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 waivers 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:
Individualized Supports Waiver

C. Waiver Number:AK.1566

D. Amendment Number:AK.1566.R00.04

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

06/13/19

Approved Effective Date: 06/13/19

Approved Effective Date of Waiver being Amended: 07/01/18

2. Purpose(s) of Amendment

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

This amendment makes two changes to the ISW: 1) it updates Appendix D-2-a Service Plan Implementation and Monitoring to reference a service provider's responsibility to report to a recipient's care coordinator on how the provider's activities are contributing to the recipient's progress towards meeting service goals; and 2) it updates Appendix G-2-a-i Safeguards Concerning the Use of Restrictive Interventions to reflect the training requirements so that all direct service workers receive training on use of restrictive interventions, in addition to other required trainings.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☐ Waiver Application	
☐ Appendix A	

Component of the Approved Waiver	Subsection(s)
Waiver Administration and Operation	
☐ Appendix B Participant Access and Eligibility	
☐ Appendix C Participant Services	
☒ Appendix D Participant Centered Service Planning and Delivery	2.a
☐ Appendix E Participant Direction of Services	
☐ Appendix F Participant Rights	
☒ Appendix G Participant Safeguards	2.a.i
☐ Appendix H	
☐ Appendix I Financial Accountability	
☐ Appendix J Cost-Neutrality Demonstration	

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

☐ **Modify target group(s)**

☐ **Modify Medicaid eligibility**

☐ **Add/delete services**

☐ **Revise service specifications**

☐ **Revise provider qualifications**

☐ **Increase/decrease number of participants**

☐ **Revise cost neutrality demonstration**

☐ **Add participant-direction of services**

☒ **Other**

Specify:

Appendix D adds requirement for service providers to report to care coordinators on recipient progress towards goals.

Appendix G adds requirement for restrictive intervention training for all direct service workers.

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*):

Individualized Supports Waiver

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**

Waiver Number:AK.1566.R00.04
Draft ID: AK.007.00.01

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/18
Approved Effective Date of Waiver being Amended: 07/01/18

1. Request Information (2 of 3)

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

☐ **Hospital**
Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**
If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**
Select applicable level of care

○ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**
If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

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

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 Eligiblity for Medicaid and Medicare.

Check if applicable:

- [x] **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 Individualized Supports Waiver (ISW)is to provide services to people with IDD living in the community who have less intensive needs than people on Alaska's IDD waiver (AK.0260.R005).

The ISW allows Medicaid-eligible individuals with an intellectual or developmental disability (I/DD) to have access to an array of support services intended to ensure community inclusion. The waiver is administered statewide and is available to individuals of all ages. The ISW provides support services to individuals who might otherwise reside in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) for more than 30 days per year. Access to the services offered on the ISW allow individuals to live and work as independently as possible in integrated community settings.

Participants select any combination of the following list of waiver services to meet his/her support needs:

- Care Coordination monthly monitoring
- Day Habilitation
- Residential Habilitation for ages< 18 (Service Name: In-Home Supports)
- Residential Habilitation for ages > 18 (Service Name: Supported Living)
- Respite
- Supported Employment (including pre-employment tasks)
- Chore
- Intensive Active Treatment for adults 21 and older
- Non-medical Transportation

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 Division of Senior and Disabilities Services (SDS) within the applicable federal regulations.

The ISW implements a point-in-time enrollment limit of 600 participants each year the waiver is in effect and does not go over the maximum number of 620 unduplicated participants served each year. The State established an individual cost limit of $28,928 that applies to all waiver participants during the first year of the waiver period, and which will be indexed to service rate inflation the following years the waiver is in effect. The individual budget limit within the individual cost limit is $19,285. ISW participants are expected to have available services and supports from other sources that, in combination with waiver services, are sufficient to assure their health and welfare.

To be considered for the ISW waiver, applicants must: 1) be determined to meet the definition of a person with a developmental disability as defined in AS 47.80.900(6), 2) request placement on the Developmental Disabilities Registration and Review ISW waitlist (DDRR-ISW), and 3) meet ICF/IID level of care.

The Developmental Disabilities Registration and Review (DDRR) is a tool that scores an individual's criticality in current life circumstances. When an individual requests placement on the DDRR they have the opportunity to indicate an interest in being considered for the ISW, IDD waiver, or both waivers.

