verifies either that a positive behavioral support plan has been developed and included in the POC, or if not included, contacts the care coordinator regarding the need for a behavior support plan. The SDS NFLOC Waiver Unit approves the POC when the positive behavioral support plan is developed and adequately addresses the requirements described in the SDS Standards for Behavioral Support Plan.

Through these and other discovery activities such as critical incident reports, the SDS Quality Assurance Unit collects and aggregates data regarding the use of restraints or time out, analyzes trends, and prepares a monthly discovery and remediation report for the Health and Welfare Task Committee. The task committee, which includes members of each SDS unit including APS, evaluates the information for possible individual remediation, patterns or trends in use of restraints time out and makes a monthly quality report to the SDS Quality Improvement Workgroup (QIW). In turn, the QIW evaluates the information in the monthly quality monitoring report, and makes recommendations for remediation including technical assistance and training, and policy implementation strategies. Recommendation for the larger system improvements are made to the DHSS Quality Improvement Steering Committee, chaired by the Deputy Commissioner. This committee has a broader departmental membership and meets monthly to review the quality monitoring report.
* Provides orientation on state regulations, licensing, and fees;
*• Investigates complaints alleging violations of state guidelines ;
* Answers questions and maintains a current list of licensed assisted living homes around Alaska;
* Monitors homes to ensure they are clean, safe, sanitary and are providing meals and activities for their residents;
* Provides technical assistance and coordinates training to assisted living care providers

Certification and Licensing monitors the use of restraints and seclusion annually during regular on-site monitoring and inspection visits to licensed assisted living homes or more frequently if needed, based on reported incidents or complaint allegations.

Through the initial and ongoing monitoring of certified providers, SDS ensures compliance with standards for the use of restraints by several mechanisms. One is requiring providers to submit policy and procedure on the use of restraints. This policy must reflect SDS "Standards for the Use of Restraints and Restrictive Interventions" and not violate the Department''s purpose and intent. Provider must indicate the level of restraint allowed and provide training to all applicable caregivers specific to the levels of intervention offered and allowed by the provider. Providers are required to report to SDS restraints that rise to the level of a critical incident. In addition, providers are required to document and evaluate at least quarterly all uses of restraint. Providers are required to report these evaluations and corrective actions taken at the time they renew their certification status and upon request of SDS.

The State assures CMS that any use of restrictive interventions involving recipients on the Children with Complex Medical Conditions waiver will comport with the home and community-based setting requirements at Section 42 CFR 441.301(c)(4)(iii) and (vi)(F), and person-centered service planning and plan requirements at 42 CFR 44.301(c)(1) and (c)(2). All restrictive interventions must be identified in the recipient's plan of care as the least restrictive possible to address the behaviors in question, and when the intervention is employed, must be documented in the case notes by the provider at the setting the service is provided in.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

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.

The state does allow the use of some types of restrictive interventions if the following conditions exist:
(1) As a response when a recipient presents an imminent danger to their own safety or the safety of others;
(2) When other types of interventions have been tried and documented as ineffective to keep the individual safe;
(3) If the intervention is safe and appropriate for the recipient's age, size, gender, and physical, medical, and psychological condition.

Restrictive interventions that are prohibited are seclusion, prone restraints, or chemical restraints.

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:

The Department of Health and Social Services is responsible for detecting unauthorized or inappropriate use of restrictive interventions. Senior and Disabilities or its partners review and investigate incidents to determine compliance with restrictive intervention policies and procedures required by certified providers of HCB services.

SDS detects the inappropriate use of restrictive interventions through onsite reviews, service plan and behavioral support plan reviews, reports from care coordinators, reports of harm, critical incidents reports, and complaints received by SDS and other partner agencies such as HCS residential licensing. Inappropriate or unauthorized use of restrictive interventions may result in a provider sanction or enforcement action up to and including termination from the Medicaid program.

The DHSS Residential Licensing Unit also monitors the prohibited use of restrictive interventions per 7AAC 75.295 through application reviews, provider agency reports and training records, annual licensing inspection reports, investigative reports, care coordinator activities, service plan reviews, critical incident reporting management, complaints, referrals, and quality assurance provider reviews. Centralized reporting allows complaints to come into a central location, but routing to Adult Protective Services, Quality Assurance, or Health Care Services Residential Licensing as warranted by scope.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

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

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

Alaska regulations at 7 AAC 130.229 require providers of waiver services to develop policies and procedures that address a prohibition on the use of seclusion as a restrictive intervention. SDS monitors adherence to this prohibition through care coordinator activities, critical incident reporting management, and quality assurance reviews.

SDS detects the prohibited use of seclusion through annual onsite reviews, service plan and behavioral support plan reviews, reports from care coordinators, reports of harm, critical incidents reports, and complaints received by SDS and other partner agencies such as HCS licensing. Use of seclusion may result in a provider sanction or enforcement action up to and including termination from the Medicaid program.

The DHSS Licensing and Certification Unit also monitors the prohibited use of seclusion through application reviews, provider agency reports and training records, annual licensing inspection reports, investigative reports, care coordinator activities, service plan reviews, critical incident reporting management, complaints, referrals, and quality assurance provider reviews. Reports received are immediately provided to SDS and are incorporated into ongoing SDS provider monitoring activities.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the State has established concerning the use of each type of 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).

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

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.

Medication management is provided through home and community-based Nursing Oversight and Care Management (NOCM) services for all children with complex medical conditions (CCMC). To receive payment for this service, a provider must employ a registered nurse to assesses a recipient's medical needs and develop a nursing plan that addresses those needs, including medications. The registered nurse provides oversight of a recipient by evaluating whether services are reasonable and necessary for the recipient's medical condition and the complexity of care required to treat that condition. To provide the required oversight, the registered nurse must remain in contact with the recipient in a manner and with a frequency appropriate to the medical condition of the recipient and to the complexity of care; at a minimum, the registered nurse must conduct an on-site evaluation every 90 days. State regulations addressing nursing duties are applicable, also; those duties include, "medication management for unstable conditions requiring ongoing assessment and adjustment of dosage or timing of administration".

In addition to NOCM, other home and community-based waiver services may be provided in a CCMC recipient's private residence, an assisted living home (ALH), or a foster home. CCMC recipients of home and community-based Residential Habilitation Services may reside in assisted living homes and foster homes.

Health-related services, including medication management, are allowed in ALHs, AS 47.33.020. The assisted living plan must address the need for health-related services and how that need will be met, AS 47.33.230 (b)(8). A physician's statement regarding the medication regimen must be included in the plan. The plan must be evaluated at three-month intervals if an ALH provides or arranged for such services. In addition to evaluation of the over-all plan by the resident or the resident's representative, and the ALH administrator, a registered nurse must review the portion of the plan that that describes how the resident's need for health-related services will be met. The registered nurse monitors the appropriateness of medications with particular attention paid to behavior-modifying medications; usage pattern; potential risks and side-effects associated with the medications; and possible medication interactions. The registered nurse must report adverse findings to the physician, and based on evaluation of the medication process in the ALH, may revise the plan to stipulate more frequent provider monitoring or additional training to direct care staff, if needed.

While foster home parents have responsibilities for children with significant medical needs, 7 AAC 50.300, medication management would remain the responsibility of the registered nurse providing NOCM. Providers of Residential Habilitation Services maintain a roster of foster homes in which a CCMC recipient could be placed, and are responsible for the management of home and community-based services in foster homes. The provider, foster parent, and registered nurse would be part of the planning team that would address a CCMC recipient's medical needs.

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.

The registered nurse providing NOCM is responsible for identifying potentially harmful practices regarding medications, and notifying the prescribing medical professional and the provider agency. The registered nurse would implement any instructions or medication changes ordered by the medical professional.

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 legal representative. SDS regulations regarding medications, 7 AAC 130.227, were developed in view of the fact that the participant or the participant's legal representative may delegate medication administration or assistance with self-administration to waiver providers.

