

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:
People with Intellectual and Developmental Disabilities

C. Waiver Number:AK.0260
Original Base Waiver Number: AK.0260.90.R2

D. Amendment Number:AK.0260.R04.04

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

02/01/16

Approved Effective Date: 02/01/16

Approved Effective Date of Waiver being Amended: 07/01/11

2. Purpose(s) of Amendment

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

This amendment will decrease the number of individuals selected from the Developmental Disability Registration and Review (DDRR)(the "waiting list") for assessment for the IDD waiver from 20 per month to 50, spread evenly across the months between the period between the approval and effective date of this amendment and June 30, 2016. The purpose of this change is to control the total expenditure related to the IDD waiver for both the State of Alaska and the federal government, and to ensure that there is enough home and community based service provider capacity to serve all waiver recipients. The reason for this change is twofold: 1) the State of Alaska is facing a major budget deficit, and 2) allowing fewer individuals onto this waiver will better align the number of recipients with available workforce resources.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
<input checked="" type="checkbox"/> Waiver Application	Main 6-I Public Input

Component of the Approved Waiver	Subsection(s)
<input type="checkbox"/> Appendix A – Waiver Administration and Operation	
<input checked="" type="checkbox"/> Appendix B – Participant Access and Eligibility	B-3, B-6
<input type="checkbox"/> Appendix C – Participant Services	
<input type="checkbox"/> Appendix D – Participant Centered Service Planning and Delivery	
<input type="checkbox"/> Appendix E – Participant Direction of Services	
<input type="checkbox"/> Appendix F – Participant Rights	
<input type="checkbox"/> Appendix G – Participant Safeguards	
<input type="checkbox"/> Appendix H	
<input type="checkbox"/> Appendix I – Financial Accountability	
<input checked="" type="checkbox"/> Appendix J – Cost-Neutrality Demonstration	J-2

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

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

Specify:

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):

People with Intellectual and Developmental Disabilities

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.0260

Waiver Number: AK.0260.R04.04

Draft ID: AK.006.04.04

D. Type of Waiver (select only one):

Regular Waiver ▼

E. Proposed Effective Date of Waiver being Amended: 07/01/11

Approved Effective Date of Waiver being Amended: 07/01/11

1. Request Information (2 of 3)

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

Hospital

Select applicable level of care

Hospital as defined in 42 CFR §440.10

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

Inpatient psychiatric facility for individuals age 21 and under as provided in 42 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:

n/a

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 Eligibility 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 People with Intellectual and Developmental Disabilities waiver is to ensure that statewide, Medicaid-eligible individuals of any age with intellectual or developmental disabilities 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 these individuals who otherwise would reside in an ICF/MR for more than 30 days per year.

The objective of this waiver is to serve approximately 1,600 individuals per year with appropriate home and community-based services in the amount, duration and frequency that will allow the individual to live as independently as possible in the community.

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 a cadre of private, SDS-certified care coordinators who screen applicants, assist in completion of an initial application and deliver the application to SDS. SDS maintains a master list of certified care coordinators, located in most areas of the state, 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. Statewide.** 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:
The State has sought input on this waiver through a variety of methods:
- Meetings with state staff who manage the waiver program to collect ideas for improvements;
 - Teleconferenced "forums" for care coordinators and other waiver service providers who interact with participants and their families;
 - Presentations to the Governor's Council on Disabilities and Special Education, the statutorily-mandated advocacy board for individuals with intellectual and developmental disabilities;
 - All Federally Recognized Alaska Native Tribes have received information, in writing, on the impending waiver renewals, and
 - Presentations to the Alaska "Medicaid Task Force," the Tribal "Mega Meeting," and the Alaska Native Tribal Health

Consortium "Long Term Care Committee."

The public was invited to comment on the proposed amendment reducing the number of recipients added to the waiver from 20/month to 50/year via an August 18, 2015, E-Alert bulletin that explained the change and asked for comments to be sent by email. This bulletin also invited the public to attend a web-based community meeting on August 24th in order to learn about the amendment and to provide input. SDS issued another E-Alert on Sept 3 that contained the presentation materials used in the web-based community meeting. Additionally, on August 24, 2015, the Director met with upset members of the public who appeared at the SDS office, and answered questions about the change on a local television news program. As a result of these requests for comment and the media attention, 34 comments were received between August 18th and September 17th, 2015. All comments were reviewed and discussed by SDS staff. In response, the Director of SDS sent, to every person and agency that provided comment, a letter and corresponding FAQ that addressed the variety of concerns voiced. SDS also sought tribal consultation through a letter dated October 15, 2015 to all tribes, and received no tribal comments during the 60 day comment period. Finally, the public was notified of the proposed amendment and opportunity to comment via public notice on November 29, 2015 in the newspapers of Alaska's three largest cities; one comment was received from this non-electronic notice.

Summary of public comment: 1) Many commenters expressed concern that individuals currently on the waiver would no longer receive services; SDS provided a letter to each commenter which included frequently asked questions (FAQs), which ensured commenters that people would not lose their waiver due to the reduction in the amount of people drawn from the Registry each year, 2) Several comments were made regarding the length of time that an individual is on the Registry and the impact that has on families; SDS response contained in FAQs stated that individuals may remain on the Registry for an extended period of time because their need for expanded supports is not acute, and many of these individuals have very low scores and are receiving early intervention, school and/or grant-funded supports, or other community services, additionally SDS provided an extensive list of resources available to people while they are on the Registry (3) Multiple commenters voiced concern that the proposed reduction would result in more individuals being sent out-of-state for services; SDS responded through the FAQs, that there are many reasons why an individual may choose out-of-state treatment, even with access to waiver services, (4) A couple of the commenters had questions regarding whether or not a child receiving a CCMC waiver would get preference for the waiver; SDS' response through the FAQs was no, these individuals would need to apply for either the APDD waiver or the IDD waiver using the current policy of practice, (5) Most commenters stated that they wanted the budget cuts to be made somewhere else and expressed dismay that the State of Alaska had to make cuts to this program; SDS responded by stating that while all options were being explored, it is necessary to take immediate action on the Registry due to the factors listed above, as well as the need to grow quality provider capacity. A final comment from the Key Coalition (an advocacy coalition comprising many agencies representing people with developmental disabilities), suggesting that the amendment allow a range from 50 to 200 recipients to be drawn from the registry, depending on the state's fiscal situation; the state determined that this language would be too arbitrary to implement, even if approved by CMS.

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:

Etheridge

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Alaska**

Zip:

Phone: **Ext:** TTY

Fax:

E-mail:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Alaska**

Zip:

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:

Deb Etheridge

State Medicaid Director or Designee

Submission Date:

Jan 8, 2016

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

Last Name:

Sherwood

First Name:

Jon

Title:

Deputy Commissioner for Medicaid and Health Care Policy

Agency:

Department of Health and Social Services

Address:

PO Box 110601

Address 2:

City:

Juneau

State:

Alaska

Zip:

99811

Phone:

(907) 465-5830 Ext: TTY

Fax:

(907) 465-1170

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:

This amendment is necessary to control the total expenditures related to the IDD waiver for the State of Alaska, which has to significantly reduce its Medicaid budget. Slowing the rate that recipients are added to the IDD waiver will also help ensure that there is enough home and community based service provider capacity to serve all IDD waiver recipients. The highest scorers on the IDD Registry will be selected to be assessed for IDD waiver eligibility, filling 50 waiver slots evenly over the remainder of the waiver year. Those not selected for assessment and IDD waiver services will remain on the Registry for future consideration.

The State supports STAR (Short Term Assistance and Referral) programs that help families uncover resources if they are determined to have a child or adult who experiences a Developmental Disability. All individuals are made aware of the STAR programs as a resource when informed of the State's decision on the individual's request for a Determination of Developmental Disability (DDD). The State also includes a program brochure on available resources when sending the DDD letter; the brochures is attached to this email. The State's IDD webpage also contains helpful links to resources: <http://dhss.alaska.gov/dsds/Pages/dd/default.aspx>

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 its waiver when it submits the next amendment or renewal.

The state's process for bringing this waiver into compliance with federal HCB settings requirements began with an internal

review by the SDS Provider Certification and Compliance Unit (PCCU) to determine, through regular monitoring and compliance activities, which providers might not meet federal settings requirements. Through this review, SDS identified some locations that required additional scrutiny regarding their settings, and made in-person site visits to those locations. In addition, providers indicated through review of their own settings and completion of the Provider Self-Assessment of Settings Survey, that they did not meet the settings requirements. SDS is developing a process for a mandatory provider survey, validation of survey results, and development of remediation plans for providers who are found to be non-compliant with the settings requirements. This process will be detailed in Transition Plan Version #3, due to CMS in draft form by January 8, 2016. For settings that appear to isolate, SDS will offer additional details in Transition Plan Version #4 for CMS to consider using its heightened scrutiny process.

Amendment of state regulations and Conditions of Participation

Through its internal review of regulations and evaluation of home and community-based service settings, SDS has determined that amendments to regulations governing the waiver program and to provider standards in the SDS Conditions of Participation will bring the state into full compliance with federal regulations. In addition, SDS will require providers to implement remedial strategies for full compliance. SDS plans for the amendments to regulations and Conditions of Participation, as well as provider implementation of remedial strategies, to be complete by July 1, 2016, the date of reauthorization for Alaska's four waiver programs.

Beginning in January 2016, in collaboration with the Alaska Department of Law and with input from stakeholders, SDS will initiate a project to amend regulations and the Conditions of Participation governing the waiver programs.

Regulation changes will include the following:

- 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

Revisions to provider standards will be done through amendments to the SDS Conditions of Participation, and will encompass:

- Specifying that residential services providers must support recipient control of personal resources
- Clarifying that the settings where services are to be provided must be physically accessible for the individual recipient.

Activities to Achieve Provider Compliance

Provider training

SDS offers in-depth information regarding the home and community-based services program, certification requirements, and state regulations and policies. SDS will revise its Provider Certification Information webpage to emphasize the required characteristics of home and community-based settings. In addition, SDS will develop an orientation class specifically for program administrators that will train them on settings requirements, and will make it a requirement for certification.

SDS requires individuals who seek certification to provide care coordination services to enroll in a basic training course, and demonstrate comprehension of course content through examination. SDS will enhance this training to emphasize the characteristics of home and community-based settings so that care coordinators will be better able to evaluate the quality of care provided to recipients.

Provider certification process

SDS will broaden the scope of its on-going certification activities by including a review of home and community-based settings characteristics. Questions suggested in the CMS Toolkit will be added to the certification checklist that is used to evaluate a provider's capacity to offer services to recipients. After enactment of state regulations regarding settings, all applicants for initial certification and for recertification will be required to answer and submit a questionnaire, similar to the Provider Self-Assessment of Settings survey developed by SDS, that indicates compliance with those requirements. As part of the State on-going certification cycle, SDS will follow-up the technical assistance process with on-site visits to providers as needed. If providers are found during on-site visits to lack settings qualities, SDS will act in accordance with 7 AAC 130.220 which authorizes a formal remediation process and a decertification path for providers unable or unwilling to comply with regulations.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

n/a

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 and 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.

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 SDSA’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 SDSA’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	<input checked="" type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: n/a	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	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
<input type="checkbox"/> Aged or Disabled, or Both - General					
	<input type="checkbox"/>	Aged			<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)			
	<input type="checkbox"/>	Disabled (Other)			
<input type="checkbox"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input checked="" type="checkbox"/> Intellectual Disability or Developmental Disability, or Both					
	<input checked="" type="checkbox"/>	Autism	0		<input checked="" type="checkbox"/>
	<input checked="" type="checkbox"/>	Developmental Disability	0		<input checked="" type="checkbox"/>
	<input checked="" type="checkbox"/>	Intellectual Disability	0		<input checked="" type="checkbox"/>
<input type="checkbox"/> Mental Illness					
	<input type="checkbox"/>	Mental Illness			
	<input type="checkbox"/>	Serious Emotional Disturbance			

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

The target group of this waiver is people of any age, who experience intellectual or developmental disabilities and meet ICF/IID level of care.