The State is actively working with individuals who would like to enroll in the ISW. Applications are being processed to determine Level of Care and to assess if applicants' health and safety needs can be met on the ISW. Once the ISW reaches capacity, individuals interested in the waiver will remain on the ISW waitlist until slots become available. A consequence of implementing the ISW there may likely be reduction in the IDD waiver waitlist.

Applicants access the waiver through a cadre of private SDS certified care coordinators. Once drawn, the individual or a care coordinator submits an initial application to SDS to assess if they meet level of care for and Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). Upon approval, the care coordinator assists with the development and plan and all subsequent waiver renewals and redeterminations. Services are delivered by SDS-certified home and community-based provider agencies.

3. Components of the Waiver Request

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

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

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver,

the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

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

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

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

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

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

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

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

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

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

4. Waiver(s) Requested

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

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

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

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

- ◉ **No**
- ○ **Yes**

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

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

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the

following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.
Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

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

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

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

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

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

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

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

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

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

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

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

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

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

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver

participants. This information will be consistent with a data collection plan designed by CMS.

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

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

H. **Quality Improvement**. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b)

individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

In general, the State secures public input on operational implementation of its waivers and amendments through a variety of methods, including:

- Information-sharing teleconferences and webinars with care coordinators and other waiver services providers;
- Regular communication with the State of Alaska's statutorily-mandated advocacy board, the Governor's Council on Disabilities and Special Education, and related advocacy coalitions that comprise the agencies serving recipient populations, the Key Coalition and the Alaska Association of Developmental Disabilities, both for people with developmental disabilities.
- Solicitations for interactive presentations to the Alaska Native Health Care Consortium (ANTHC) Long Term Care Committee.

In the interests of transparency, the State opted to conduct a joint public comment for tribal consultation period for all four waivers that were being amended and for related amendments to governing regulations.

The State made copies of the proposed amendments to the four existing waivers available to the public at all three SDS offices, and posted the proposed waiver amendments to the SDS website. The State posted notice of the proposed amended waivers via an advertisement in the state's largest newspaper, an Online Public Notice, and an E-Alert sent to 1700+ subscribers. The E-Alert was then circulated to specific membership list-serves by each advocacy group.

Twelve commenters representing nine agencies and three individuals provided a total of 35 comments. All of these comments related to proposed regulatory content and did not affect any content of the proposed waiver amendments. The proposed amendments to Alaska's four approved waivers generated no public comment.

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:

Deb

Title:

Acting Director, Division of Senior and Disabilities Services

Agency:

Department of Health and Social Services

Address:

PO Box 110680

Address 2:

none

City:

Juneau

State: **Alaska**

Zip:

99811

Phone:

(907) 465-5481 **Ext:** ☐ **TTY**

Fax:

(907) 465-1170

E-mail:

deb.etheridge@alaska.gov

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

Last Name:

Etheridge

First Name:

Deb

Title:

Acting Director, Division of Senior and Disabilities Services

Agency:

Department of Health and Social Services

Address:

PO Box 110680

Address 2:

none

City:

Juneau

State: **Alaska**

Zip:

99811

Phone:

(907) 465-5481 **Ext:** ☐ **TTY**

Fax:

(907) 465-1170

E-mail: deb.etheridge@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: Jetta Whittaker

State Medicaid Director or Designee

Submission Date: May 16, 2019

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

Last Name: Steward

First Name: Donna

Title: Deputy Commissioner

Agency: Department of Health and Social Services

Address: 3601 C Street, Suite 902

Address 2: none

City: Anchorage

State: **Alaska**

Zip: 99503

Phone: (907) 269-7800 **Ext:** ☐ **TTY**

Fax: (907) 465-1170

E-mail: donna.steward@alaska.gov

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:

n/a

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.

See Appendix C-5.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix D-1-b, continued:

When developing the support plan, a care coordinator must disclose, to the participant and the participant's planning team, if he/she works for an agency that provides other home and community-based waiver services. In addition, when the participant chooses to receive home and community-based services from an entity that has been granted an exception to conflict-free requirements, the care coordinator and entity are required to ensure administrative separation between home and community-based services and care coordination. The entity must also ensure the following: that the care coordination participant is offered choice for home and community-based services between and among available service providers; care coordination participants are not limited to home and community-based services provided only by the entity; and care coordination participants are given choice of care coordinators within the entity.