SDS requires specified waiver providers to administer, or assist a participant to self-administer, medications when needed or requested by a participant or participant's representative if no other individual otherwise responsible for medication for the participant is available at the time the participant requires medication. The provider must have a written delegation from the participant, participant's representative, a registered nurse, or another health care professional in accordance with statutes or regulations applicable to that professional. The provider must develop and implement written policies and procedures that address medication administration while participants are in the care of and receiving services from the provider; documentation of all medications in an individual participant record; the name of the medication; the dosage administered; the time of administration; the name of the individual who assists with self-medication or who administers a medication to the recipient; monitoring and evaluation of medication administration; medication error reporting requirements; and medication administration training requirements. The provider may assist a recipient to self-administer medication provided the assisting employee is supervised as necessary. ALH staff may assist with self-administration by reminding the participant to take medication; opening a medication container or pre-packaged medication for a participant; reading a medication label to a participant; observing a participant while the participant takes medication; checking a participant self-administered dosage against the label of the medication container; reassuring a participant that the participant is taking the dosage as prescribed; and directing or guiding, at the request of the participant, the hand of a participant who is administering his or her own medications, AS 47.33.020.

State regulations include standards for delegation of nursing duties to others, including non-medical, unlicensed personnel, and specifically allow delegation of assistance with participant self-administration of medications and administration of medication to waiver service providers, 12 AAC 44.950 – 44.965. The registered nurse must provide a delegation plan, to be reviewed at least every 90 days, that includes the frequency and methods of evaluating the performance of the duty by the waiver provider; directions for the storage and administration of medication; possible medication interactions; how to observe and report side effects, possible complications, and errors; and what to do when medications are changed by the health care provider.

Delegation of both the administration of medication and assistance with self-administration of medication requires the delegating registered nurse to provide ongoing supervision of the non-medical waiver provider. In addition, the individual to whom these duties are delegated must be able to document successful completion of a training course approved by the BON and provided by a registered nurse licensed under AS 08.

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:

Waiver providers are required to record and report medication errors to SDS. If an error resulted in medical intervention, the provider must submit, within 24 hours or one business day, critical incident report to SDS. In addition, providers must track all medication errors and analyze them quarterly; take corrective actions based on that analysis; and summarize the errors and corrective actions in a report that must be submitted to SDS with the provider's application for recertification.

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

Whether a medication is self-administered with assistance or administered by the provider under delegation, the provider must record and document the following medication errors that might occur while the participant is in the care of or receiving services from, the provider:
1) failure to document medication administration;
2) failure to administer medication administration at, or within one hour before or one hour after, the scheduled time;
3) the delivery of medication
a. at a time other than when a medication was scheduled, if the time was outside the acceptable range in (2);
b. other than by the prescribed route;
c. other than in the prescribed dosage;
d. not intended for the participant; or
e. intended for the participant, but given to another person.

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

Providers must report the medication errors cited in (b). If the error resulted in medical intervention, the providers must report the error as a critical incident, 7 AAC 130.224.

○ **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 quality improvement efforts, SDS monitors provider compliance with required critical incident report training and provider medication errors that result in the need for medical intervention. When necessary, SDS works with the provider to develop and implement a corrective action plan. In addition, SDS reviews the provider medication management policy and medication administration corrective action plans at least every two years as part of provider re-certification or whenever necessary to address risks to participant health and safety.

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 demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. **Sub-Assurances:**

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
HW 16: # and % of participants who received information on reporting A/N/E (abuse, neglect, and exploitation). Numerator: # of participants who received information on reporting A/N/E. Denominator: # of participants who were included in the case review sample.

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 = 95%, +/- 5%, and 50% distribution
☐ **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:
HW 17: # and % of central intake reports involving possible A/N/E of adults providers submitted w/in required timeframe. Numerator: # of central intake reports involving possible A/N/E of adults providers submitted w/in required timeframes and reporting period. Denominator: Sample of central intake reports involving possible A/N/E of adults providers submitted w/in 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 = 95%, +/- 5% and 50% distribution
☐ **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:
HW 18: # and % of central intake reports involving critical incidents referenced in 7AAC 130.224 that providers submitted w/in required timeframe. Numerator: # of central intake reports involving critical incidents submitted by provider w/in required timeframes and reporting period. Denominator: Sample of critical incident reports submitted to SDS by provider w/in 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 = 95%, +/- 5% and 50% distribution
☐ **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:
HW 19: # and % of deaths reported by providers. Numerator: # of participant deaths recorded by Vital Statistics that were reported to SDS by providers within the reporting period. Denominator: Sample of participant deaths recorded by Vital Statistics 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 = 95%, +/- 5% and 50% distribution
☐ **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 = 95%, +/- 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 demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
HW 20: # and % of central intake reports involving possible A/N/E of adults reviewed w/in one business day of receipt. Numerator: # of central intake reports involving possible A/N/E of adults reviewed w/in one business day of receipt and submitted w/in reporting period. Denominator: Sample of central intake reports involving possible A/N/E of adults submitted w/in 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 = 95%, +/- 5% and 50% distribution
☐ **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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW 21: # and % of alleged non-waiver victims involved in founded A/N/E central intake reports. Numerator: # of alleged non-waiver victims involved in A/N/E central intake reports and were founded within the reporting period. Denominator: Sample of alleged non-waiver victims involved in founded A/N/E central intake reports that were founded 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 = 95%, +/- 5% and 50% distribution
☐ **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 state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:
HW 22: #/% of critical incidents reporting restrictive intervention that was prohibited/inappropriate/ resulted in need for med intervention. Numerator: # of critical incidents reporting restrictive intervention that was prohibited/inappropriate/resulted in need for med intervention. Denominator: Sample of critical incidents reporting restrictive intervention w/in 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 = 95%, +/- 5% and 50% distribution
☐ **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: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

Performance Measure:
HW 23: # and % of critical incident reports reporting provider medication errors that resulted in the need for medical intervention. Numerator: # of critical incident reports reporting provider medication errors that resulted in the need for medical intervention. Denominator: Sample 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 = 95%, +/- 5% and 50% distribution
☐ **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:
HW 24: # and % of waiver central intake reports involving med intervention that resulted in an investigation. Numerator: # of waiver central intake reports submitted during the reporting period involving med intervention that resulted in an investigation. Denominator: Sample of waiver central intake reports involving med intervention submitted by providers during 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 = 95%, +/- 5% and 50% distribution
☐ **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 comprises 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 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 Health and Welfare Committee Manager who performs weekly reviews of participant data found in the SDS management information system, DS3, as well as a sample of case records. Additional methods of discovery include complaints from providers, participants or their representatives, which are reviewed, processed and addressed as they are received, as well as provider onsite visits that include document reviews and participant and provider staff interviews.

The Health and Welfare Committee prepares standardized monthly reports for the Quality Improvement Workgroup (QIW) based on the Health and Welfare measures approved by the Department of Health and Social Service Quality Improvement Steering Committee (QISC). QIW reports include at minimum:
* Monthly, quarterly and annual cumulative aggregated data of findings and corrective actions taken at the program/ unit levels as identified through the task committee review activities;
* Historical data for use in comparing similar reporting periods;

* A summary of findings and recommended action, including preliminary trends identified by the task committee.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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.

For those providers who are out of compliance with health and safety requirements or for whom a trend of unsafe outcomes for participants has been identified, the Manager directs staff to issue a "report of findings". 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 the basis for the finding. In addition, the report specifies the remediation action required to achieve compliance, including development of a corrective action plan or additional training and/or technical assistance, the date by which compliance is required and the method of provider confirmation of compliance.

If provider deficiencies point to an immediate risk to participant health, safety, or welfare, SDS will dispatch Adult Protective Services (APS) staff to conduct an investigation, determine the level of risk and if necessary, facilitate a change in service providers or develop a protective placement that will ensure the health and safety of the participant. In addition, SDS may act without offering an opportunity for remediation by the provider; actions include, but are not limited to suspending or terminating certification, or suspending or withholding payment for services. SDS may also perform focused studies and conduct agency onsite surveys including document reviews and participant or provider staff interviews. SDS then monitors remediation requirements through review and analysis of provider reports, information provided by participants and reviews of complaints.

When discovery activities reveal problems with the State's performance in timely reviews of critical incident reports the Manager of the "Services Quality Assurance Unit (SQA)" is responsible for initiating remediation activities. If the problem involves performance issues with individual staff, the Manager meets personally with the staff person, assigns additional training or other corrective measures, and if performance issues persist, uses the State-prescribed progressive discipline process for on-going remediation. If the Manager believes the problem relates to systemic issues within SDS regarding policy or procedures for receiving or reviewing critical incident reports, responsibility falls to the Chair of the Policy Task Committee who facilitates changes through the State of Alaska regulation development process or the SDS policy and procedure development process as appropriate.

ii. Remediation Data Aggregation

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

Responsible Party*(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**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☑ **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 QIS 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 OIS* 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 QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

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 comprises SDS Unit Managers, and the Quality Improvement Workgroup (QIW) comprises SDS Unit Managers and the Division's Executive Team. Activities of the QIW are overseen by the DHSS Quality Improvement Steering Committee (QISC) led by the Department's Commissioner and Deputy Commissioner.