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

- Not applicable. There is no maximum age limit**
- The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

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	1762
Year 2	1814
Year 3	1966
Year 4	2206
Year 5	2256

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:

To be eligible for IDD waiver selection, applicants must first complete the SDS Eligibility Determination and Request for Services application and be found to meet the state's definition of a person with a developmental disability (DD eligible). Alaska statute at AS 47.80.900 defines a person with a developmental disability as one who experiences a severe, chronic developmental or intellectual disability that is attributable to a mental or physical impairment or combination of mental and physical impairments that manifested before the person is age 22, is likely to continue indefinitely, and results in substantial functional limitation in three or more major life activities including self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency. In addition, the disability must reflect the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment or other services that are of lifelong or extended duration.

To complete the application, the applicant, assisted by a guardian or representative, provides a description of their physical and/or cognitive impairment and completes a functional self-assessment. In addition, the applicant submit any medical or psychological evaluations that support the statutory definition.

Once determined IDD, the individual, their family or legal representative then completes the SDS "Developmental Disabilities Registration and Review" form. The individual's score and circumstances, rather than their application date, establishes their priority for services. The form is scored with the highest score indicating greatest or most immediate need for services to lowest score indicating lesser need. All applicants are then placed on the State of Alaska "Developmental Disabilities Registry" and are eligible to receive limited home and community-based services through State-fund grants.

During the period between the approval (effective date) of this amendment and June 30, 2016, the end of Year 5 of this waiver, 50 individuals will be drawn from the Registry, spread evenly across the remaining months of the waiver year. The draw selects those with the highest IDD Registry score, which includes current circumstances, such as the imminent risk of substantial harm or significant regression, an unsafe or unhealthy living arrangement, risk of involvement with the Justice system, or a caregiver who no longer is able to continue in that capacity.

Those applicants drawn from the Registry will be assessed for eligibility for the IDD waiver using the "Inventory for Client and Agency Planning (ICAP)." The application and all documentation are reviewed by an SDS Qualified Mental Retardation Professional (QMRP) who makes the determination of whether an applicant meets the ICF/IID

level of care. SDS notifies the applicant of the SDS determination, and if found eligible for the IDD waiver provides a list of agencies certified by SDS to provide care coordination services. The care coordinator is then authorized to complete a Plan of Care.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

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 (TWWIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
 Working individuals with disabilities who buy into Medicaid (TWWIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
 Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
 Medically needy 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 Individuals Extended Medicaid due to increased child support.

Secs.407(b), 1902(a)(10)(A)(1) & 1905(m)(1) – Qualified family members

§435.116 Pregnant women.

§435.117 Newborn children.

§435.118 Infants and children under age 19.

Sec. 1902(a)(10)(A)(i)(IX) Former foster care

§435.119 Coverage for individuals age 19 or older and under age 65 at or below 133 percent FPL.

Mandatory Coverage of the Aged, Blind, and Disabled

§435.120 Individuals receiving SSI.

§435.121 Qualified blind and disabled under 65

Sec. 1634(c) Under 18 lost SSI eligibility due to OASDI

§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.

§435.139 Coverage for certain aliens for emergency medical services.

§435.145 Children for whom adoption assistance or foster care maintenance assistance payments are made under IV-E.

§435.170 Pregnant women eligible for extended coverage.

§435.210 Individuals who meet the income and resource requirements of the cash assistance programs.

§435.218 Individuals with MAGI-based income above 133 percent FPL.

§435.222 Individuals under age 21 who meet the income and resource requirements of AFDC.

§435.225 Individuals under age 19 who would be eligible for Medicaid if they were in a medical institution.

§435.227 Individuals under age 21 who are under State adoption assistance agreements.

§435.229 Optional targeted low-income children.

§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 the participant resides in a licensed assisted living facility
\$1396 if the participant resides in a licensed assisted living facility

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:

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

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

Other

Specify:

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

Select one:

Allowance is the same

Allowance is different.

Explanation of difference:

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

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

Not Applicable (see instructions)*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:

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 waiver eligibility require extensive professional experience in order to evaluate the functional capacity of an applicant and determine if the applicant requires a level of care available at an intermediate care facility for individuals with intellectual and developmental disabilities (ICF/IID). Known as "assessors", these individuals must have knowledge of all relevant state and federal regulations and policy around program eligibility. Because waiver assessments are functional in nature, an IDD waiver assessor must meet the criteria for a Qualified Intellectual Disabilities Professional (QIDP), as defined at 42 CFR 483.430(a)(1). Individuals performing initial evaluations do not provide any other direct home and community-based waiver services,

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

Applicants for the IDD waiver are drawn from those individuals who have been found by the state to experience a severe, chronic developmental or intellectual disability as defined by Alaska statute at AS 47.80.900. Once determined IDD, the individual, their family or legal representative then completes the SDS "Developmental Disabilities Registration and Review" form. The form is then scored with the highest score indicating greatest or most immediate need for services to lowest score indicating lesser need.

All applicants are then placed on the State of Alaska "Developmental Disabilities Registry" and are eligible to receive limited home and community-based services through State-fund grants. Between the effective date of the amendment and June 30, 2016, the names of 50 individuals will be drawn, spread evenly across the remaining months of waiver Year 5, to be assessed for eligibility for the IDD waiver.

The QIDP assessor begins the level of care process with a review of the application material including medical, developmental, and functional information records, and for reevaluations, the most recent level of care evaluation, plans of care and amendments.

SDS uses the "Inventory for Community and Agency Planning" (ICAP) for all level of care assessments. The assessor begins the ICAP assessment with interviews of three respondents. The respondents must be people who have known the applicant/participant for at least three months, sees him/her on a daily basis, and can provide information regarding the applicant/participant's current skills and behaviors. As necessary, the assessor collects additional information by contacting the care coordinator to request records related to condition of the applicant/participant, and/or others knowledgeable about the applicant/participant's condition. The assessor uses the information collected to complete the ICAP.

The ICAP assessment is scored by the ICAP Compuscore software that generates an "independence domain score". The determination of applicant ICF/IDD level of care is made by considering a combination of the ICAP score and the applicant's diagnosis and functional abilities as defined in criteria specified in 7 AAC 140.600 (c) and (d). These regulations state that the applicant must have either an intellectual or developmental disability that meets the diagnostic criteria as set out in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, and must have an intelligence quotient of 70 points or less as determined by an individual, standardized psychological evaluation, plus up to five points to account for any measurement error; a condition,

other than mental illness, psychiatric impairment, or a serious emotional or behavioral disturbance, that is found to be closely related to intellectual or developmental disability because the condition results in impairment of general intellectual functioning and adaptive behavior similar to that of individuals with intellectual or developmental disabilities; the condition must be diagnosed by a licensed physician and require treatment or services similar to those required for individuals with intellectual or developmental disabilities; cerebral palsy diagnosed by a licensed physician - a deficit in intellectual ability need not be present; seizure disorder that is diagnosed by a licensed physician, a deficit in intellectual ability need not be present; or autism that has been diagnosed by a mental health professional clinician and that meets the diagnostic criteria set out in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. Each condition must have originated before the age of 22 years, be likely to continue indefinitely, and constitute a substantial disability to the individual's ability to function in society.

Because the ICAP is not an appropriate tool to assess children under 36 months of age, SDS conducts an annual developmental review to determine if the participant continues to meet criteria for the ICF/IDD level of care. The developmental review includes a review of an evaluation completed as part of the Early Intervention/Infant Learning Program, an Individual Education Program or an evaluation that was completed within the previous 12 months, is age appropriate, standardized, norm-referenced and includes a comparison of applicant/participant skills attainment to that of peers in the following developmental areas or their equivalents: self-help, communication, learning, mobility and self-direction.

An applicant/participant three years of age and older must be diagnosed by a licensed psychologist, psychological associate, or developmental pediatrician as having a condition specified in 7 AAC 140.600 (c)(1) or determination by a school psychologist of eligibility for special education services, indicated in a diagnostic report, and specifying a category of Intellectual Disability, Cognitive Impairment, or Early Childhood Developmental Delay; and assessment with an individually-administered, standardized intelligence test of an IQ (intelligence quotient) of 70 or less (plus or minus 5 points allowed as a possible measurement error depending on the test used) or the following alternatives: when IQ cannot be measured due to the severity of impairment, a statement from the evaluator indicating IQ could not be assessed because of the degree of impairment; when IQ is not ascertained due to inability to test because of age; diagnosis of a syndrome or chromosomal abnormality likely to result in intellectual or developmental disability, and evidence of cognitive impairment demonstrated by a delay of at least 25%, or two standard deviations below the mean in comparison to peer norms, or a statement of clinical judgment of significantly below average intellectual functioning, on provider letterhead and signed and dated by a licensed psychologist, psychological associate, or developmental pediatrician.

For other intellectual or developmental-related conditions, documentation must include a diagnosis by a licensed physician, psychologist, psychological associate, school psychologist of a condition specified in 7 AAC 140.600(c) (2), and evidence of an cognitive impairment demonstrated by a delay of at least 25%, or two standard deviations, below the mean, in comparison to peer norms in at least three developmental areas or their equivalents (i.e., self-care, communication, learning, mobility, self-direction, and for those over age 16, independent living and economic self-sufficiency). For a diagnosis of Autism Spectrum Disorder, SDS requires two evaluations, with a consistent diagnostic conclusion, that were completed on separate occasions by different professional mental health clinicians; for Cerebral Palsy or Seizure Disorder, a diagnosis by a licensed physician, and for Autism, diagnosis by a licensed psychologist, child psychiatrist, or developmental pediatrician.

- 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:

The process used by SDS for level of care determination includes a review of documents verifying diagnosis, and for applicants or participants over the age of three, the results of an assessment using the Inventory for Client and Agency Planning (ICAP). The ICAP is used for initial determinations, then every three years or when a significant change in functioning occurs. During the years an ICAP is not conducted, an SDS QIDP conducts a developmental review that includes a diagnostic evaluation completed within the previous 12 months and completes the "Interim ICF/MR Level of Care Information" form. Neither individuals who perform the initial ICAP determination, the ICAP redeterminations, nor those who conduct the Interim ICF/MR Level of Care developmental review provide any other direct home and community-based direct waiver service.

Because the ICAP is not an appropriate tool to assess children under the age of three years, SDS conducts an annual developmental review including a diagnostic evaluation completed within the previous 12 months to determine whether the ICFMR level of care requirements are met.

Between the ages of 3 and 7 years, the ICAP is administered annually; thereafter, the ICAP is administered every three years, with the "Interim ICF/MR Level of Care Information" form completed in the intervening years.

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 Institutional 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, also a QIDP, conducts a quality control review (QC) of the reassessment tool and supportive documentation for scoring validity as well as consistency and completeness, and reviews any newly received documentation of the recipient's diagnosis or functional ability. The supervisor seeks additional clarifying information if needed.