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

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

The criteria that were used to identify which census areas were allowed to apply for exceptions to conflict-free care coordination included:

(1) The number of conflict-free care coordinators could not meet the capacity for the number of recipients in the census area.

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

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

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

The process for obtaining an exception involved submitting a complete application.

SDS used the following criteria for determining whether an agency was granted an exception:

(1) Review of narrative description ensuring administrative separation of HCB services from care coordination:
a. Include a basic description of the duties of the home and community-based services supervisor(s) and the care coordination supervisor(s).
b. Explain how recipients are given choice of care coordinator.
c. Explain how recipients are given choice of home and community-based services and other natural supports or services offered in the community.
d. Explain how the agency ensures that the care coordinator is free from influence of direct service providers regarding recipient care plans.

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

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

1. I attest that the agency has and uses a plan/policy/procedure to ensure administrative separation of home and community-based services from care coordination. This plan/policy/procedure ensures that:
a. The agency has administrative separation of supervision of care coordination and home and community-based services.
b. The attached organization chart shows two separate supervisors, one for care coordination and one for home and community-based services.

c. Care coordination recipients are offered choice for home and community-based services between and among available service providers.
d. Care coordination recipients are not limited to home and community-based services provided only by this agency.
e. Care coordination recipients are given choice of care coordinators within the agency.
f. Disputes between care coordination and home and community-based services units are resolved.

2.I attest that the agency has and uses a plan/policy/procedure to implement dispute resolution. This plan/policy/procedure ensures that:

a. Recipients are free to choose or deny home and community-based services without influence from the internal agency care coordinator and home and community-based service staff.
b. Recipients choose how, when, and where to receive their approved home and community-based services.
c. Recipients are free to communicate grievance(s) regarding care coordination and/or home and community-based services delivered by the agency.
d. The grievance/complaint procedure is clear and understood by recipients and legal representatives.
e. Grievances/complaints are resolved in a timely manner.

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

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

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

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

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

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

A management-level SDS committee approves applications for exceptions after thorough vetting, including requests for additional information, if needed. Exceptions are awarded for three years, to provide agencies with sufficient program operation time before revisiting the continued need for an exception. During the three year exception period, SDS has the right, per 7 AAC 130.200, to review agency policies and operations, whether based on complaints filed with central intake (by participants or other providers) or random surveys and investigations.

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

Appendix I-1: Financial Integrity and Accountability Continued:

Complete Claims Documentation Testing, Medicaid Payment Testing and Service Limits Testing work papers and attempt to resolve any issues from the desk review claims review process.

The work papers document the review procedures completed. The purpose of the review procedures are described below.

- Claims Documentation Testing; Review patient records and other supporting documentation to ensure services billed meet the requirements of state and federal Medicaid rules, policies and regulations. Ensure the documentation maintained by the

provider meets all applicable requirements and is consistent with the recipient, place of service, date of service and procedure code billed to the Medicaid program.

- Medicaid Payment Testing; this procedure is used to ensure that each claim under review was reimbursed according to the appropriate Alaska Medicaid reimbursement methodology and rate for the specific date of service.
- Service Limits Testing: review to ensure services were prior authorized as required and ensure adequate units of service were available for payment on the date of service for the sampled claim.

If claims documentation testing during the desk review indicates any special concerns, consider the need for an expanded and targeted sample of claims for review:

- Verify that providers followed proper Medicaid policies to bill other third party payers. Review other Medicaid claims for the participant, the participant eligibility file and the Medicaid participant documentation for indicators of other third party coverage.
- Review the provider's billed charges for sampled claims. Perform testing of the provider's usual and customary charges. A provider's Medicaid charges are compared with the provider charge master, or other listing of rates or service charges to the general public for the same date of service. The objective is to ensure the Medicaid program is not being charged more than the general public for same service.
- Review provider accounts receivable records for selected claims. Review credit balances or other indicators of payments received in excess of Medicaid allowed amounts.