The CQI plan incorporates input from stakeholders, participants, providers and the public as necessary. SDS holds occasional information sharing teleconferences open to all stakeholders and covering a variety of topics and issues impacting the waiver programs, specifically when changes are made to operations or there are noted issues to address. SDS uses these opportunities to report SDS performance status, changes in waiver program administration and anticipated system changes resulting from discovery activities. SDS also gathers and shares information regularly at meetings of provider professional associations such as the AgeNet and the Care Coordinator Network.
The QIS and Task Committees perform discovery and remediation activities for all Medicaid waivers. Data is separately aggregated and analyzed for each waiver.

The QIW establishes Task Committees charged with discovery and remediation responsibilities associated with operation of four Medicaid waivers and measured by established performance measures. Task Committees meet monthly to review performance measure data, identify performance deficiencies, implement and report on corrective action on individual cases, and recommend system improvement to QIW. The following Task Committees are currently in operation:

Mortality Review Team. The Mortality Review Team identifies and reviews all deaths reported throughout the centralized intake reporting system. Membership includes the Quality Assurance Unit Manager (Chair) and SDS staff including a Qualified Intellectual Disability Professional (QIDP), a Registered Nurse (RN), the SDS Mortality Review Coordinator , an Adult Protective Services (APS) Unit

representative, a Residential Licensing Unit representative and an Office of Long Term Care Ombudsman (OLTCO) representative. The Committee reviews information on participant deaths obtained through the SDS critical incident reporting process, medical records, vital statistics, Medical Examiner's office and law enforcement reports and determines if the death is the result of an action or omission (or inaction) on the part of a provider agency or SDS. The Committee also compares SDS findings with information obtained from the Bureau of Vital Statistics to discover additional deaths not reported by providers. Untimely deaths or deaths involving unusual circumstances of waiver participants are vetted carefully by the committee and may trigger an investigation.

Level of Care Review. The Level of Care Review Task Committee discovers and remediates SDS performance including timeliness of initial and annual assessments and level of care determinations and other administrative factors identified in the SDS LOC performance measures. Membership includes the Managers of the IDD Waiver Unit, NFLOC Unit (Co-Chairs), Research and Analysis Team, Quality Assurance Unit, Policy and Program Development and Personal Care Assistance Units. On a weekly basis the unit manager's review Level of Care status reports generated by the Research and Analysis Unit, identifies deficiencies in performance and plans and implements remediation activities. On a monthly basis the Committee reviews aggregated monthly, quarterly and annual data, analyzes trends, and makes recommendations for systems improvement to the QIW.

Qualified Providers Review. The Qualified Providers Task Committee gathers and reviews data from SDS performance measures regarding provider qualifications to determine whether certification standards, including required training, are met. Membership includes the Managers of the Provider Certification and Compliance Unit (Chair), Research and Analysis Unit, Operations Integrity Unit (OIU), Policy and Program Development, Grants, Certification Unit staff, and the SDS Training Coordinator. On a monthly basis, the Committee reviews certification and training records and aggregated data to discover the status of provider compliance with certification standards, and plans and implements remediation activities.

Service Plan Review. The Service Plan Review Task Committee gathers and reviews data from SDS performance measures that reveal if service plans are timely, person centered, identify personal goals and address needs identified in the assessments and provide choices to the participant. Membership includes the Managers of the IDD Waiver Unit and NFLOC Unit (Co-Chairs), QA Unit, OIU and the Research and Analysis Team. The Committee reviews results of monthly service plan record reviews and reports findings to the manager of the applicable waiver unit. The Manager identifies and initiates remediation activities needed to cure identified deficiencies. The Committee also submits reports on remediation completed to the QA unit for inclusion in the monthly QIW meetings and makes system improvement recommendations to QIW.

Policy and Procedure. The Policy and Procedure Task Committee develops and reviews SDS policies and procedures with input from SDS staff content experts." Membership includes the Managers of the Policy and Program Development Unit (Chair), IDD Waiver Unit, NFLOC Unit, QA Unit, Provider Certification and Compliance(PCC) Unit, OIU, PCA Unit, Adult Protective Services Unit, Research and Analysis Team, and Grants Unit,. Before finalizing, all SDS policies are reviewed by participants, stakeholders, providers and the public. Input is collected and analyzed by the Committee, and incorporated whenever possible. The Committee also oversees policy implementation including staff and provider training and communication plans pertaining to new or revised policy and procedures.

Health and Welfare Review Task Committee. The Health and Welfare Review Task Committee monitors performance measures related to reports of harm and other critical incidents. Membership includes the Managers of the QA Unit and Adult Protective Services (Co-Chairs), IDD Waiver Unit, NFLOC Unit, OIU, APS Unit, PCA Unit, Grants Unit and Policy and Program Development Unit. The Committee reviews reports of harm, critical incident and complaint reports, discovers deficiencies and plans and conducts individual and system remediation.

Information Technology Task Committee. The Information Technology (IT) Task Committee monitors the coordination and integration of SDS information technology and supports data collection and analysis activities of all the Task Committees. Membership includes the Manager of the Research and Analysis Team, DHSS Finance Management Systems/IT Project Manager (Chair), SDS Deputy Director, SDS Administrative Operations Manager; and a representative of the DHSS IT Business Analysis Unit. The

Committee supports and coordinates development and functionality of the SDS management information system, DS3, including identification of system performance enhancements and coordination with other DHSS and partner systems.

Financial Accountability Task Committee. The Financial Accountability Task Committee ensures that Medicaid waiver claims for reimbursement are coded and paid in accordance with the waiver reimbursement methodology. Committee membership includes Operations and Integrity Unit, PCA Unit Manager (Co-chairs), PCC Unit, QA Unit, Policy and Program Development, and representatives from the DHSS Division of Health Care Services and the Program Integrity Office. The Committee monitors regulations, policy, and procedure regarding claims and service utilization and reviews DHSS audit reports and other surveillance reports generated by the DHSS Division of Health Care Services (HCS) to discover deficiencies in provider billing compliance. The committee addresses deficiencies that can be remediated at the SDS level, and supports DHSS efforts to recoup overpayments and sanction providers as needed to maintain the financial integrity of waiver programs.

Quality Improvement Workgroup (QIW). The QIW reviews and analyzes aggregated data collected through activities of Task Committees and determines if system changes are necessary to meet performance targets. The QIW drafts the CQI plan and performance measures, reviews findings and first level remediation activities, and determines the need for remediation. QIW meets monthly to develop plans of action that include a statement of the problems/risk to be corrected, desired results/changes, specific action steps, identification of person/s responsible, timeframe for completion of the corrective action plan, and plans for monitoring the effectiveness. Additional responsibilities include comparison of monthly, quarterly and annually aggregated data to identify trends or potential system changes and recommendations for system change activities.

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.

Within 90 days after receiving each audit report, the department begins administrative procedures to recoup overpayments identified in the audits. The department is required to allocate the reasonable and necessary financial and human resources to ensure prompt recovery of overpayments unless the attorney general has advised the commissioner in writing that a criminal investigation of an audited provider has been or is about to be undertaken. In these cases the commissioner holds the administrative procedure in abeyance until a final charging decision by the attorney general has been made. The commissioner provides copies of all audit reports to the attorney general so that the reports can be screened for the purpose of bringing criminal charges.

In addition, HCB service providers are expected to perform an internal evaluation including client satisfaction surveys, which are reviewed by SDS QA staff and considered when the agency seeks recertification.

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**

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☐ **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 functions.

QISC Committee Membership includes:
• •Deputy Commissioner for Family, Community and Integrated Services, Committee Chair
• •Deputy Commissioner for Medicaid and Health Care Policy
• •Director, SDS
• •Deputy Director, SDS
• Chief of Quality, SDS
• Chief of Programs, SDSState Medicaid Director
• Program Integrity Manager, Office of the Commissioner
• Medicaid Special Project Administrator and
• Additional division or department staff at the invitation of the committee.