After the QC review, the third step in the MIRP is a comprehensive review with a committee consisting of a minimum of 3 QIDPs. In preparation for this analysis, the QIDP 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. The QIDP then uses the "Material Improvement Reporting for IDD Waivers" form, adopted by reference into State regulations at 7 AAC 130.219(e)(4)(A)(ii and iii), focusing on the specific diagnostic or functional ability change since the recipient's qualifying assessment. The review committee analyzes all existing and new information, and develops a detailed narrative explanation of how the recipient's diagnosis or functional ability 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 QIDPs who independently review the qualifying and denial assessments and all accompanying documentation. The contractor

- 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 Manager of the SDS Research and Analysis Unit generates a report of upcoming IDD reassessment dates that the Manager of the IDD Unit reviews. No later than 60 days before the expiration of a participant’s level of care approval, IDD Unit staff notifies the care coordinator and the QMRP 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. The IDD Unit Manager is responsible for tracking adherence to these timelines, investigates individual cases of overdue reassessments and remediates problems daily.

- 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:

and % of participants who received initial LOC determination prior to receipt of waiver services. Numerator = Number of participants who received initial level

of care determination prior to receipt of waiver services within the reporting period. Denominator = Number of participants who entered the waiver 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 <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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.

Performance Measure:

and % participants receiving annual LOC within 12 mos. of initial determination or previous LOC determination. Numerator = # of participants who received annual LOC determination within 12 months of the initial or previous LOC determination and were due to receive LOC determination in reporting period. Denominator = # of parts. who were due to receive 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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:

and % of LOC determinations completed and applied by a QMRP correctly as identified in the approved waiver. Numerator = Number of participant who received a level of care determination by a QMRP in the reporting period. Denominator = Initial and annual level of care determination completed 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 <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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:

and % of initial and annual LOC determined using approved forms. Numerator = Number of participants who received a level of care determination using approved forms in the reporting period. Denominator = Number of participants who received a level of care determination in the reporting period

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

and % of initial and annual LOC determinations completed and applied by QMRP correctly as identified in the approved waiver. Numerator = Number of initial and annual level of care determinations applied correctly. Denominator = Number of initial and annual level of care determinations completed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify:	

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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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Quality Improvement Strategies are founded upon data-driven discovery activities. Task Committees (TC) have been developed to focus on specific areas of performance and to implement systems for data collection. The “Level of Care” Task Committee is comprised of Managers of the Nursing Facility Level of Care Unit (Co-Chair), IDD Unit (Co-Chair), Research and Analysis Team, Quality Assurance Unit, Policy and Program Development Unit and the Personal Care Assistance Unit. These managers are the first line of discovery and are charged with identification of Level of Care problems within the waiver program through monitoring and evaluation of established performance measure data.

Initial discovery is the responsibility of the Level of Care 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, which are reviewed, processed and addressed as they are received, participants or their representatives, and other state agencies. The Level of Care Committee prepares standardized monthly reports for the Quality Improvement Workgroup (QIW) based on the Level of Care 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.

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 (NFLOC) Waiver Unit” and the “Intellectual and Developmental Disabilities (IDD) Waiver Unit” are responsible for initiating remediation activities.

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

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 <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

- No**
- Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and
- ii. given the choice of either institutional or home and community-based services.

- a. **Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

After an applicant is found eligible for the waiver, the participant, and/or their legal representative, along with the participant's care coordinator, completes a waiver Plan of Care (POC) of feasible service alternatives under the waiver. Section IV of the POC "Participant Choice of Services" requires the participant or legal representative to initial a series of statements indicating that they understand the choices available – either receiving Medicaid-funded care in an institution, through Medicaid home and community-based services, only non-Medicaid services, or receiving no services at all. The section also outlines the assistance SDS and/or the participant's care coordinator will provide after a choice is made. Finally, the section requires the participant and/or their legal representative to indicate their choice. The POC is then signed by everyone involved in the planning effort. The "Participant Choice of Services" section of the POC is updated and reviewed with the participant at least annually.

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	Intensive Active Treatment		
Other Service	Meals		
Other Service	Nursing Oversight and Care Management		
Other Service	Specialized Medical Equipment		
Other Service	Specialized private duty nursing		
Other Service	Transportation		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Service:

Alternate Service Title (if any):

Care Coordination

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

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. 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. All care coordination services must be pre-authorized.

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	Care Coordinator
Agency	Certified care coordination agency

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" under 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 waiver 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 confidentiality 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: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Care Coordination

Provider Category:

Agency

Provider Type:

Certified care coordination agency

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 Coordination" under 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: 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:

04 Day Services 04020 day habilitation

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 such as sheltered workshop.

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: 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 at 7AAC 130.214, Provider certification and enrollment.

Other Standard (specify):

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 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 confidentiality 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.

A Program Administrator for a day habilitation 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: 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:

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	Residential Habilitation Provider
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:

Provider Type:

Residential Habilitation Provider

Provider Qualifications

License (specify):

n/a

Certificate (specify):

SDS Certified Residential Habilitation provider under 7AAC 130.214, Provider certification and enrollment.

Other Standard (specify):

SDS "Standards for Residential Habilitation" under 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 confidentiality 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.

A Program Administrator for a residential habilitation 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.

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 ALI 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 2 years

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Residential Habilitation

Provider Category:Agency **Provider Type:**

Assisted Living Home

Provider Qualifications**License** (*specify*):

State of Alaska Assisted Living Home License under statute at AS 47.33 and regulations at 7 AAC 75

Certificate (*specify*):

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

Other Standard (*specify*):

SDS "Standards for Residential Habilitation Services" under 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 confidentiality 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.

A Program Administrator for a residential habilitation 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.

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 ALI 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:

Certification: SDS Providers Quality Assurance Unit, Provider Certification Section

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

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 Foster Home License under AS 47.33 and regulations at 7 AAC 50, Community care licensing.

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, Office of Children’s Services

Frequency of Verification:

License: every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

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. Respite may be provided in the participant’s home or the private residence of the respite provider. Respite services may also be provided 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
- 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	General Acute Care Hospital
Individual	Foster Home
Agency	Skilled Nursing Facility
Agency	Assisted Living Home
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: Respite

Provider Category:

Agency

Provider Type:

General Acute Care Hospital

Provider Qualifications

License (specify):

State of Alaska license 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, Licensing and Certification Unit

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Individual

Provider Type:

Foster Home

Provider Qualifications

License (specify):

State of Alaska Foster Home License under AS 47.33 and Alaska regulations at 7 AAC 50, Community care licensing.

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, Office of Children's Services

Frequency of Verification:

License: Emergency – 90 days; Standard – two years

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Skilled Nursing Facility

Provider Qualifications

License (specify):

State of Alaska license 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, Licensing and Certification Unit

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Assisted Living Home

Provider Qualifications

License (specify):

State of Alaska Assisted Living Home License under statute at AS 47.33 and regulations at 7 AAC 75. Licensing of assisted living homes

Certificate (specify):

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

Other Standard (specify):

"SDS Standards for Respite Services" under 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 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 confidentiality 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.

A Program Administrator for a residential habilitation 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.

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 ALI 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: Senior and Disabilities Services

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

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" under 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 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 confidentiality 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.

A Program Administrator for a residential habilitation 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.

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 ALI 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 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:

Service:

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):

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

In addition, Supported Employment services assist those participants interested in self-employment with help identifying potential business opportunities, business planning including assistance with identifying potential sources of business financing and other assistance in developing and launching a business, identification of the supports that are necessary in order for the participant to operate the business, and ongoing assistance, counseling and guidance once the business is in operation.

Supportive Employment services are provided in an agency setting, in the participant’s home or in the community and in the participant’s work site. When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision, and training required by participants receiving waiver services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting.

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):

Additional standards for supported employment providers are currently being developed. Once developed those standards will 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. The recently released CMCS Informational Bulletin updating waiver instructions and the technical guide regarding employment and employment related services are also under review.

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:

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

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Chore

Provider Category:

Agency

Provider Type:

Certified home and community-based service agency

Provider Qualifications

License (specify):

n/a

Certificate (specify):

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

Other Standard (specify):

"SDS Standards for Chore Services" under 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 confidentiality 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.

A Program Administrator for a chore 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. 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 Unit

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:

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

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Tribal Housing Authority
Individual	Certified and bonded contractor
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:

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):

The Native American Housing Assistance and Self-Determination Act of 1996 (NAHASDA), 25 U.S.C. §§ 4101-4243 contains the requirements for being considered a Tribal Housing Authority. E-mod providers may not be an Medicaid excluded provider. E-mod providers also must adhere to applicable general provider standards such as reporting suspected abuse, neglect and exploitation of a vulnerable adult or child.

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:

Individual

Provider Type:

Certified and bonded contractor

Provider Qualifications

License (specify):

State of Alaska Contractor's License under AS 47.08

State of Alaska business license under AS 47.08

Certificate (specify):

n/a

Other Standard (specify):

Bonding requirements under AS 08.18.E-mod providers are required to have a current General contractor's license and maintain insurance and bonding eligibility as well as not be an Medicaid excluded provider. E-mod providers also must adhere to applicable general provider standards such as reporting suspected abuse, neglect and exploitation of a vulnerable adult or child.

Verification of Provider Qualifications

Entity Responsible for Verification:

AK 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:

Certified home and community-based service agency

Provider Qualifications

License (specify):

n/a

Certificate (specify):

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

Other Standard (specify):

n/a

Verification of Provider Qualifications

Entity Responsible for Verification:

SDS Provider Quality Assurance Unit, Provider Certification Section

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Intensive Active Treatment

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):

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

All IAT 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: Other Service
Service Name: Intensive Active Treatment

Provider Category:

Agency

Provider Type:

Certified home and community-based service agency

Provider Qualifications

License (specify):

Professional license or paraprofessional under AS.08

Certificate (specify):

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

Other Standard (specify):

n/a

Verification of Provider Qualifications

Entity Responsible for Verification:

License: AK Department of Commerce, Community and Economic Development, Division of Corporations, Business and Professional Licensing.

Certificate: 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 age 18 and older 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.

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 agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Meals

Provider Category:

Provider Type:

Certified home and community-based service agency

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” under 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 confidentiality 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.

A Program Administrator for a meal 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.

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

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	Certified Home and Community-Based Service agency
Agency	Private Duty Nursing Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Nursing Oversight and Care Management

Provider Category:

Agency

Provider Type:

Certified Home and Community-Based Service agency

Provider Qualifications

License (*specify*):

Nurse licensed under AS 08.

Certificate (*specify*):

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

Other Standard (*specify*):

n/a

Verification of Provider Qualifications

Entity Responsible for Verification:

Certification: SDS Providers Quality Assurance Unit, Provider Certification Section

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

Frequency of Verification:

every two years

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Nursing Oversight and Care Management

Provider Category:

Agency

Provider Type:

Private Duty Nursing Agency

Provider Qualifications

License (*specify*):

State of Alaska Licensing under AS 32

Certificate (*specify*):

Certification under 42 CFR 484

Other Standard (*specify*):

n/a

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialized Medical Equipment

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.

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

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.

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 and 7 AAC 12

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:

Business license: AK Department of Commerce, Community and Economic Development, Division of Corporations, Business and Professional Licensing

Medicaid enrollment: State Medicaid Agency provider enrollment section

Frequency of Verification:

Business license: Every two years

Medicaid enrollment: annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialized private duty nursing

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):

Services consist of individual and continuous care or part time or intermittent care provided by licensed nurses within the scope of the State’s Nurse Practice Act. The intermittent, part time care may offer assessment, monitoring and patient education. The nurse will develop a nursing plan of care, which supports the client’s waiver plan of care. These services are provided to an individual at home. Specialized Private Duty Nursing Services are tailored to the specific needs of a particular client and are necessary to prevent institutionalization.

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	Private Duty Nursing agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Specialized private duty nursing

Provider Category:

Agency

Provider Type:

Private Duty Nursing agency

Provider Qualifications

License (specify):

State of Alaska license and certification under AS 32.