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

Selection of Claims Samples: A statistically valid random sample of claims is drawn from the universe of claims submitted to Alaska Medicaid by the provider, using a Sampling Extrapolation Procedures document. The State employs a conservative approach to its extrapolation methodology. The State uses the greater or actual overpayments or the lower bound of a 90% confidence interval. The methodology employs the greater of actuals language because in some cases where there is a very low error rate, the extrapolated amount may be a negative number.
An explanatory excerpt follows:

"A. Sampling Procedures

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

- Determination of the Universe Population

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

Typically, the sampling unit will be a claim at the "header" level (under current Alaska MMIS data definitions, this implies claims that have the same 11 digit root for the claim control number). Selection at the header level implies that all line items associated with the "header" level claim are included in the selection of one header claim. If alternate sampling units are used, the sampling unit should be clearly documented and universe definitions, sample size determinations and sampling protocols should consistently use the same sampling unit definition.

At this stage of the sampling process, the potential for stratified sampling should be considered when specialized circumstances exist. If stratified sampling techniques are used, the sampling strata should have a rational basis and the sub-set of the universe for each strata should be clearly defined.

- Sample Size Determination

The statistical formula that is used to determine appropriate sample size is:

N= Zs2
---
r

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

- Selection of Claims

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

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

A. Implement computer algorithms to test for duplicate billings. Note exceptions.
B. As applicable to provider type, implement computer algorithms to test for improper unbundled billings, split billings, inappropriate use of “junk” codes and inappropriate overlap with inpatient hospital stays. Note exceptions.
C. As applicable to provider type and service type, implement computer algorithms to test for provider billings in excess of 24 hours per day. Note exceptions.
D. Verify that reimbursed services were provided to participants who were Medicaid eligible at the time that services were rendered. Compare dates of service in the Medicaid claim with the eligibility dates in the participant eligibility file. Note exceptions.
E. As appropriate, review exceptions from the computerized analysis with the provider and/or the Department of Health and Social Services (and possibly with the Department’s fiscal agent). Review feedback and other comments relating to noted exceptions.”

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

Role of Families in Audits: If the family member is also a care provider, they may be interviewed as part of on-site procedures. Typical question asked during a provider interview include entrance conference questions, gaining familiarity with provider operations, records and internal control and compliance environment, seeking clarification to any question that arose from the desk review and sharing any findings identified during the exit interview process. The process is no different for family member care providers.

Periodic Independent Audit: As stated above, for Single Audit Act of 1984 and the US OMB A-133 audit requirements, these audits are conducted every year through the single state audits performed by the Division of Legislative Audit for the State’s financial statements and a contractor for the federal program requirements. These audits include all of the department’s federal programs. These audits are posted online and via this link: http://legaudit.akleg.gov/audits/statewide/

http://legaudit.akleg.gov/docs/audits/single/statewide/40016rpt-2016%20(2).pdf

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:

Attachment 1.2-A Page 1 of the Medicaid State Plan identifies the Department of Health and Social Services as the single State Agency responsible for administering the Medicaid State Plan, under AS 47.07.040. This effective date of this page is 10/1/95. The Department subsequently underwent a reorganization, and page 4 of the Attachment 1.2-A identifies the Division of Senior and Disabilities Services as the agency responsible for administration of all Medicaid home and community-based waivers. This page became effective 7/1/2003. SDS conducts administrative responsibilities associated with providing waiver services and ensures that that 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 waivers.

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

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

Appendix A: Waiver Administration and Operation

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

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

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

Appendix A: Waiver Administration and Operation

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

◉ **Not applicable**

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

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

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

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

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

Appendix A: Waiver Administration and Operation

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

Appendix A: Waiver Administration and Operation

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

Appendix A: Waiver Administration and Operation

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

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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 States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

n/a

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: n/a	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: n/a

c. Timelines

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

- (●) **No**
- ( ) **Yes**

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

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

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

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

This waiver's target group is people of any age who experience intellectual or developmental disabilities, meet ICF/IID level of care (LOC), and whose service needs and health and welfare can be met within the individual cost limit.

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 ISW is intended to provide services for people with IDD living in the community who have less intensive needs than people on Alaska's IDD waiver (AK.0260.R05).

The State established an individual cost limit of $28,928 that applies to all waiver participants during the first year of the waiver period, and which will be indexed to service rate inflation the following years the waiver is in effect. The individual budget limit (referenced in Appendix C-4) that is at or below the individual cost limit can be no higher than the individual cost limit.

This waiver allows the participant to select any combination of services up to the individual budget limit as described in Appendix C-4.

The individual cost limit is based upon statistical analyses of service utilization patterns from the State-funded Community Developmental Disabilities grants which serves a similar target group to the group served on the ISW. These analyses indicate that a majority of grant recipients would be able to receive the same or an increased amount of services within the individual cost limit.