Committee responsibilities:
• •Oversee the development and implementation of the Quality Improvement Strategy including the CQI Plan and the work of the Quality Improvement Workgroup (QIW);
• •Approve the CQI Plan;
• •Annually review and approve SDS's performance measures;
• •Review QIW reports and QIW recommendations and determine the need for systemic improvement;
• •Identify important areas for study by the QIW and make recommendations for incorporating knowledge gained to improve upon standards and practices;
• •Advocate for resources necessary to meet the purpose of the CQI plan;
• •Inform of and assist with DHSS-level activities to reduce duplication of effort and to streamline processes;
• •Advise Commissioner of DHSS on the status of quality improvement measures;
• •Evaluate the composition of the QISC; and
• •Coordinate efforts and exchange information with external stakeholders.

The QISC meets at least quarterly, according to the state fiscal year. The QISC may call meetings more frequently as needed.

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 Family, Community and Integrated Services, Committee Chair

• Deputy Commissioner for Medicaid and Health Care Policy
• Director, SDS
• Deputy Director, SDS
• Chief of Quality, SDS
• Chief of Programs, SDS
• State Medicaid Director
• Program Integrity Manager, Office of the Commissioner
• Medicaid Special Project Administrator, and
• Additional division or department staff at the invitation of the committee.

As the Committee Chair, the Deputy Commissioner for Family, Community and Integrated Services has the authority to make administrative/programmatic decisions in response to information received by the QISC and to report any findings, outcomes and/or corrective actions taken to the DHSS Commissioner. The QISC provides monitoring to the Quality Improvement Workgroup.

The Steering Committee may invite additional DHSS staff representatives as necessary to accomplish the work of the committee. This committee meets quarterly and more often if necessary to address concerns of SDS. They review the Quarterly Quality Improvement Steering Committee Report submitted by the Quality Improvement Workgroup (QIW). This report provides the status of performance measures, remediation efforts, system improvement efforts and action plans. The QISC reviews the reports, evaluates the results, approves the actions of the QIW and/or makes recommendations for augmenting remediation or system improvement efforts that were initiated at the program level by Unit Managers and monitors system improvement efforts.

The QISC is responsible for approving, implementing and monitoring the Quality Improvement Strategies. The QISC assumes responsibility for the proper implementation of SDS policies and procedures affecting the health, safety and welfare of waiver recipients and the provision of quality services to these recipients. The QISC monitors, recommends, and implements changes in the Quality Improvement Strategy to assure the health, safety and welfare of waiver recipients and improve the quality of services provided to recipients. The QISC reviews and approves the development of Performance Measures and reviews data collection processes to ensure that useful information is gathered to improve quality of service delivery and to assure the health, safety and welfare of waiver recipients. The QISC identifies training, technical assistance or other activities based upon analysis of Quality Improvement Workgroup data or other available information sources. The QISC ensures that information obtained from analysis of Performance Measures data is disseminated, as appropriate, to stakeholders and staff. The QISC interfaces with the DHSS Audit Committee to participate in implementation of financial accountability monitoring.

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.

For Single audit act of 1984 and the US OMB A-133 audit requirements, these audits are conducted every year through the single state audits performed by the Division of Legislative Audit for the state's financial statements and a

contractor (currently BDO) for the federal program requirements. Prior to SFY15, The Division of Legislative Audit performed both components of the single state audit. These audits include all of the department's federal programs. These audits are posted online and via this link:
http://legaudit.akleg.gov/docs/audits/single/statewide/40016rpt-2016%20(2).pdf

Within 90 days after receiving each audit report, the department begins administrative procedures to recoup overpayments identified in the audits. The department is required to allocate the reasonable and necessary financial and human resources to ensure prompt recovery of overpayments unless the attorney general has advised the commissioner in writing that a criminal investigation of an audited provider has been or is about to be undertaken. In these cases the commissioner holds the administrative procedure in abeyance until a final charging decision by the attorney general has been made. The commissioner provides copies of all audit reports to the attorney general so that the reports can be screened for the purpose of bringing criminal charges.

In addition, HCB service providers are expected to perform an internal evaluation including client satisfaction surveys, which are reviewed by SDS QA staff and considered when the agency seeks recertification.

Additional Detail:
Desk Procedures: Desk procedures are performed at the auditor's location, onsite procedures are conducted at the agency's location. All audits start as Desk Reviews. Approximately 33% of audits then move on to an on-site review based on the results of the desk review. Providers are selected for on-site review based on the results of the desk review. A Contract Audit Sample Selection Methodology is used, and an excerpt of that is provided here:

"Sample Selection Methodology

The methodology used in sample selection process took into consideration a variety of goals:
• Use of risk-based selection protocols such that desk reviews and field examinations are focused on providers with a higher risk for Medicaid overpayments.
• Geographic diversity.
• Provider-type diversity.
• Primary focus on providers with higher levels of Medicaid payments.
• Some element of randomness.

To some degree, these goals complemented one another, but in other ways they worked to produce opposing outcomes. For example, a strict focus on selecting providers with higher levels of Medicaid payments may work against the goal to have provider type and geographic diversity in the sample. The sample selection methodology used represents an attempt to blend these goals. For all providers, a matrix of risk factors was constructed. These risk factors were the result of various mathematical algorithms used to quantify a particular attribute of the provider that was relevant to an assessment of Medicaid overpayment risk. These risk factors were combined into a composite risk score assigned to each provider. This risk score, adjusted by a mathematical formula, was used to determine the probability that a provider had of being randomly selected into the sample. A higher risk score mean increased probability for selection into the sample. Risk factors were either general to all providers, or, in some cases, specific to certain provider types. The assessment of a risk factor is not an assertion that any claims of the selected providers are in error or fraudulent, but is rather a tool to help focus desk reviews and on-site field examinations on an optimal set of Medicaid providers."

Scope of Review: The scope of review is the providers' universe of Medicaid claims for a one year period. A statistically valid random sample is chosen from the universe of claims. Documentation supporting the paid claims is requested from the provider for desk review testing procedures. The following details are taken from the Agreed Upon Procedures (AUP) for on-site reviews:

Complete Claims Documentation Testing, Medicaid Payment Testing and Service Limits Testing work papers and attempt to resolve any issues from the desk review claims review process. If claims documentation testing during the desk review indicates any special concerns, consider the need for an expanded and targeted sample of claims for review.

a. Verify that providers followed proper Medicaid policies to bill other third party payers. Review other Medicaid claims for the recipient, the recipient eligibility file and the Medicaid recipient documentation for indicators of other third party coverage.

b. Review the provider's billed charges for sampled claims. Perform testing of the provider's usual and customary charges.

c. Review provider accounts receivable records for selected claims. Review credit balances or other indicators of payments received in excess of Medicaid allowed amounts.

Corrective Action Plans: Not all audit reports result in overpayments. Corrective actions plans are requested of agencies, depending on the audit findings.

Selection of Claims Samples: A statistically valid random sample of claims is drawn from the universe of claims submitted to Alaska Medicaid by the Provider, using a Sampling Extrapolation Procedures document. An explanatory excerpt follows:

"A. Sampling Procedures
After a provider is selected for a desk review or on-site audit, a random sample of claims is selected for review. Sample claim selection should be done according to statistically valid procedures.

1) Determination of the Universe Population
Prior to sample selection, the universe of claims from which claims are to be sampled should be clearly defined. Providers are typically selected by their "billing provider number". The universe of claims should be consistently defined in terms of the same provider identifier. The time period of the claim universe should be clearly defined. Claim time frames are typically defined in terms of claims with dates of services within a specified time interval. Any other restrictions on the universe definition should be determined and documented. Other restrictions typically include limiting the universe to non-zero paid claims (i.e., to exclude denied claims, "zero-paid" claims, and all claim reversals and adjustments) The sampling unit should also be clearly defined.

Typically, the sampling unit will be a claim at the "header" level (under current Alaska MMIS data definitions, this implies claims that have the same 11 digit root for the claim control number). Selection at the header level implies that all line items associated with the "header" level claim are included in the selection of one header claim. If alternate sampling units are used, the sampling unit should be clearly documented and universe definitions, sample size determinations and sampling protocols should consistently use the same sampling unit definition. At this stage of the sampling process, the potential for stratified sampling should be considered when specialized circumstances exist. If stratified sampling techniques are used, the sampling strata should have a rational basis and the sub-set of the universe for each strata should be clearly defined.