Certificate (specify):

Certification under 42 CFR 484

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service ▼

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

Service Title:

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 under 42 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 Meal Services” under 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 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 confidentiality 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.

A Program Administrator for a transportation 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.

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 a 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.

(c) 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 unit, or, SDS can independently verify the background check information. In addition, applicants assure SDS by affidavit that they their employees and volunteers will comply with the background check requirement.

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

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

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Appendix C: Participant Services

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

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

- No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

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

Facility Type	
Licensed assisted living facility	
Licensed Foster Home	

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

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

In addition, regulations at 7AAC 75.260 call for “general environmental requirements” for licensed assisted living homes including reasonable privacy when sharing a room, minimum requirements for the size of a single and double occupancy bedroom, furniture that is typical for residents of homes in the community and neighborhood in which the assisted living home is located, including the resident’s own furniture, storage space for clothing and personal possessions, adequate linen, soap, and personal hygiene facilities necessary for cleanliness, and appropriate storage. If the assisted living home offers residents personal kitchens with cooking facilities there must be adequate room for food preparation and serving. If the home includes a congregate dining area, it must be maintained in a small, homelike setting that promotes relaxation and socialization. If the assisted living home does not offer personal kitchens with cooking facilities, residents have the opportunity to eat at regularly scheduled meal time, or, have the flexibility to eat a meal or a snack at a time they choose.

Finally, the SDS “Standards for Residential Supported Living” require providers to allow participants the opportunity to socialize, be outdoors, exercise, enjoy range of motion and participate in household activities as appropriate to the participant’s service needs, and to establish contact information for family and friends of the participant’s choosing and provide assistance and opportunity for contact and visits.

In Alaska, foster homes are defined as a residence in which the adult head of household provides 24-hour care on a continuing basis. Regulations at 7 AAC 50.430, Program in foster homes, promote a home and community character by requiring the foster parent provide a family structure and daily activities designed to promote the physical, social, intellectual, spiritual, and emotional development and good health habits of the child, and must treat the foster child equitably with the foster parent's own children. A foster parent must give the child an opportunity to learn responsibility for chores appropriate to the child's age, health, and ability. In addition, the foster parent must allow the foster child to bring and acquire personal belongings and must provide the foster child with the child's own clean, well fitting, attractive, seasonal clothing appropriate to age, sex, and individual needs and comparable in quality, quantity, and appearance to that worn by other children in the community. Foster homes do not restrict the number of children who may share a room, but arrangements must be similar to those for a family's own children.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Licensed assisted living facility

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Specialized private duty nursing	<input checked="" type="checkbox"/>
Day Habilitation	<input type="checkbox"/>
Supported Employment	<input type="checkbox"/>
Respite	<input checked="" type="checkbox"/>
Intensive Active Treatment	<input checked="" type="checkbox"/>
Specialized Medical Equipment	<input checked="" type="checkbox"/>
Environmental Modifications	<input type="checkbox"/>
Nursing Oversight and Care Management	<input type="checkbox"/>
Transportation	<input type="checkbox"/>
Care Coordination	<input checked="" type="checkbox"/>
Chore	<input type="checkbox"/>
Residential Habilitation	<input checked="" type="checkbox"/>
Meals	<input type="checkbox"/>

Facility Capacity Limit:

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

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

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

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

n/a

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Licensed Foster Home

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Specialized private duty nursing	<input type="checkbox"/>
Day Habilitation	<input type="checkbox"/>
Supported Employment	<input type="checkbox"/>
Respite	<input checked="" type="checkbox"/>
Intensive Active Treatment	<input checked="" type="checkbox"/>
Specialized Medical Equipment	<input checked="" type="checkbox"/>
Environmental Modifications	<input checked="" type="checkbox"/>
Nursing Oversight and Care Management	<input checked="" type="checkbox"/>
Transportation	<input type="checkbox"/>
Care Coordination	<input checked="" type="checkbox"/>
Chore	<input type="checkbox"/>
Residential Habilitation	<input checked="" type="checkbox"/>
Meals	<input type="checkbox"/>

Facility Capacity Limit:

six children

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

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

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

Appendix C: Participant Services

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

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

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

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

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.

Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

- The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

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

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

Payment may be made for any waiver services for which the relative/guardian is qualified to furnish, except for further restrictions on care coordination and residential supporting living (assisted living home) services. To protect against conflict of interest, regulations at 7AAC 130.240(e) 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 participants personal care assistant. Regulations at 7 AAC 130.320 prohibit the provision of residential supported living services to a participant when the care coordinator who prepared the plan of care has a close familial relationship. The state may waive this restriction if another care coordination agency provider is not reasonably available to serve the participant, or if the person rendering the care coordination services is not subject to supervision or control by the owner, administrator, or staff of the

residential supported living provider.

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 7 years and are subject to audit requirements.

- 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:

and % of providers who are certified prior to providing waiver services.
 Numerator = Number of providers who are certified prior to providing waiver services within the reporting period. Denominator = Number of providers within the reporting period.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MMIS error reports

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="text"/>	
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

and % of providers who continue to meet state certification requirements following initial certification. Numerator = Number of providers who who continue to meet state certification requirements following initial certification. Denominator = Number of providers within the reporting period.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MMIS error reports

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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:

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

Data Source (Select one):

Training verification records

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

and % of Care Coordinators in compliance with required SDS training.

Numerator = Number of care coordinators that are in compliance with required SDS training, and that are currently certified within the reporting period.

Denominator = Number of Waiver care coordinators that are currently certified within the reporting period.

Data Source (Select one):

Training verification records

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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 managers are the first line of discovery and are charged with identification of provider problems within the waiver program through

monitoring and evaluation of established performance measure data.

Initial discovery is the responsibility of the Qualified Providers Review 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, which are reviewed, processed and addressed as they are received, participants or their representatives, and other state agencies, as well as provider onsite visits that include document reviews and participant and provider staff interviews.

The Qualified Providers Review Committee prepares standardized monthly reports for the Quality Improvement Workgroup (QIW) based on the Level of Care 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.

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input type="checkbox"/>	
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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, HCBS Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

The State submitted its Statewide Transition Plan to CMS on March 17, 2015 and it is under review.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Plan of Care

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

- Registered nurse, licensed to practice in the State**
- Licensed practical or vocational nurse, acting within the scope of practice under State law**
- Licensed physician (M.D. or D.O)**
- Case Manager** (qualifications specified in Appendix C-1/C-3)
- Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

- Social Worker**
Specify qualifications:

- Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

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

Required, SDS-provided care coordinator training includes content regarding participant choice and conflict of interest. Topics include the six assurances of the Medicaid waiver program, highlighting service plan and stresses that each participant must be given the opportunity to choose providers and to convey his/her choice in the planning document. The training materials focus on the care coordinators responsibility to assist the participant in understanding his or her options in choice of service providers and states “The care coordinator role is to explain and facilitate understanding about options. Choice of service provision means that person chooses from all available providers (rather than one agency that provides multiple services). The participant must be offered choice of providers from all available to him/her. Informed choice is a foundational part of the HCB system.”

When developing the plan of care, a care coordinator must disclose to the participant and the participant’s planning team if he or she works for an agency that provides other home and community-based waiver services. The care coordinator, using the Participant Rights form, explains to the participant and planning team that they always have a choice of providers, and can request a different care coordinator or agency to develop the plan of care. The care coordinator is also required to give the participant and planning team a copy of the SDS Medicaid Waivers brochure that lists all the services available on the waiver, as well as a list of service providers in their city or region. In addition, when the participant chooses to receive services from the same agency that developed the plan of care, the care coordinator is required to administratively separate the plan development function from the direct services provision, and is prohibited from providing any other direct services on the service plan.

Alaska is a large and sparsely populated state. The two largest cities of Anchorage and Fairbanks have sufficient provider capacity to ensure participants choice in service providers. This is not the case in smaller cities, rural hub towns and village regions as a number of remote areas have only one or two service providers. This makes it difficult to ensure that participants in these areas are served by different agencies for care coordination and other home and community-based services. Nevertheless, care coordinators in remote regions are always prohibited from providing any other direct services on the service plan.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Regulations at 7 AAC 130.230(d) provide the participant the authority to decide who should be included in the POC development process. The care coordinator is responsible for alerting those individuals identified, and coordinating the meeting at a time convenient for all.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

By regulation at 7AAC 130.230, 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 of care identifies the provider responsible for providing each service to the participant.

By SDS policy, the POC must be submitted no later than 60-days after the determination of ICFMR LOC. 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 ICAP 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, IDD 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 telephonically or during the minimum once a month face-to-face contact and reported monthly to IDD staff.

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 ICFMR level of care. 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 ICFMR 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. 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, they are required to disclose this "conflict of interest" and ensure that the participant understands that they still have the right to choose a provider from other than the care coordinators agency.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Every POC is reviewed and signed by the participant or the participant's legal representative before being submitted to SDS for review. Each POC is reviewed by IDD 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:

HCBS Agencies providing services
 Completed plan of care is given to the recipient by the care coordinator

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.

- 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 and may work for agencies that provide 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:

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

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample

		Confidence Interval = 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

and % of participants reviewed who have documented personal goals identified in the POC. Numerator = Number of participants whose POCs had documented personal goals. Denominator = Number of participants reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review

<input checked="" type="checkbox"/> State Medicaid Agency		
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

and % of waiver participants reviewed whose POCs address health and safety factors. Numerator = Number of participants whose POCs addressed health and safety factors. Denominator = Number of participants reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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.

Performance Measure:

and % of completed POCs submitted to SDS within required regulatory timeframes (7 AAC 130.230 (h)) Numerator = Number of POCs submitted to SDS within the regulatory timeframes that were due for submissions within the reporting period. Denominator = Number of POCs due for submission to SDS within the regulatory timeframes (reporting period)

Data Source (Select one):

Provider performance monitoring

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

and % of POCs that were submitted on approved forms. Numerator = Number of POCs that were submitted on approved forms and submitted within the reporting period on approved forms. Denominator = Number of POCs that were submitted within the reporting period.

Data Source (Select one):

Provider performance monitoring

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

Performance Measure:

and % of POCs that include participant signature indicating participation in plan development. Numerator = Number of POCs reviewed that included participant signature indicating participation in plan development. Denominator = Number of participants reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%
<input type="checkbox"/> Other	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified

Specify: <input type="text"/>		Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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:

and % of POCs reviewed and updated as needed prior to annual redetermination date. Numerator = Number of POCs reviewed and updated as

needed prior to the annual redetermination date. Denominator = Number of POCs due for an annual redetermination within the reporting period.

Data Source (Select one):

Provider performance monitoring

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

Data Source (Select one):
Record reviews, on-site
 If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = + or - 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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:

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

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%

<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

and % of participants who received services as documented in the POC in the amount, duration and frequency described in the POC. Numerator = Number of participants reviewed who received services in the amount, duration and frequency described in the POC, and who were included in the case review sample. Denominator = Number of participants reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review

<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):
Financial records (including expenditures)
 If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

- 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:

and % of participant records with an appropriately completed freedom of choice form that specified choice was offered among waiver services. Numerator = Number of POCs that include evidence the participant received a choice in waiver services. Denominator = Number of participants reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review

<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

and % of participant records with documentation that participant received list of qualified providers and was provided choice of providers Numerator = # of POCs that included evidence that participant received list of providers and was provided choice in providers. Denominator = # of participants reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

and % of participant records with an appropriately completed and signed freedom of choice form that specified choice was offered between institutional care and HCB waiver services. Numerator = Number of POCs that included evidence the participant signed an affirmative statement of choice between institutional care and HCB waiver services. Demominator = Number of participants reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/>	
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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 “Case Record Review” Task Committee is comprised of Managers of the Quality Assurance Provider Unit (chair), Nursing Facility Level of Care Unit, IDD Unit, Operations Integrity Unit and the Research and Analysis Unit. These managers are the first line of discovery and are charged with identification of plan of care problems within the waiver program through monitoring and evaluation of established performance measure data.

Initial discovery is the responsibility of the Case Record Review 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, which are reviewed, processed and addressed as they are received, participants or their representatives, and other state agencies, as well as provider onsite visits that include document reviews and participant and provider staff interviews.

The Case Record Review Committee prepares standardized monthly reports for the Quality Improvement Workgroup (QIW) based on the plan of care 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 responsibility for a participant’s POC development and implementation. When discovery activities reveal that a POC has not been submitted in a timely fashion, or is inadequate to meet the participant’s needs identified in the LOC assessment or the changing needs of the participant, does not identify personal goals, is deficient in addressing health and safety factors or is unsigned, the Manager of the “Providers Quality Assurance Unit” (PQA) is responsible for remediation activities.

The PQA Manager identifies the care coordinator who submitted the POC and prepares a “report of findings” outlining POC deficiencies or lack of timeliness. The report must include a description of the evidence supporting the finding of deficiencies as well as the specific standard, policy, regulation, or statute that is 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 <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

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 than 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 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.

When a participant files for a fair hearing because the choice of home and community-based services is not offered, they are denied the service(s) of their choice or the provider(s) of their choice; or, when their services are denied, suspended, reduced or terminated, SDS offers the opportunity for a non-binding “alternative dispute resolution” (ADR) process. The purpose of the ADR process is to informally address the issues that led the participant to a request fair hearing, and devise creative solutions to quickly resolve those issues that can be resolved outside the fair hearing.

SDS operates the ADR process statewide. Requests for fair hearing are routed immediately to the Operations and Training Unit where a Fair Hearing Representative reviews the request and contacts the participant within 10 business days by telephone to schedule the ADR process by phone or in person, or, if the participant is amenable, conduct the ADR. The Fair Hearing Representative assures the participant that the ADR process is not a pre-requisite to or in lieu of a fair hearing; if the dispute cannot be resolved, the participant is still entitled to the fair hearing regardless of the outcome of the ADR. In addition, the Fair Hearing process continues while the ADR process is requested and attempted and does not interrupt the Fair Hearing process or timelines.

During the ADR process the Fair Hearing Representative asks the participant for background on the adverse action taken by the state, the reason for requesting a fair hearing, and what the participant anticipates as an acceptable outcome for the hearing. The Fair Hearing Representative probes for additional information, and answers program-related questions.

The desired outcome of the ADR is resolution of the dispute through discussion and understanding of the issues. If resolution is not achieved, the Fair Hearing Representative reminds the participant of the date of the scheduled fair hearing.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

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

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

The Division of Senior and Disabilities Services has developed 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 are reviewed by the Provider Quality Assurance Unit (QA). If the complaint involves a vulnerable adult QA staff forwards the complaint to the SDS Adult Protective Services Unit (APS) for investigation and disposition. If the complaint involves a provider of assisted living home services or a resident, QA staff refer the case to the Office of the Alaska Long Term Care Ombudsman. When referrals are made to another agency, the QA Unit places the case in monitoring status until a report is obtained from the other agency. If the case is not referred to another agency, the QA unit records the complaint in the Complaint System database and initiates an 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) within three business days QA distributes the complaint to the appropriate SDS program unit. Within 15 business days of receipt, the Unit staff investigate the complaint and reports its findings and resolution to the QA Unit. 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 program staff then review 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 SDS complaint 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 complaint review and 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. As part of continuous quality improvement, SDS is developing a process to inform the participant who lodged the complaint that he or she can request a copy of the written summary or report of findings.

Ongoing complaint process oversight is conducted by the SDS QA Unit and the system is monitored to assure all complaints, including provider related complaints, reach an outcome or resolution. The QA Unit reviews provider reports submitted for recertification, and complaints about providers as part of the overall provider review and monitoring process. The QA Unit also reviews and analyzes aggregated complaint data on a monthly basis and

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.

In addition to the SDS complaint system, all certified provider agencies are required to develop and implement policy and procedures for the handling and resolution of complaints and grievances. 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 are required to describe the methods in which complaints may be filed and processed and how outcomes are recorded. 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.

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 extent 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, APS refers the case to the Division of Health Care Services Certification and Licensing Unit for investigation. APS continues to monitor referrals and has staff that collaborates with Certification and Licensing by phone, in-person meetings and joint site visits throughout the investigation. All information received from Licensing is incorporated into the APS investigative file.

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 multiple reports on an assisted living home have been received or there are immediate risks to the health and safety of the participants. Licensing also informs APS of reports of harm received that indicate a participant might be vulnerable, but are not appropriate for Licensing and Certification Unit action.

Upon completion of investigation and disposition of the case, the Certification and Licensing Unit sends the official report to APS and to Services QA. The QA Unit maintains the information in the provider file, and if warranted initiates provider remediation activities. The report remains in the provider file indefinitely, and is considered as part of provider recertification. After the case has been screened, investigated or referred, APS forwards the Report of Harm or Critical Incident Report SDS to the QA Services Unit. 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 SDS Adult Protection Services Unit (APS) through the SDS-sponsored "Centralized Reporting" electronic portal. Within 24 hours or one business day of receipt, APS reviews the report of harm or CIR to determine if the report indicates risk for or suspected abuse, neglect, exploitation that require 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.

The timeline for APS investigations is based on criteria for overall risk:

HIGH: when overall assessment indicates a threat to life or a serious imminent threat to physical safety a face-to-face interview of the vulnerable adult is required within 24 hours;

MEDIUM: when the overall assessment indicates a moderate threat to physical safety, but no immediate danger of serious injury or illness, even if protective services are refused a face-to-face interview of the vulnerable adult is required within three calendar days;

LOW: when overall assessment 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 days;

Depending on the information gathered at the interview and mitigating circumstances, in SFY 2010 the average number of days for completing an investigation of substantiated cases was 169 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 OCS or the Certification and Licensing Unit for investigation, those agencies forward reports of investigation and case disposition to SDS. 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 participants, their families or legal guardians by mail when a case has been assigned to an APS investigator. The letter states that the report of harm, or critical incident report meets the criteria as set for APS, that a case has been opened, and outlines confidentiality requirements as prescribed in AS 47.24.505. At the conclusion of an investigation the investigator sends a second letter which states if the allegation(s) have been substantiated, not-substantiated, if the need for protective services no longer exists or the allegations wither substantiated, but the adult refused services. Due to confidentiality the letter does not describe what actions were/are being taken, nor how the determination was made.

- 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 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 of 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 and seclusion through care coordinator activities, plan of care processing, critical incident reporting management, and quality assurance reviews.

The SDS QA and APS units in cooperation with the DHSS Licensing and Certification Unit monitor the use of restraints 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.

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 seclusion. 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 development of the plan of care or when necessitated by the participant's challenging or dangerous behavior, the care coordinator may facilitate the discussion of the need for a positive behavioral support plan. After the planning team is convened and a plan developed by a licensed professional, the care coordinator incorporates the positive behavioral support plan into the POC. During each of the monthly face-to-face contacts the care coordinator reviews the behavior support plan and any use of restraints or seclusion with the participant, family and/or legal representative and documents the responses in the record of service. If restraints or seclusion have been used, the care coordinator discusses the event with the provider who used restraints or seclusion and verifies if use was for circumstances that presented imminent danger or as outlined in a behavior support plan. The care coordinator also submits an SDS Critical Incident Report when he/she believes that the use of restraints or seclusion was used in a manner not authorized in a behavioral support plan or in the "SDS Standards for the Use of Restraints and Restrictive Interventions."

During plan of care processing, if the use of restraints or seclusion is a contingency, the SDS IDD 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 IDD 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.

When the data reveals inappropriate use of restraints on an individual participant, staff in the SDS Provider QA Unit contact the provider to request a corrective action plan that may include training and technical assistance. QA staff monitor the plan until complete or until they assess a low risk of occurrence.

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, 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 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.

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. The provider must indicate the level of restraints allowed and provide training to all applicable caregivers on those specific levels of intervention. Providers are required to report to SDS restraints that rise to the level of a critical incident. In addition, providers will be required to document and evaluate at least quarterly all uses of restraint, and are required to report these evaluations and corrective actions taken at the time they renew their certification status and upon request of SDS.

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.

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

SDS permits the use of restrictive interventions when other types of intervention are ineffective and in two circumstances only: as a response when a participant presents an imminent danger to him or herself or another person’s safety, and as an element of a behavioral support plan. In either circumstance, the provider must consider the health and safety of the participant and the participant’s right to be free of restrictive interventions used for disciplinary purposes, staff convenience, or as a substitute for adequate staffing.

To ensure that restrictive interventions 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 restrictive intervention is inappropriate, prohibited practices are used, restrictive intervention is used in an emergency, or restrictive interventions results in the need for medical intervention. The provider must describe their policy and procedure for the use of restrictive interventions at application for both certification and licensure. 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 restrictive interventions.

SDS promotes the use of time-limited positive behavioral support plans that make use of the least restrictive methods needed to assist and manage behavior and eliminate the circumstances in which restrictive interventions 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, ; the behavior that required restrictive intervention 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, environments, 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 restrictive intervention when deemed necessary. The plan also includes a method for measuring and documenting the plan's effectiveness.

During development of the plan of care or when necessitated by the participant's challenging or dangerous behavior, the care coordinator may facilitate the discussion of the need for a positive behavioral support plan. After the planning team is convened and a plan developed by a licensed professional, the care coordinator incorporates the positive behavioral support plan into the POC. During each of the monthly face-to-face contacts the care coordinator reviews the behavior support plan and any use of restrictive intervention with the participant, family and/or legal representative and documents the responses in the record of service. If restrictive intervention has been used, the care coordinator discusses the event with the provider who used restrictive intervention and verifies if use was for circumstances that presented imminent danger or as outlined in a behavior support plan. The care coordinator also submits an SDS Critical Incident Report when he/she believes that the use of restrictive intervention was used in a manner not authorized in a behavioral support plan or in the "SDS Standards for the Use of Restraints and Restrictive Interventions."

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 has not worked to 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.

Allowable restrictive interventions in an approved behavioral support plan include interrupting or preventing a challenging or dangerous behavior that is physically harmful or that causes significant emotional or psychological stress to participant or others; interrupting or preventing a behavior that causes significant damage to the property of others; controlling food consumption for participants who have behavioral issues related to food (e.g. stealing food, running away to get food, being assaultive when denied certain food) when there is a long term threat to client's health as determined in writing by participant's physician or a short term threat exists (e.g. eating raw meat, uncontrolled water intake, etc.); physically moving a participant from an area for the protection of the participant or others; necessary supervision to prevent dangerous behavior; taking away of items that could be used as weapons when the participant has a history of making threats or inflicting harm with those items. (e.g., knives, matches); removing participant property that is being used to inflict injury on one's self, others or property.

Prohibited methods of restrictive intervention include corporal punishment; overcorrection where a participant is compelled to repeat an action repeatedly; forced compliance including exercise or physical work; humiliating or cruel actions; verbal abuse or ridicule; discipline of one recipient by another; denial of meals, sleep, clothing, or shelter; use of aversive techniques such as electric shock, spraying water on participant or using noxious substances; and denial of contact with family, legal representative or other supports.