2) Sample Size Determination
The statistical formula that is used to determine appropriate sample size is:

N= Zs2
---
r

where n is the minimum sample size, s is the sample standard deviation (a measure of variability), and r is the acceptable range for the sample mean around the true mean. Z represents the standard normal statistic chosen to represent the desired confidence level.

3) Selection of Claims
Claim selection must be performed according to statistically valid principles. The predetermined number of claims are selected from the clearly defined universe of claims (or strata, if applicable). Selection should be performed using computer algorithms with appropriate random number generation. Random numbers used in the claims selection process and seed numbers used for random number generation should be documented. Selected claims are assigned a reference number for further tracking procedures throughout the remainder of the review process."

The computerized analysis is performed on the universe of claims submitted by the agency for they calendar year, not just the random sample of claims used in detail testing.

A. Implement computer algorithms to test for duplicate billings. Note exceptions.
B. As applicable to provider type, implement computer algorithms to test for improper unbundled billings, split billings, inappropriate use of "junk" codes and inappropriate overlap with inpatient hospital stays. Note exceptions.
C. As applicable to provider type and service type, implement computer algorithms to test for provider billings in excess of 24 hours per day. Note exceptions.
D. Verify that reimbursed services were provided to recipients who were Medicaid eligible at the time that services

were rendered. Compare dates of service in the Medicaid claim with the eligibility dates in the recipient eligibility file. Note exceptions.

E. As appropriate, review exceptions from the computerized analysis with the provider and/or the Department of Health and Social Services (and possibly with the Department's fiscal agent). Review feedback and other comments relating to noted exceptions."

Procedures for Suspected Fraud Activity: The Contractor informs the Medicaid Program Integrity (PI) Section within the DHSS. Documentation is reviewed by PI and a meeting is scheduled with the Medicaid Fraud Control unit and the Division of Senior and Disabilities Services to discuss the case. A determination is made on how to proceed based on the outcome of the meeting.

Role of Families in Audits: If the family member is also a care provider, they may be interviewed as part of on-site procedures.

Periodic Independent Audit: As stated above, for Single audit act of 1984 and the US OMB A-133 audit requirements, these audits are conducted every year through the single state audits performed by the Division of Legislative Audit for the state's financial statements and a contractor (currently BDO) for the federal program requirements. Prior to SFY15, The Division of Legislative Audit performed both components of the single state audit. These audits include all of the department's federal programs. These audits are posted online and via this link: http://legaudit.akleg.gov/docs/audits/single/statewide/40016rpt-2016%20(2).pdf

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. *(For waiver actions submitted before June 1, 2014, this assurance read "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. **Sub-Assurances:**

a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
FA 25: # and % of claims that were coded and paid correctly. Numerator: # of claims that were not identified as overpayments within the reporting period. Denominator: Sample of waiver claims paid within the reporting period, including care coordination services.

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 = 95%, +/- 5% and 50% distribution
☐ **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:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
FA 26: # and % of claims for services that were prior authorized. Numerator: # of paid claims that were prior authorized. Denominator: Sample of waiver claims paid within the reporting period, excluding care coordination services (because prior authorization is not required).

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 = 95%, +/- 5% and 50% distribution
☐ **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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

Performance Measures

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

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

Performance Measure:
FA 27: # and % of rates that are consistent with the approved rate methodology. Numerator: # of claims that were priced and paid correctly as defined in the approved rate methodology. Denominator: # of claims selected in the random sample.

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 = 95%, +/- 5% and 50% distribution

☐ **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 "Financial Accountability" Task Committee is comprised of Managers of the PCA Unit, Chair, QA Provider Unit, OIU Manager, Policy and Program Development 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.

Discovery is the responsibility of the Financial Accountability Task Committee Manager who reviews, or directs Unit staff in the review of data found in the SDS management information system, DS3, and in the state's MMIS system. Additional methods of discovery include review of complaints from providers, participants or their representatives, and other state agencies, as well as provider onsite visits including document reviews and participant and provider staff interviews.

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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.

When the data reveals a possible overpayment, the Unit Manager analyzes the data to discover if the problem involves individual provider billing practices or systemic problems in the MMIS. For provider billing issues such as automatic rebilling, the Unit Manager works with the provider to seek recovery and refer to provider billing training. If the provider does not cooperate with SDS' attempt to seek a refund or demonstrate billing practices improvements, the overpayments are referred to the DHSS Program Integrity Unit. Systemic problems regarding the MMIS are brought to the Financial Accountability Task Committee for analysis and development of recommendations to the Quality Improvement Workgroup. If remediation involves amendments to SDS regulations or policy and procedure improvements, responsibility falls to the Chair of the Policy Task Committee who facilitates changes through the State of Alaska regulation development process or the SDS policy and procedure development process as appropriate.

ii. Remediation Data Aggregation

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

Responsible Party*(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).

The department's Office of Rate Review is responsible for setting and reviewing Medicaid rates for home and community-based (HCB) waiver services.

The public has regular opportunity to participate in and comment on the ratesetting process. The department has worked very closely with the public to design the rate methods described in this waiver. This process includes:

• Numerous publicly noticed work sessions and webinars on all aspects of the methods described in this Waiver
• Numerous meetings with provider trade associations that represent both providers and recipients that live and work throughout the entire state of Alaska, including:
o Alaska Association on Developmental Disabilities
o Community Care Coalition
o AgeNet
o Assisted Living Association of Alaska
o Governor's Council on Disabilities and Special Education
o Alaska Mental Health Trust
o Alaska PCA Association
o Alaska Care Coordination Network
• Regular updates with the public through the department's E-Alert system
• Making information available on the department's website, including rate charts, policy documents, and regulations

Medicaid reimbursement rates for home and community-based waiver services are rebased at least every four years, and are annually adjusted for inflation in non-rebase years. The inflation factor is determined using the CMS Home Health Agency Market Basket in Global Insight's Healthcare Cost Review. Enhanced care coordination is not subject to inflation.

Reimbursement rates are set using provider cost reports. Providers report their costs in cost centers for: general service costs, non-covered costs, waiver services direct care costs (separate cost centers for each service) and non-waiver direct care costs. Non-covered costs include bad debt, fines, penalties, lobbying, fund raising, donations, entertainment, contingency funds, grant costs, certain marketing, and certain legal fees. Costs from the non-waiver direct care costs are not included in the rates because they are costs for services that are not reimbursed through HCB waiver services such a behavioral health, federally qualified health center services, etc.

All direct care costs, excluding room and board costs for residential services, and the applicable general service costs are included in rate setting after being geographically adjusted. The costs for each cost center after overhead has been allocated are inflated to the midpoint of the proposed rate year and are divided by units of service to arrive at raw rates. The applicable general service costs are allocated to each cost center based on a percentage that is determined by the following formula:

[cost center's costs - building & maintenance costs] / [total costs - building & maintenance costs].

Additionally, to protect providers and recipients of HCB waiver services from dramatic rate swings when rates are reestablished, reestablished rates or aggregate costs cannot increase or decrease more than 5%. The raw rates are converted into final rates after final adjustment from a comparison to the rates in effect during the state fiscal year preceding the effective date of the new, rebased rates.

Since rate increases or decreases cannot exceed + or - 5% (and aggregate increases or decreases for certain services) during rebasing, inflation adjustments in the non-rebase years following the rebasing and prior to the next rebasing are modified to allow the capped rates to gradually self-correct. Modified inflation adjustments only apply to the non-rebase years that follow the adjustment. The process starts over in the next rebasing.

During non-rebase years, the State will modify inflation adjustments so that reduced inflation adjustments are provided to codes where reductions over 5% were capped during the most recent rebasing. During non-rebase years, the State will also use the estimated savings realized from paying reduced inflation adjustments in place of full inflation adjustments to provide enhanced inflation adjustments to codes where increases over 5% were capped during the most recent rebasing. The enhanced adjustments will be, in aggregate, no more than the lesser of the estimated savings realized from reduced inflation adjustments provided that year or the amount necessary to offset the rate increases that were capped. Again, modified inflation adjustments—both reduced inflation and enhanced inflation—only apply to the non-rebase years that follow the application of the adjustment. The process starts over in the next rebasing.