Agency direct care workers who meet the following qualifications and have received the prescribed training may administer restrictive interventions. 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; 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 regarding appropriate safety, de-escalation and crisis management techniques as well as environmental factors and triggers to challenging behavior;

prohibitions on the use of restrictive intervention as a convenience for themselves or other staff; the risks of restrictive intervention, prohibited practices and the least restrictive methods to manage behavior appropriate to the population served by provider; proper application of restrictive intervention while considering gender, age, physical condition and negative effects; prohibition on the use of the restrictive intervention for which they have been not been trained. Direct service workers must be supervised by the Agency Administrator or their designee.

The provider agency must document the use of restrictive intervention implemented during the provision of services including the type of restrictive intervention used, the environment in which the restrictive intervention was used, the event or circumstances necessitating the use of restrictive intervention, 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 restrictive intervention through an internal critical incident management process, and must develop specific steps in an individual plan to reduce and eliminate the use of restrictive intervention. The evaluation must identify strategies to prevent use of restrictive intervention, 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 restrictive intervention.

A provider must use the following less restrictive interventions prior to the implementation of restrictive interventions: prompting by using verbal cues, physical gestures or physical assistance; simple correction by explanation, demonstration, or guidance of a participant; ignoring or not attending to 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 to 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 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 monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

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

SDS detects and monitors the use, unauthorized use and prohibited use of restrictive interventions 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 such as HCS licensing. Non-compliance may result in a sanction or enforcement action up to and including termination from the Medicaid program.

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

The DHSS Licensing and Certification Unit, responsible for the licensure of assisted living homes, provides orientation related to restrictive intervention 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 restrictive intervention. Care coordinators are mandated to report any suspected abuse, neglect or exploitation as well as any restrictive intervention that is prohibited, inappropriate, used in an emergency or results in the need for medical attention.

Through these and other discovery activities such as critical incident reports, the SDS Quality Assurance Unit collects and aggregates data regarding the use of restrictive interventions, 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 restrictive intervention 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.

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.

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

Assisted living home regulations at 7 AAC 75.240 provide that an assisted living home administrator is responsible and must document that each direct care provider working in the home, within the first 14 days of employment, is oriented to the assisted living home's (ALH) policies and procedures, including monitoring participant medication regimens. In addition, State statute at AS 47.220-240, requires each resident to have an “assisted living plan” developed and approved by the resident that specifies the resident’s need for health-related services, and how that need will be met. If the health-related services include medication management, a physician’s statement regarding the resident’s medication regimen must be included, and a registered nurse licensed under AS 08.68 must, at three month intervals, review the plan for the appropriateness of medications prescribed, usage patterns, special monitoring of the use of behavior modifying medications, any potential risks or side-effects associated with the medication and possible occurrence of dangerous medication interactions. The statute also requires that the resident or their representative, the ALH administrator and the licensed nurse review the assisted living plan at three-month intervals to evaluate whether the plan is meeting the resident’s needs. If the nurse discovers potentially harmful practices the nurse must provide additional training to direct care staff, and must revise the plan to stipulate more frequent provider monitoring as needed.

- 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 Alaska Department of Health and Social Services, Division of Health Care Services, Certification and Licensing Unit (C&L) is the agency responsible for oversight of medication management practices within assisted living homes including monitoring participant medication regimens. Regulations at 7 AAC 75.320 require annual monitoring of assisted living homes by C&L staff in order to show continuing compliance with statute and regulations.

The annual monitoring done by the DHSS C&L incorporates a review of resident “assisted living plans” to

ensure that, as required, medication management activities have been completed by a licensed nurse at three-month intervals, and that any concerns or problems with a resident's medication regimen, type of medication used or usage patterns have been documented, addressed and resolved. The DHSS C&L also responds to complaints or incidents involving medication management in Assisted Living Homes with an investigation of the circumstances that led to the medication error including information on harmful or potentially harmful practices contributing to the error.

When the investigation reveals medication management deficiencies, the Assisted Living Home is required to develop and submit a Plan of Correction to DHSS for approval. If the assisted living home is afforded the opportunity to cure noted violations, DHSS specifies the timeframe within which the assisted living home must submit its Plan of Correction, which is generally 30 days from the date of issuance, depending upon the violation noted. Violations that present imminent risk require immediate correction. Once violations have been cured, an allegation of compliance is submitted to and reviewed by DHSS. Should additional concerns be noted, DHSS may conduct a follow up investigation or inspection to determine compliance. If the provider does not comply with the plan, the C&L has the authority under regulations at 7AAC 75.020-070 to convert an Assisted Living Home license from "standard" to "probationary" until problems are corrected, or may also suspend or revoke the Assisted Living Home license.

In addition the C&L regularly consults with Alaska's Board of Nursing (BON) in regards to questions, clarifications and concerns having to do with medication. C&L also reports any substantiated findings or concerns regarding the performance of a nurse or nurse's aide directly to the BON. The mission of the BON is to actively promote and protect the health of the citizens of Alaska through the safe and effective practice of nursing as defined by the law. The board adopts regulations to carry out the laws governing the practice of nursing and the work of nurse aides in Alaska. It makes final licensing decisions and takes disciplinary action against people who violate the licensing laws.

As soon as an Assisted Living Home's report of inspection or investigation is complete, the Licensing and Certification Unit sends the report to the SDS Provider Quality Assurance Unit. These reports are reviewed and are considered during the provider's SDS recertification process.

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).

SDS 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 legal authority such as a licensed health care provider, the participant or the participant's family or legal representative.

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

When a nurse delegates assistance with participant self-administration of medication, he or she must develop a nursing delegation plan that includes the frequency and methods of evaluating the performance of the duty by the community-based provider. The delegating nurse must evaluate a delegation at least every 90 days, and keep a record of the evaluations conducted. State statute at AS 47.33.020 allows the community-based service provider to 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.

When a nurse delegates administration of medication duties to a home and community-based provider, the delegating nurse must provide written instructions including directions for the storage and administration of medication, possible medication interactions, how to observe and report side effects, 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 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 Alaska State Board of Nursing and provided by a nurse licensed under state statute at AS 08.

State nursing regulations, however, do not apply to all circumstances in which medication administration or assistance with self-administration may be delegated. Accordingly, SDS recognizes that other licensed health care providers as well as the participant or their representative may delegate medication administration or assistance with self-medication to waiver service providers. Regulations at 7 AAC 130.215 require a home and community-based provider to administer to or assist a participant to self-administer medications when a nurse is not involved. In such situations the regulation requires the provider to 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, and the name of the individual who assists with self-medication by the recipient or who administers a medication to the recipient, monitoring and evaluation of medication administration, medication error reporting requirements and medication administration training requirements to include successful completion of a training course approved by the Alaska State Board of Nursing and provided by a nurse licensed under state statute at AS 08. Any provider agency may assist a recipient to self-administer medication provided the employee is supervised as necessary and evaluated at least every 90 days by an individual designated by the provider agency and approved by the department.

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:

Providers are responsible reporting medication errors to the prescribing physician and to SDS in a Critical Incident Report.

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

Providers must record medication errors occurring in a 24-hour care setting, whether medication is self-administered or administered by staff with delegated nursing authority, 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.

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

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

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

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

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

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

When provider Critical Incident reports or quarterly medication error reports reveal a pattern or trend toward unsafe outcomes for participants, or when complaints or reports from providers, families or other stakeholders reveal medication errors, SDS works with the provider to develop and implement a corrective action plan. Corrective action may include additional staff training, development of more effective procedures or sanctions including de-certification. In addition, SDS reviews the provider medication management policy and medication management corrective action plans at least every two years as part of provider re-certification or when 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 instances of 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:

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

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = + or - 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

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

Data Source (Select one):

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>

	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>
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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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

Performance Measure:

and % CIRs involving children submitted to SDS within the reporting period that were reviewed by SDS within one business day of receipt. Numerator = # of CIRs involving children reviewed by SDS within one business day of receipt, and report was submitted to SDS within the reporting period. Denominator = # of CIRs involving children that were reported to SDS within the reporting period.

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 100%;" type="text"/>
<input type="checkbox"/> Other	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified

Specify: <input type="text"/>		Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

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

Data Source (Select one):

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

and % of deaths reviewed by Mortality Review Task Committee. Numerator = Number of deaths reviewed by Mortality Review Task Committee within the reporting period. Denominator = Number of deaths reported to State of Alaska Vital Statistics within the reporting period.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

<input type="text"/>	<input type="text"/>	<input type="text"/>
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Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

and % of participant deaths reported by providers. Numerator = Number of participant deaths reported by providers within the reporting period.
 Denominator = Number of deaths reported to State of Alaska Vital Statistics within the reporting period

Data Source (Select one):

Other

If 'Other' is selected, specify:

State of Alaska Vital Statistics

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Mortality reviews

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	

		<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

and % of CIRs reporting medication errors that resulted in the need for medical intervention. Numerator = Number of CIRs reporting medication errors that resulted in the need for medical intervention. Denominator = Number of CIRs submitted to SDS within the reporting period.

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

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Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

and % CIRs reporting restrictive intervention that was prohibited, inappropriate or resulted in need for medical intervention. Numerator= # CIRs reporting use of restrictive interventions that were prohibited, inappropriate or resulted in need for medical intervention. Denominator = # of CIRs reporting use of restrictive intervention 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="text"/>	
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

and % CIRs that report inappropriate use of restraint. Numerator = number of CIRs that report inappropriate use of restraint. Denominator = number of CIRs that report use of restraint in the reporting period.

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

and % of CIRs that report the use of seclusion. Numerator= number of CIRs that report the use of seclusion. Denominator= number or CIRs in the reporting period.

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other	

	Specify: <input type="text"/>	
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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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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.

- 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.

- 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.

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Quality Improvement Strategies are founded upon data-driven discovery activities. Task Committees (TC) have been developed to focus on specific areas of performance and to implement systems for data collection. The "Health and Welfare" Task Committee is comprised of Managers of the Quality Assurance Provider Unit (chair), Quality Assurance Service Provider Unit, Co-Chair, IDD Waiver Unit, NFLOC Unit, Operations Integrity Unit, Adult Protective Services Unit, PCA Unit, Grants Unit and the Policy and Program Development Unit. These 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 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 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 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 <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

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

The CQI plan incorporates input from stakeholders, participants, providers and the public. SDS holds a monthly “information sharing teleconferences” open to all stakeholders and covering a variety of topics and issues impacting the waiver programs. 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 at meetings of provider professional associations such as the AADD, AgeNet, and the Care Coordinator Network.

The QIS and Task Committees perform discovery and remediation activities for this waiver as well as the Alaskans Living Independently (0261), Adults with Physical and Developmental Disabilities (0262) and the Children with Complex Medical Conditions (0263) waivers. Data is separately aggregated and analyzed for each waiver.

Task Committees. 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 investigates any untimely deaths or deaths involving unusual circumstances (as defined in SDS policy “Mortality Review”) of waiver participants. Membership includes the Services Quality Assurance Unit Manager (Chair) and SDS staff including a Qualified Mental Retardation Professional (QMRP), a Registered Nurse (RN), the SDS Mortality Review Coordinator and an Adult Protective Services (APS) Unit representative. The Committee reviews information on participant deaths obtained through the SDS’s 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.

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, Service Quality Assurance Unit, Policy and Program Development and Personal Care Assistance. On a weekly basis the Committee reviews Level of Care status reports, 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 Quality Assurance Unit (Chair), 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 Service Unit, OIU and 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.

Fair Hearing Review. The Fair Hearing Task Committee gathers and analyzes fair hearing data and data trends to assist the QIW in determining if systemic changes are needed to improve services. Membership includes the Managers of the OIU (Chair), IDD Waiver Unit, NFLOC Unit, Service QA Unit, PCA Unit, Policy and Program Development Unit and the SDS Fair Hearing Coordinator. On a quarterly basis the Committee collects and analyzes fair hearing data including the type of fair hearing requested, the outcome/disposition of the fair hearing request, comparison of aggregated historical data, a summary, analysis, and recommendations for systemic improvement.

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, Service QA Unit, Provider QA Unit, OIU, PCA Unit, Adult Protective Services Unit, Research and Analysis Team, 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 Welfare Review Task Committee monitors the critical incident and the QA complaint processes to ensure proper response from waiver service providers and SDS. Membership includes the Managers of the Service QA Unit and Provider QA Unit (Co-Chairs), IDD Waiver Unit, NFLOC Unit, OIU, APS Unit, PCA Unit, Grants Unit and Policy and Program Development Unit. The Committee reviews 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 Health Program Manager IV, Service, SDS Health Program Manager IV, Quality; 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 Managers of the PCA Unit (Chair), Provider QA Unit, OIU, 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. The QIW develops a “Monthly Key Indicator” report for the DHSS Commissioner that includes the status of performance measures and issues identified for corrective action as well as a “Quarterly Quality Improvement Steering Committee” report for the QISC that identifies resources necessary to fulfill requirements of quality assurance plan, new or additional task committees needed, evaluation of the composition of the workgroup and assistance in coordinating efforts and exchange information with external parties, partners, self-advocates and advocates.

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Quality Improvement Committee	<input type="checkbox"/> Annually
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Other Specify: <input type="text"/>

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;
- Health Program Manager IV, Service SDS;
- Health Program Manager IV, Quality SDS
- State Medicaid Director;
- Program Integrity Manager, Division of Finance and Management Services;
- 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 monthly according to the state fiscal year. Meeting schedule is 3rd Friday of each month. 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 Medicaid and Health Care Policy;
- Deputy Commissioner for Family, Community and Integrated Services, Committee Chair;
- Director, SDS;
- Deputy Director, SDS;
- Health Program Manager IV, Service SDS;
- Health Program Manager IV, Quality SDS ;
- State Medicaid Director;
- Program Integrity Manager, Finance and Management Services;
- 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 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.

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:

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

Data Source (Select one):
Financial records (including expenditures)
 If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

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

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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.

- 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 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 Financial Accountability 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, which are reviewed, processed and addressed as they are received, participants or their representatives, and other state agencies, as well as provider onsite visits that include document reviews and participant and provider staff interviews.

The Financial Accountability Committee prepares standardized monthly reports for the Quality Improvement Workgroup (QIW) based on the Level of Care 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.

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 <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- No
- Yes

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

Appendix I: Financial Accountability

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

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

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

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

Specialized medical equipment is reimbursed at the lesser of billed charges or the Department's fee schedule for various items of equipment.

Environmental modifications are reimbursed at billed charges, with an additional administrative fee for a provider acting as an organized health care delivery system.

Specialized Private Duty Nursing rates are established in regulation (7 AAC 145.250) per 15 minutes for an RN and LPN.

Effective March 1, 2011 rates for Nurse Oversight and Care Management were established at \$20.42 per 15 minute increment for services delivered within 200 miles of the provider (T2034 U2) and \$40.84 per 15 minute increment for services delivered farther than 200 miles of the provider (T2034 U4).

To provide payment parity between like services of Nurse Oversight and Care Management (NOCM) and Specialized Private Duty Nursing (SPD) the department analyzed the adequacy of the \$20.00 per 15 minute increment required by the current approved HCBS Waiver Application and state regulation.

A review of average Registered Nurse wage rates contained on the Alaska Department of Labor and Workforce Development website showed an average rate of \$38 to \$40. The addition of an additional \$40 per hour for benefits, overhead, and administration would be adequate to reimburse those costs. The department concluded that the \$80 per hour, as approved for SPD nursing, would be adequate for NOCM services. Inflation increase of 2.1% resulted in a per 15 minute rate of \$20.42 for services delivered within 200 miles of the provider (T2034 U2).

The inclusion of an additional \$80 per hour to cover costs related to a nurse functioning in remote parts of Alaska was arrived at utilizing cost and utilization estimates from experienced individuals in the department. Covered costs needed to include airfare/s, hotel, local transportation, per diem, the analysis of the number of recipients per average trip, and the average number of billable units of service. See example calculation below. The department concluded that the \$80 per hour increase would be appropriate and adequate for non-local NOCM services. Inflation increase of 2.1% resulted in a per 15 minute rate of \$40.84 for services delivered farther than 200 miles of the provider (T2034 U2).

Example: 1 overnight, 2 clients, and 2 hours of service per client:

Airfare/s \$800

Hotel 200

Ground 150

Per Diem 100

\$1,250 / 16 units of service = \$78 per unit of additional costs.

Result is \$80 for labor hour plus \$80 for out of town expenses, with inflation was \$40.84 per 15 minute increment. NOCM services were changed from quarterly units to 15 minute increments effective March 1, 2011. Several providers of NOCM services raised serious concerns about the adequacy of the rate. These 4 providers provided almost all of the NOCM services in the state. As a result the Department agreed to conduct a more thorough cost survey and incorporate the new survey into the regulations.

A more detailed survey of the costs and units was undertaken and was completed in late July and early August. Three of the four largest service providers participated in the NOCM cost survey.

This change to the NOCM rates is not anticipated to have any significant impact on payments in total. Based on the recent detailed cost survey the local (less than 200 miles) rate should be approximately \$15 to \$16 dollars. This represents a decrease of approximately \$5 per unit. Non-local (more than 200 miles) rate should be approximately \$53 to \$54 dollars. This represents an increase of approximately \$11. There are more local units than non-local units and the full impact cannot be determined until there is a reliable history of units billed and paid.

Explanation of how public comments on rate determination methods are solicited:

The public was given the change to provide the department with comments in multiple formats over a period of time:

- Publicly noticed work sessions were held on all aspect of the regulation changes,
- These work sessions were held both before and after the public received the regulation changes demonstrating the NOCM changes.
- The department public noticed changes to the NOCM unit of service and payment rate.
- The department utilized it's E-Alert system to assist in making interested provider aware of these sessions and changes. The E-Alert system is designed to provide important information and maintain communications with waiver and PCA service providers and interested parties.

Explanation of how information on payment rates is made available to waiver participants:

- Public notices of changes,
- Public notices of work sessions,
- E-Alert information sharing,
- Website information availability including rate charts and regulations, and
- Adopted State Administrative Law

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

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

The HCB Agency requests reimbursement for service on an invoice that includes the prior 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 in a nursing home on the date of service,
- service provided was on the signed Plan of Care,
- provider certification was current,
- recipient's Medicaid number is correct to assure the right person received the service
- prior authorization number is verified to ensure that there are units and dollars available on the PA, 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.**
- The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

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

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

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

Appendix I: Financial Accountability**I-3: Payment (3 of 7)**

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

- No. The State does not make supplemental or enhanced payments for waiver services.**
- Yes. The State makes supplemental or enhanced payments for waiver services.**

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

Appendix I: Financial Accountability**I-3: Payment (4 of 7)**

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

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

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

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 OHCD; (d) the method(s) for assuring that providers that furnish services under contract with an OHCD meet applicable provider qualifications under the waiver; (e) how it is assured that OHCD contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCD arrangement is used:

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

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

No environmental modifications are provided unless the provider meets the minimum applicable provider qualifications as described under Participant services, and 7 AAC 43.1054 environmental modification services.

As per regulations at 7 AAC 130.300 – 302, all environmental modifications require extensive documentation and evaluation prior to State approval to authorize the service. Financial accountability is achieved by limiting prior authorizations to no more than \$18,500 every three years, issuing prior authorizations only to certified providers, and recertifying providers every two years.

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) (MCO) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

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

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

Appendix I: Financial Accountability

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

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

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

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching

arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Other State Level Source(s) of Funds.

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

Appendix I: Financial Accountability

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

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

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

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

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

Other Local Government Level Source(s) of Funds.

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

Appendix I: Financial Accountability

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

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

None of the specified sources of funds contribute to the non-federal share of computable waiver costs

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

- Provider-related donations**
- Federal funds**

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

Appendix I: Financial Accountability

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

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

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

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

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

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

Appendix I: Financial Accountability

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

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

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

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

Appendix I: Financial Accountability

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

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

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

i. Co-Pay Arrangement.

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

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

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

Specify:

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

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

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

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

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

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

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

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

Appendix I: Financial Accountability

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

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

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

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

Appendix J: Cost Neutrality Demonstration

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

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-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: ICF/IID

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	49876.23	12171.72	62047.95	218888.12	12161.95	231050.07	169002.12
2	52216.25	12415.16	64631.41	223703.66	12405.19	236108.85	171477.44
3	75697.08	12663.47	88360.55	228177.73	12653.29	240831.02	152470.47
4	74117.57	12916.73	87034.30	232741.29	12906.36	245647.65	158613.35
5	82177.69	13175.07	95352.76	237396.11	13164.49	250560.60	155207.84

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:	
		ICF/IID	
Year 1	1762		1762
Year 2	1814		1814
Year 3	1966		1966
Year 4	2206		2206

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:	
		ICF/IID	
Year 5	2256		2256

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 FY12 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 FY12. The average length of stay in FY '09 was 340 days.

Appendix J: Cost Neutrality Demonstration

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

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

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

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

Service costs used to project future total waiver costs include cost growth indexing which closely matches Alaska’s historical practice of periodic waiver rate increases. Historically Alaska has increased waiver rates approximately 2% every two to three years. The specific calculations for the cost projections were based on the following:

1. Historical analysis of service costs for waiver participants in FY09 (years 1-2) and FY12 (years 3-5).
2. For the year one projections, the population growth rate projections from the Department of Labor were used to calculate the total number of participants in years 1 through 5.
3. With the population projections identified, and average service unit costs identified, the service cost increases were calculated based on the following periodic rate increases:
 - a. Year 1 = 1% increase in waiver service costs across every category of service
 - b. Year 2 = 2% increase in waiver service costs across every category of service
 - c. Year 3 = new rates became active
 - d. Year 5 = 2% increase in waiver service costs across every category of service

These same percentage increases were also applied to Factor D, Factor G, and Factor G for each respective year.

The average length of stay (ALOS) variable was not used for these cost projection estimates. Cost estimates were based on actual historical billing information from the Alaska MMIS for FY09 (years 1-2) and FY12 (years 3-5). The analysis included individuals who only utilized services for a part of the year. Additionally, the unique rate structure employed in Alaska for Medicaid reimbursement prevents the use of a methodology that would rely on a single rate for a specific service. Rates are indexed regionally for many services, and

providers are also assigned cost-based rates which are unique to the specific provider. Average utilization and average unit costs were calculated based on actual utilization which was collected from the Alaska MMIS for FY09 (years 1-2) and FY12 (years 3-5).

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

This estimate was calculated based on the average cost of non-waiver services (excluding prescription drugs) for waiver participants. This information is based on the Alaska MMIS paid billing claims for FY09 (years 1-2) and FY12 (years 3-5). Rate increases were applied to the average cost for these services in years: 1, 2, and 5. The specific cost increases were applied as follows:

1. Year 1 = 1% increase in average cost of non-Medicaid waiver services
2. Year 2 = 2% increase in average cost of non-Medicaid waiver services
3. Year 3 = new rates became active
4. Year 5 = 2% increase in average cost of non-Medicaid waiver services

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

This estimate was calculated based on the average cost of ICF/ID care. The number of participants receiving these various levels of care was proportionally used to compute an average cost that includes the aforementioned ICF/ID levels of care. This average cost was then applied to the projected waiver populations to derive an estimated cost of ICF/ID level of care for the target population.