For residential supported living services, Medicaid rates will be acuity-based and set using Medicare Cost Reports from the nursing facilities operating in Anchorage, Alaska that are not predominately dedicated to providing transitional care services. This methodology relies on the cost reports to derive direct service wages, direct service fringe benefits, and overhead for a rate calculation that produces four tiers of acuity-based rates. To ensure that Medicaid is not reimbursing room and board for residential supported living services, this methodology specifically excludes room and board expenses in its calculation of overhead.

Starting July 1, 2016, the department will establish new rates for care coordination services in order to comply with the federal "conflict free" rules that took effect March 17, 2014. The department will use a method that results in two rates for care coordination: one for "basic" care coordination, and one for "enhanced" care coordination. The enhanced rate will be used during a time-limited study designed to determine best practice for the delivery of person-centered, conflict-free care coordination. Providers who meet additional criteria will enter into a contractual agreement with SDS. The additional criteria include 1) having an established employer/employee relationship, with direct lines of qualified supervision and training, 2) not having a rural exception to conflict-free status, 3) having dedicated personnel to perform quality oversight measures, 4) not exceeding a caseload of 25 recipients per care coordinator, 5) serving all four waiver types, unless case by case exceptions are agreed upon by SDS, 6) serving at least one rural census area, 7) building capacity by having recruitment, retention, and replacement plans for each service area, and 8) agreeing to quarterly monitoring of targets for delivery outcomes, and annual cost reporting, as specified in the contractual agreement.

The methodology to set care coordination rates establishes wages, fringe benefits, program support costs, administrative and general costs and caseload size using public sources such as the Alaska Bureau of Labor Statistics, the Internal Revenue Services, and other states' approved 1915(c) waivers. Hourly wage costs for the 'basic' and 'enhanced' care coordination are the same. The fringe benefits factor for the 'enhanced' care coordination is greater to account for the fact that worker's compensation, federal unemployment insurance, and state unemployment insurance are required in an employer-employee relationship but are not required by independent care coordinators under the 'basic' model. In addition, as determined by the University of Anchorage Alaska Institute of Social and Economic Research, health insurance costs for employer health insurance were larger than the estimated costs for independent care coordinators who would receive health insurance under the Healthcare Exchange. Program support services, such as provider in-house supervision and training, are required under the 'enhanced' care coordination service and not under the 'basic' service. Therefore, no factor for program support was included in the 'basic service' while a factor was included for the 'enhanced' service. The administration factor for 'basic' and 'enhanced' care coordination is the same. The caseload size for 'basic' and 'enhanced' care coordination is the same.

The State pays 100 percent of billed charges to a HCB waiver services provider that oversees the purchase and installation of an Environmental Modification for a recipient. In addition, the department will pay the provider an

administrative fee of two percent of the billed charges or $100, whichever is greater.

The State pays the lesser of the provider's billed charges or the state maximum allowable for Specialized Medical Equipment. The state maximum allowable is listed in the Specialized Medical Equipment Fee Schedule and is determined by periodic reviews of the prevailing charges from various online vendors. The Specialist Medical Equipment Fee Schedule was last updated in January 2014.

The State pays the lesser of the provider's billed charges or $20 per 15 minutes of services provided by a registered nurse or advanced nurse practitioner, and $18.75 per 15 minutes of service provided by a licensed practical nurse, for the service of Specialized Private Duty Nursing.

As of January 1, 2018, the department will establish new rates for residential supported living services. The department will use a method to set rates that account for the acuity of the recipients receiving residential supported living services. There will be four acuity tiers and four corresponding rates. The rates will be based on a percentage of the average Anchorage long-term care facility rate. More specifically, allowable expenses will be identified in the Anchorage long-term care facilities' Medicare cost reports, and then applied and stepped down between the acuity tiers based on hours per patient day. Note, the final rates for each tier will not reimburse for room and board as all expenses related to room and board will be excluded from the rate calculations.

As of January 1, 2018, the department will establish new rates for all other HCB waiver services. The department will use a method that sets rates based on comprehensive cost surveys and financial audits from providers of the highest volume of Medicaid services in a given year. While reported costs from the high-volume providers is the most efficient starting point for establishing these rates, the costs will be adjusted upwards so that the final rates are accessible to all providers, large and small, in a manner that ensures that quality of care and services are available to Medicaid recipients to the extent that such care and services are available to the general public. Additionally, to protect providers and recipients of HCB Waiver services and personal care attendant services from dramatic rate swings when rates are reestablished, reestablished rates or aggregate costs cannot increase or decrease more than 5% from the rates or costs that are in effect at the time the rates are reestablished. Rates that are capped at 5% can self-correct on an annual basis through enhanced or reduced inflation adjustments, and every four years when the rates are again reestablished. Note, rates for residential services will not reimburse for room and board because the department will exclude from the rate calculations the amount the State pays for living expenses for adults on public assistance, which is derived from social security income standards.

At the same time that ORR's proposed rates are posted for public comment (Fall, 2017), SDS will post for public comment a waiver amendment using ORR's proposed rates in Appendix J-2.

While all rates for HCB waiver services are and will be reestablished at least every four years, the Department may increase the Medicaid reimbursement rate or rates if it finds by clear and convincing evidence that the rate or rates established do not allow for reasonable access to quality recipient care provided by efficiently and economically managed providers of services, and that increasing the reimbursement rate is in the public interest.

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:

The State's claim payment system is billed directly from fee-for-service providers. There are no other alternative arrangements. 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 Plan of Care. Based on this document, service authorizations are requested 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 service authorization and documents that the service was actually rendered on the date shown on the provider billing.

The HCB Agency requests reimbursement for service on an invoice that includes the service authorization number, number of units and total dollars.

MMIS checks to verify that the:
• recipient was eligible for service on the date of service,
• recipient was not admitted to a nursing facility or hospital on the date of service,
• provider certification was current,
• recipient's Medicaid number is correct to assure the right person received the service
• service authorization number is verified to ensure that there are units and dollars available on the service authorization, and
• none of the prohibited service limitations have been exceeded.

If any one of these conditions are not met, the bill is denied, or pended until the issue is resolved.

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.**
- [x] **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.

SDS will conduct a time-limited study on improving delivery of care coordination services through an enhanced fee-for-service payment rate. SDS will pay an enhanced care coordination rate to certified care coordination agencies that can meet additional requirements, as detailed in a provider agreement that serves as a payment contract. At the end of the two year period, or if the provider does not maintain compliance with the contractual agreement during the two year period, the payment for care coordination services will revert to the basic care coordination rate, unless SDS determines that the enhanced care coordination rate should be made permanent through rate-setting regulations and a waiver amendment.

The enhanced rate may be made permanent if it serves to build capacity for and improve quality in the delivery of person-centered conflict-free care coordination services. Final policy decisions on the structure of the service will be based on a qualitative and integrated process that includes SDS personnel, service recipients, providers in the study project, and other service providers.

As part of the waiver renewal process, the Office of Rate Review (the entity responsible for establishing Medicaid payment rates) analyzed potential cost implications of establishing conflict-free care coordination in Alaska. This analysis resulted in recommendations to maintain the existing rate structure for the “basic” care coordination service and to offer an enhanced rate for care coordination providers who agree to meet additional criteria.

The study will solicit interested agencies from the pool of certified care coordination agencies. Interested agencies will be advised that participation is voluntary. Agencies will be required to complete a provider agreement stating that that they meet the conditions of participation for the study and acknowledging that they may be removed from the study at any time for failure to adhere to the conditions of participation. Continued participation in the study will be assessed quarterly by a study committee established within the division of SDS. Should study participants fall below 85% compliance with the agreed upon expectations, they will be notified in writing that if their compliance continues to fall below 85% at the next quarterly reporting period, their participation in the study will cease effective the last day of that month.

Agencies applying to participate in the study must be in good standing as certified care coordination agencies at the time of application. In addition to meeting all conditions of participation, study participants must meet the following requirements for the study:

Organizational Structure
• Employer – employee relationship as defined by the Fair Labor Standards Act (FLSA) with two or more certified care coordinators. Subcontracting for care coordination services is not allowed
• Dedicated personnel for quality oversight of the conditions of participation for the study

• Established process for secondary review of plans of care and related documentation prior to submission to SDS. This process must be reviewed and approved of by Senior and Disabilities Services
• Demonstrated direct lines of qualified supervision and training for certified care coordinators

Capacity Building
• Staff development plans for all care coordinators to develop subject matter expertise in areas to include but not be limited to:
o Formalized person centered planning curriculum
o Techniques/curriculum in developing goals to address challenging behaviors
o Dementia Care
o Ethics and professional boundaries for home visits
• Recruitment, retention and replacement plans for each certified service area
• Demonstrate internal capacity to serve all four 1915(c) waiver types
• Mandatory quarterly study assessment meetings with SDS and other study participants to identify person centered and conflict free care coordination best practices

Service delivery
• Caseloads limited to 25 service recipients per care coordinator
• Serve all waiver recipients requesting their services in the service area unless caseload size is at capacity , conflict or safety concerns are documented

Reporting – Quarterly
The designated quality oversight personnel must develop a system to monitor care coordination delivery outcomes. At a minimum, the provider must determine whether:
o care coordinators had sufficient time to ensure that waiver services were delivered and acceptable to the recipient in protecting the recipient's health, safety, and welfare.
o waiver services assisted the recipient in goal attainment
o % of plans of care submitted on time and complete
o # and type of staff learning objectives met
o retention rate of care coordinators
o % growth in number of certified care coordinators

Settings Review
The provider will complete and submit to SDS one settings assessment tool per year for each of the following settings serving their care coordination recipients:
• Group home
• Family habilitation home
• Adult day program
• Facility based day habilitation
• Supported employment
• Residential Supported Living – Assisted Living Home

Cost reporting
Submit annual cost survey data to the Office of Rate Review

Consumer satisfaction
Coordinate annual 3rd party consumer satisfaction survey of recipient with results sent directly to SDS

The source of the non-Federal for the enhanced payment rate during the two year study period will be the same as the State's source of non-Federal share of computable waiver costs: Appropriation of State Tax Revenues to the State Medicaid Agency.

The State assures CMS that the enhanced care coordination payments made during the two year study period will be handled the same as the State's assurance in Appendix I -3-f: Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.

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:

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:

OHCDS arrangements are allowed when an environmental modification contractor does not wish to become enrolled and certified. The provision is rarely used but was left in as an option to ensure rural access. The State pays 100% of billed charges (subject to the service limitations for Environmental Modifications), and pays the OHCDS provider the administrative fee stated above.

In cases where an environmental modification provider is directly certified and enrolled, administrative fees are not billable.

The State pays 100 percent of billed charges to a HCBS waiver services provider that oversees the purchase and installation of an Environmental Modification for a recipient (subject to the service limitations). In addition, regulations at 7 AAC 130.300 (f) state that the department will pay an administrative fee under 7 AAC 145.520(e) to a home and community-based waiver services provider that is acting in an administrative capacity in providing the environmental modification services, if that provider
1) is an organized health care delivery system under 42 C.F.R.447.10;
2) oversees the purchase of an environmental modification for a recipient; and
3) upon completion of the environmental modification, verifies that the environmental modification is in

compliance with the applicable requirements of AS 18.60.705 (a), 8 AAC 70.025, 8 AAC 80.010, 13 AAC 50, 13 AAC 55, and any similar municipal codes.

Care coordinators are responsible for ensuring that recipients have free choice of qualified providers for environmental modifications, through plan of care approval and amendments.

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.**
- ( ) **This waiver is a part of a concurrent □1115/□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 □1115 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*:

- [x] **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-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d 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	41048.89	52920.14	93969.03	159843.65	6748.01	166591.66	72622.63
2	42056.21	54190.22	96246.43	163360.21	6909.96	170270.17	74023.74
3	43035.18	55490.79	98525.97	166954.14	7075.80	174029.94	75503.97
4	44030.22	56822.57	100852.79	170627.13	7245.62	177872.75	77019.96
5	45094.10	58186.31	103280.41	174380.93	7419.51	181800.44	78520.03

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 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	296	296
Year 2	305	305
Year 3	314	314
Year 4	324	324
Year 5	334	334

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 FY15 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 FY15. Estimates based on an average length of stay of 312 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:

FY2015 average CCMC waiver cost per participant was utilized as the starting point. A 2.6% increase was applied for the first year with a 2.4% each subsequent year to reflect inflation together with the effect of increase in waiver participants at 3.1% each year (average growth of this waiver for the last 9 years).

Inflation Rates: The State provides as evidence for using a 2.4% inflation rate annually the CMS Home Health Agency Market Basket contained in the most recent quarterly publication of IHS Global Insight's Healthcare Cost Review, which is available 60 days before July 1. Three HIS Global Insights Market Baskets books were used as evidence of continued inflation at the 2.4% rate: Q4 of 2008, on page 59/96, shows 3.1 - 3.5% inflation during 2006-2008; Q1 of 2012, on page 54/78, indicates 2.4 - 2.9% inflation during 2013-2014; and more recently, Q1 of 2016, on page 61/90, indicates 2.1 - 2.9% inflation.

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:

FY2015 average cost for Medicaid non-waiver services per ALI waiver participant was utilized as the starting point. A 2.4% increase was applied for each subsequent year to reflect inflation.

Prescribed Drugs: The SDS Research and Analysis Unit set up the MMIS query to estimate factor D'. The query for the calculation of D' was set up to exclude the costs of prescribed drugs by excluding the claims with the category of services and procedure codes designated as prescribed drugs. In this manner, only non-waiver claims (excluding prescribed drugs) were utilized in D' calculation and estimates.

The State confirms that WY1 Factor D' numbers are based on FY2015 average cost for Medicaid non-waiver services (not data reported in the FY14 372s). The following table presents FY2015 average cost data for each waiver:

Waiver	FY2015 Medicaid non-waiver claims data retrieved from MMIS	D' in WY1
0260 (IDD)	$11,377.38	$11,930.05
0261 (ALI)	$22,663.26	$23.714.15
0262 (APDD)	$42,547.69	$44,614.49
0263 (CCMC)	$50,468.58	$52,920.14

WY1 estimates for D' inflate the FY15 actuals by 2.4% for two years.

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 average cost of skilled nursing facility care and intermediate care nursing facility care. FY2015 average cost of nursing facility care was utilized as the starting point. A 2.2% increase was applied for each subsequent year to reflect the rate increase for these types of facilities.

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:

FY 2015 average cost for Medicaid non-nursing facility services per nursing facility service recipient was utilized as the starting point. A 2.4% increase was applied for each subsequent year to reflect inflation.

The State uses actual Medicaid claims data to estimate future Medicaid expenses for Factor G' and Factor D'. The forecasting of Factor D' (regular Medicaid expenses for waiver participants) being lower than G' (regular Medicaid expenses for the comparison institutionalized population) reflects that people who

remain in their homes and communities do not use as many regular medical services as people who reside institutions.

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	
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:						**986781.12**
Care Coordination	1 month	296	12.00	277.81	**986781.12**	
Day Habilitation Total:						**1599597.52**
Group Day Habilitation	15 minutes	13	856.00	8.29	**92251.12**	
Individual Day Habilitation	15 minutes	141	920.00	11.62	**1507346.40**	
Residential Habilitation Total:						**6928163.55**
Residential Habilitation	15 minutes				**5891870.88**	
				GRAND TOTAL:		**12150470.87**
				Total Estimated Unduplicated Participants:		**296**
				Factor D (Divide total by number of participants):		**41048.89**
				Average Length of Stay on the Waiver:		312

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		153	3297.00	11.68		
Residential Habilitation	daily	29	189.00	189.07	1036292.67	
Respite Total:						1537865.74
Respite	15 minutes	197	980.00	6.76	1305085.60	
Respite	daily	83	9.00	311.62	232780.14	
Supported Employment Total:						4646.90
Individual Supported Employment	15 minutes	1	330.00	12.73	4200.90	
Group Supported Employment	15 minutes	1	50.00	8.92	446.00	
Chore Total:						12533.04
Chore	15 minutes	4	507.00	6.18	12533.04	
Environmental Modifications Total:						161460.00
Environmental Modifications	Per project	16	3.00	3363.75	161460.00	
Meals Total:						1127.50
Meals	Per meal	1	50.00	22.55	1127.50	
Nursing Oversight and Care Management Total:						890299.92
Nursing Oversight and Care Management	15 min.	296	107.00	28.11	890299.92	
Specialized Medical Equipment Total:						15914.88
Specialized Medical Equipment	Per item	16	6.00	165.78	15914.88	
Transportation Total:						12080.70
Transportation	Per ride	3	155.00	25.98	12080.70	
				GRAND TOTAL:		12150470.87
				Total Estimated Unduplicated Participants:		296
				Factor D (Divide total by number of participants):		41048.89
				Average Length of Stay on the Waiver:		312