This information is based on the Alaska MMIS paid billing claims for FY09 (years 1-2) and FY12 (years 3-5). Rate increases were applied to the average cost for these services in years: 1, 2, and 5. The specific cost increases were applied as follows:

1. Year 1 = 1% increase in average cost of ICF/ID
2. Year 2 = 2% increase in average cost of ICF/ID
3. Year 3 = new rates became active
3. Year 5 = 2% increase in average cost of ICF/ID

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

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

This information is based on the Alaska MMIS paid billing claims for FY09 (years 1-2) and FY12 (years 3-5). Rate increases were applied to the average cost for these services in years: 1, 2, and 5. The specific cost increases were applied as follows:

1. Year 1 = 1% increase in average cost of non-Medicaid waiver services
2. Year 2 = 2% increase in average cost of non-Medicaid waiver services
3. Year 3 = new rates became active
4. Year 5 = 2% increase in average cost of non-Medicaid waiver services

Appendix J: Cost Neutrality Demonstration

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

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

Waiver Services	
Care Coordination	
Day Habilitation	
Residential Habilitation	
Respite	
Supported Employment	
Chore	
Environmental Modifications	

Waiver Services	
Intensive Active Treatment	
Meals	
Nursing Oversight and Care Management	
Specialized Medical Equipment	
Specialized private duty nursing	
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:						3716333.50
Care Coordination	1 month	1525	11.00	221.54	3716333.50	
Day Habilitation Total:						0.00
Individual Day Habilitation	15 minutes	0	0.02	0.02	0.00	
Group Day Habilitation	15 minutes	0	0.02	0.02	0.00	
Residential Habilitation Total:						78768814.41
residential habilitation	15 minutes	1287	2135.50	28.66	78768814.41	
Respite Total:						4280608.08
respite	15 min.	630	954.30	7.12	4280608.08	
Supported Employment Total:						0.00
Individual Supported Employment	15 minutes	0	0.02	0.02	0.00	
Group Supported Employment	15 minutes	0	0.02	0.02	0.00	
Chore Total:						16484.65
Chore	15 min.	10	362.30	4.55	16484.65	
GRAND TOTAL:						87881908.79
Total Estimated Unduplicated Participants:						1762
Factor D (Divide total by number of participants):						49876.23
Average Length of Stay on the Waiver:						340

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Modifications Total:						22043.86
Environmental Modifications	per project	4	1.01	5456.40	22043.86	
Intensive Active Treatment Total:						130592.04
Intensive Active Treatment	15 min.	17	229.31	33.50	130592.04	
Meals Total:						30986.12
Meals	per meal	13	194.10	12.28	30986.12	
Nursing Oversight and Care Management Total:						761113.76
Nursing Oversight and Care Management	15 min.	172	178.00	24.86	761113.76	
Specialized Medical Equipment Total:						11643.75
Specialized Medical Equipment	per item	15	172.50	4.50	11643.75	
Specialized private duty nursing Total:						727.20
Specialized private duty nursing	15 min.	2	18.00	20.20	727.20	
Transportation Total:						142561.42
Transportation	per ride	39	223.30	16.37	142561.42	
GRAND TOTAL:						87881908.79
Total Estimated Unduplicated Participants:						1762
Factor D (Divide total by number of participants):						49876.23
Average Length of Stay on the Waiver:						340

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:						4007077.36
Care Coordination	1 month				4007077.36	
GRAND TOTAL:						94720269.81
Total Estimated Unduplicated Participants:						1814
Factor D (Divide total by number of participants):						52216.25
Average Length of Stay on the Waiver:						340

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		1612	11.00	225.98		
Day Habilitation Total:						0.00
Individual Day Habilitation	15 minutes	0	0.02	0.02	0.00	
Group Day Habilitation	15 minutes	0	0.02	0.02	0.00	
Residential Habilitation Total:						84892104.40
residential habilitation	15 min.	1360	2135.50	29.23	84892104.40	
Respite Total:						4614193.19
respite	15 min.	666	954.30	7.26	4614193.19	
Supported Employment Total:						0.00
Individual Supported Employment	15 minutes	0	0.02	0.02	0.00	
Group Supported Employment	15 minutes	0	0.02	0.02	0.00	
Chore Total:						16810.72
Chore	15 min.	10	362.30	4.64	16810.72	
Environmental Modifications Total:						28100.46
Environmental Modifications	per project	5	1.03	5456.40	28100.46	
Intensive Active Treatment Total:						142804.12
Intensive Active Treatment	15 min.	18	229.36	34.59	142804.12	
Meals Total:						34049.02
Meals	per meal	14	194.10	12.53	34049.02	
Nursing Oversight and Care Management Total:						819618.80
Nursing Oversight and Care Management	15 min.	182	178.00	25.30	819618.80	
Specialized Medical Equipment Total:						11876.62
Specialized Medical Equipment	per unit	15	172.50	4.59	11876.62	
Specialized private duty nursing Total:						741.60
Specialized private duty nursing	15 min.	2	18.00	20.60	741.60	
GRAND TOTAL:					94720269.81	
Total Estimated Unduplicated Participants:					1814	
Factor D (Divide total by number of participants):					52216.25	
Average Length of Stay on the Waiver:						340

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transportation Total:						152893.51
Transportation	per ride	41	223.30	16.70	152893.51	
GRAND TOTAL:					94720269.81	
Total Estimated Unduplicated Participants:					1814	
Factor D (Divide total by number of participants):					52216.25	
Average Length of Stay on the Waiver:					340	

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:						4772010.38
Care Coordination	1 month	1840	11.03	235.13	4772010.38	
Day Habilitation Total:						32854399.10
Individual Day Habilitation	15 minutes	1073	2440.44	8.89	23279283.95	
Group Day Habilitation	15 minutes	536	2440.44	7.32	9575115.15	
Residential Habilitation Total:						94154340.28
residential habilitation	15 min	1518	522.23	118.77	94154340.28	
Respite Total:						4939204.81
respite	per diem	775	21.77	292.75	4939204.81	
Supported Employment Total:						8452819.07
Individual Supported Employment	15 minutes	434	1516.90	10.07	6629429.42	
Group Supported Employment	15 minutes	145	1516.90	8.29	1823389.64	
Chore Total:						29330.53
Chore					29330.53	
GRAND TOTAL:					148820451.71	
Total Estimated Unduplicated Participants:					1966	
Factor D (Divide total by number of participants):					75697.08	
Average Length of Stay on the Waiver:					340	

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	15 min	9	498.31	6.54		
Environmental Modifications Total:						70000.00
Environmental Modifications	per project	7	1.00	10000.00	70000.00	
Intensive Active Treatment Total:						840727.07
Intensive Active Treatment	15 min.	153	167.58	32.79	840727.07	
Meals Total:						36782.35
Meals	per meal	14	123.58	21.26	36782.35	
Nursing Oversight and Care Management Total:						1846781.52
Nursing Oversight and Care Management	15 min.	191	177.87	54.36	1846781.52	
Specialized Medical Equipment Total:						22863.36
Specialized Medical Equipment	1 unit	26	4.58	192.00	22863.36	
Specialized private duty nursing Total:						720.00
Specialized private duty nursing	15 min.	2	18.00	20.00	720.00	
Transportation Total:						800473.25
Transportation	per ride	359	154.95	14.39	800473.25	
GRAND TOTAL:						148820451.71
Total Estimated Unduplicated Participants:						1966
Factor D (Divide total by number of participants):						75697.08
Average Length of Stay on the Waiver:						340

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:						5352950.77
GRAND TOTAL:						163503363.24
Total Estimated Unduplicated Participants:						2206
Factor D (Divide total by number of participants):						74117.57
Average Length of Stay on the Waiver:						340

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Care Coordination	1 month	2064	11.03	235.13	5352950.77	
Day Habilitation Total:						36875536.49
Individual Day Habilitation	15 minutes	1204	2440.44	8.89	26121395.97	
Group Day Habilitation	15 minutes	602	2440.44	7.32	10754140.52	
Residential Habilitation Total:						105691038.10
residential habilitation	15 min	1704	522.23	118.77	105691038.10	
Respite Total:						5398072.87
respite	per diem	847	21.77	292.75	5398072.87	
Supported Employment Total:						6322545.38
Individual Supported Employment	15 minutes	325	1516.90	10.07	4964434.48	
Group Supported Employment	15 minutes	108	1516.90	8.29	1358110.91	
Chore Total:						32589.47
Chore	15 min	10	498.31	6.54	32589.47	
Environmental Modifications Total:						80000.00
Environmental Modifications	per project	8	1.00	10000.00	80000.00	
Intensive Active Treatment Total:						939636.14
Intensive Active Treatment	15 min.	171	167.58	32.79	939636.14	
Meals Total:						39409.66
Meals	per meal	15	123.58	21.26	39409.66	
Nursing Oversight and Care Management Total:						1846781.52
Nursing Oversight and Care Management	15 min.	191	177.87	54.36	1846781.52	
Specialized Medical Equipment Total:						25501.44
Specialized Medical Equipment	1 unit	29	4.58	192.00	25501.44	
Specialized private duty nursing Total:						720.00
Specialized private duty nursing	15 min.	2	18.00	20.00	720.00	
GRAND TOTAL:						163503363.24
Total Estimated Unduplicated Participants:						2206
Factor D (Divide total by number of participants):						74117.57
Average Length of Stay on the Waiver:						340

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transportation Total:						898581.39
Transportation	per ride	403	154.95	14.39	898581.39	
GRAND TOTAL:						163503363.24
Total Estimated Unduplicated Participants:						2206
Factor D (Divide total by number of participants):						74117.57
Average Length of Stay on the Waiver:						340

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:						5967852.97
Care Coordination	1 month	2256	11.03	239.83	5967852.97	
Day Habilitation Total:						41709413.61
Individual Day Habilitation	15 minutes	1335	2440.44	9.07	29549945.72	
Group Day Habilitation	15 minutes	667	2440.44	7.47	12159467.90	
Residential Habilitation Total:						119513562.74
residential habilitation	15 min.	1889	522.23	121.15	119513562.74	
Respite Total:						6110695.32
respite	per diem	940	21.77	298.61	6110695.32	
Supported Employment Total:						7923709.18
Individual Supported Employment	15 minutes	362	1516.90	10.27	5639439.81	
Group Supported Employment	15 minutes	178	1516.90	8.46	2284269.37	
Chore Total:						36561.00
Chore					36561.00	
GRAND TOTAL:						185392864.14
Total Estimated Unduplicated Participants:						2256
Factor D (Divide total by number of participants):						82177.69
Average Length of Stay on the Waiver:						340

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	15 min.	11	498.31	6.67		
Environmental Modifications Total:						91800.00
Environmental Modifications	per project	9	1.00	10200.00	91800.00	
Intensive Active Treatment Total:						1065054.69
Intensive Active Treatment	15 min.	190	167.58	33.45	1065054.69	
Meals Total:						45567.65
Meals	per meal	17	123.58	21.69	45567.65	
Nursing Oversight and Care Management Total:						1883812.28
Nursing Oversight and Care Management	15 min.	191	177.87	55.45	1883812.28	
Specialized Medical Equipment Total:						29599.26
Specialized Medical Equipment	1 unit	33	4.58	195.84	29599.26	
Specialized private duty nursing Total:						734.40
Specialized private duty nursing	1 hour	2	18.00	20.40	734.40	
Transportation Total:						1014501.04
Transportation	per ride	446	154.95	14.68	1014501.04	
GRAND TOTAL:						185392864.14
Total Estimated Unduplicated Participants:						2256
Factor D (Divide total by number of participants):						82177.69
Average Length of Stay on the Waiver:						340