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:						**1041196.80**
Care Coordination	1 month	305	12.00	284.48	**1041196.80**	
Day Habilitation Total:						**1681936.72**
Group Day Habilitation	15 minutes	13	856.00	8.49	**94476.72**	
Individual Day Habilitation	15 minutes	145	920.00	11.90	**1587460.00**	
Residential Habilitation Total:						**7328043.66**
Residential Habilitation	15 minutes	158	3297.00	11.96	**6230274.96**	
Residential Habilitation	daily	30	189.00	193.61	**1097768.70**	
Respite Total:						**1623648.20**
Respite	15 minutes	203	980.00	6.92	**1376664.80**	
Respite	daily	86	9.00	319.10	**246983.40**	
Supported Employment Total:						**4759.70**
Individual Supported Employment	15 minutes	1	330.00	13.04	**4303.20**	
Group Supported Employment	15 minutes	1	50.00	9.13	**456.50**	
Chore Total:						**12837.24**
Chore	15 minutes	4	507.00	6.33	**12837.24**	
Environmental Modifications Total:						**165335.04**
Environmental Modifications	Per project	16	3.00	3444.48	**165335.04**	
Meals Total:						**1154.50**
Meals	Per meal	1	50.00	23.09	**1154.50**	
Nursing Oversight and Care Management Total:						**939561.65**
Nursing Oversight and Care Management	15 min.	305	107.00	28.79	**939561.65**	
			GRAND TOTAL:			**12827144.12**
			Total Estimated Unduplicated Participants:			**305**
			Factor D (Divide total by number of participants):			**42056.21**
			Average Length of Stay on the Waiver:			312

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Equipment Total:						**16296.96**
Specialized Medical Equipment	1 unit	16	6.00	169.76	**16296.96**	
Transportation Total:						**12373.65**
Transportation	Per ride	3	155.00	26.61	**12373.65**	
				GRAND TOTAL:		**12827144.12**
				Total Estimated Unduplicated Participants:		**305**
				Factor D (Divide total by number of participants):		**42056.21**
				Average Length of Stay on the Waiver:		312

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:						**1097656.08**
Care Coordination	1 month	314	12.00	291.31	**1097656.08**	
Day Habilitation Total:						**1773775.36**
Group Day Habilitation	15 minutes	14	856.00	8.69	**104140.96**	
Individual Day Habilitation	15 minutes	149	920.00	12.18	**1669634.40**	
Residential Habilitation Total:						**7707418.95**
Residential Habilitation	15 minutes	163	3297.00	12.25	**6583284.75**	
Residential Habilitation	per diem	30	189.00	198.26	**1124134.20**	
Respite Total:						**1710959.80**
Respite	daily	88	9.00	326.75	**258786.00**	
Respite	15 minutes	209	980.00	7.09	**1452173.80**	
				GRAND TOTAL:		**13513047.59**
				Total Estimated Unduplicated Participants:		**314**
				Factor D (Divide total by number of participants):		**43035.18**
				Average Length of Stay on the Waiver:		312

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Employment Total:						**4873.00**
Individual Supported Employment	15 minutes	1	330.00	13.35	**4405.50**	
Group Supported Employment	15 minutes	1	50.00	9.35	**467.50**	
Chore Total:						**16426.80**
Chore	15 minutes	5	507.00	6.48	**16426.80**	
Environmental Modifications Total:						**179884.65**
Environmental Modifications	Per project	17	3.00	3527.15	**179884.65**	
Meals Total:						**1182.00**
Meals	Per meal	1	50.00	23.64	**1182.00**	
Nursing Oversight and Care Management Total:						**990469.04**
Nursing Oversight and Care Management	15 min.	314	107.00	29.48	**990469.04**	
Specialized Medical Equipment Total:						**17730.66**
Specialized Medical Equipment	1 unit	17	6.00	173.83	**17730.66**	
Transportation Total:						**12671.25**
Transportation	Per ride	3	155.00	27.25	**12671.25**	
				GRAND TOTAL:		**13513047.59**
				Total Estimated Unduplicated Participants:		**314**
				Factor D (Divide total by number of participants):		**43035.18**
				Average Length of Stay on the Waiver:		312

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:						
				GRAND TOTAL:		**14265789.84**
				Total Estimated Unduplicated Participants:		**324**
				Factor D (Divide total by number of participants):		**44030.22**
				Average Length of Stay on the Waiver:		312

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
						1159790.40
Care Coordination	1 month	324	12.00	298.30	1159790.40	
Day Habilitation Total:						1874824.00
Group Day Habilitation	15 minutes	14	856.00	8.90	106657.60	
Individual Day Habilitation	15 minutes	154	920.00	12.48	1768166.40	
Residential Habilitation Total:						8135350.02
Residential Habilitation	per diem	31	189.00	203.02	1189494.18	
Residential Habilitation	15 minute	168	3297.00	12.54	6945855.84	
Respite Total:						1810834.20
Respite	daily	91	9.00	334.60	274037.40	
Respite	15 minute	216	980.00	7.26	1536796.80	
Supported Employment Total:						4990.10
Individual Supported Employment	15 minutes	1	330.00	13.67	4511.10	
Group Supported Employment	15 minutes	1	50.00	9.58	479.00	
Chore Total:						16832.40
Chore	15 minute	5	507.00	6.64	16832.40	
Environmental Modifications Total:						184201.80
Environmental Modifications	Per project	17	3.00	3611.80	184201.80	
Meals Total:						1210.50
Meals	per meal	1	50.00	24.21	1210.50	
Nursing Oversight and Care Management Total:						1046626.92
Nursing Oversight and Care Management	15 min.	324	107.00	30.19	1046626.92	
Specialized Medical Equipment Total:						18156.00
Specialized Medical Equipment	1 unit	17	6.00	178.00	18156.00	
Transportation Total:						

GRAND TOTAL:	14265789.84
Total Estimated Unduplicated Participants:	324
Factor D (Divide total by number of participants):	44030.22
Average Length of Stay on the Waiver:	312

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
						12973.50
Transportation	Per ride	3	155.00	27.90	12973.50	
			GRAND TOTAL:			14265789.84
			Total Estimated Unduplicated Participants:			324
			Factor D (Divide total by number of participants):			44030.22
			Average Length of Stay on the Waiver:			312

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:						1224283.68
Care Coordination	1 month	334	12.00	305.46	1224283.68	
Day Habilitation Total:						1978752.48
Group Day Habilitation	15 minutes	14	856.00	9.12	109294.08	
Individual Day Habilitation	15 minutes	159	920.00	12.78	1869458.40	
Residential Habilitation Total:						8586714.57
Residential Habilitation	per diem	32	189.00	207.89	1257318.72	
Residential Habilitation	15 minutes	173	3297.00	12.85	7329395.85	
Respite Total:						1906335.78
Respite	per diem	94	9.00	342.63	289864.98	
Respite	15 minute	222	980.00	7.43	1616470.80	
Supported Employment Total:						5110.50
Individual Supported Employment	15 minutes	1	330.00	14.00	4620.00	
					490.50	
			GRAND TOTAL:			15061428.30
			Total Estimated Unduplicated Participants:			334
			Factor D (Divide total by number of participants):			45094.10
			Average Length of Stay on the Waiver:			312

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Group Supported Employment	15 minutes	1	50.00	9.81		
Chore Total:						**17212.65**
Chore	15 minutes	5	507.00	6.79	**17212.65**	
Environmental Modifications Total:						**199717.92**
Environmental Modifications	Per project	18	3.00	3698.48	**199717.92**	
Meals Total:						**1239.50**
Meals	Per meal	1	50.00	24.79	**1239.50**	
Nursing Oversight and Care Management Total:						**1104661.58**
Nursing Oversight and Care Management	15 min.	334	107.00	30.91	**1104661.58**	
Specialized Medical Equipment Total:						**19686.24**
Specialized Medical Equipment	1 unit	18	6.00	182.28	**19686.24**	
Transportation Total:						**17713.40**
Transportation	Per ride	4	155.00	28.57	**17713.40**	
				GRAND TOTAL:		**15061428.30**
				Total Estimated Unduplicated Participants:		**334**
				Factor D (Divide total by number of participants):		**45094.10**
				Average Length of Stay on the Waiver:		312