Currently, Alaska has a prioritization system (a "waitlist") that allows people with the greatest needs to be have access to the IDD waiver, which does not have an individual cost limit.

Individuals who are waiting for a slot on the IDD waiver are served by providers who receive State-only funded grants. Although these grants do not have individual cost limits, the total amount a grantee agency in a particular geographic area can receive is capped. The grantees make decisions about how best to allocate these funds to serve people with intellectual and developmental disabilities. These grants have been sufficient for serving people safely in the community. The state believes that utilization patterns among these grantees provide a reasonable basis for estimating need among future ISW participants. People who develop more extensive needs are offered the opportunity to apply for the IDD waiver.

Because the shift to Medicaid removes the current cost control mechanisms (i.e., allowing each grantee flexibility on who to serve, how much to provide, and what rate to pay as long as they stay below an overall cap), the state needed to establish a new mechanism for controlling costs so that the ISW serves its intended purpose of providing services to people with less intensive needs a distinctly different population than that served by the IDD waiver.

The state discussed a variety of approaches to cost control mechanisms with both participant stakeholders and other stakeholders, including care coordinators and service providers (both grant and waiver). Approaches discussed included establishing multiple tiers based on age and type of residence. After much discussion, stakeholders believed that a single fixed cap had the benefit of being easiest to administer and the most transparent. Both the participant and the other stakeholder councils endorsed this approach by consensus. There was also a consensus to include an additional allocation to assist with temporary emergencies.

Because the rates for services for the State-funded grants are negotiated by the grantees and differ by grantee, the state analyzed monthly utilization data from grant-funded services to establish the basis for the number of anticipated waiver service units, and attached costs to these projected units of service using the Medicaid IDD waiver rates.

The state then analyzed a variety of service cost caps and emergency allocation amounts. These analyses indicated that only 18% of the individuals on the grants would have their service levels reduced to the individual budget limit. When the $5,000 emergency allocation (see Appendix B-2-c "Participant Safeguards) is also included, the percentage of grant recipients is reduced to 12%. Eighty-eight percent of people receiving grant services will not be affected by the individual budget limit and an additional $5,000 emergency allocation, if needed.

The state conducted further analyses of these 18% of the grant recipients and found they tended to be concentrated among a few provider agencies. After translating units into Medicaid services, the per client cost across agencies ranged from $2,494 to $39,831 even though the state allocated funding on a geographic basis. These spending differences are likely attributable to some agencies giving more services to a smaller number of people and not shifting their highest cost participants to the IDD waiver. A substantial number of these participants were receiving more than $70,000 or $80,000 per year worth of services (including residential services) and should never have remained on State-funded grants.

The state selects people from its wait list (called the “Registry”) to place the people with the highest needs on the IDD waiver; a parallel waitlist has been established for the ISW. As the state has moved toward ISW implementation, those who have greater needs than appropriate for the ISW have been selected for the IDD waiver. To address those with evolving needs, the state has established reserve capacity mechanisms (see Appendix B-2-c “Participant Safeguards”) to ensure that people who are enrolled on the ISW and develop increased needs for services that do not meet the terms for the emergency allocation will be referred to another waiver.

If an individual is denied entrance to the waiver, SDS offers the individual the opportunity to request a Fair hearing, as provided in Appendix F.

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

◉ **The following dollar amount:**

Specify dollar amount: 28928

The dollar amount *(select one)*

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

Specify the formula:

The cost limit is adjusted each year that the waiver is in effect by applying a 2.4% inflation adjustment annually. The basis for this formula is outlined in Appendix J-2-c-i.

○ **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)

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:

The State established an individual cost limit of $28,928 that applies to all waiver participants during the first year of the waiver period, and which will be indexed to service rate inflation the following years the waiver is in effect. The individual budget limit (referenced in Appendix C-4) can be no higher than the individual cost limit. The individual cost limit of $28,928 governs entrance to the waiver.

The individual cost limit comprises the individual budget limit plus the highest applicable geographic differential as described in the Appendix C-4 “Additional Limits on the Amount of Waiver Services.”

ISW applicants are expected to have available services and supports from other sources that in combination with waiver services are sufficient to assure their health and safety within the individual cost limit. If the applicant’s needs or desired supports exceed the scope or cost limit of the waiver, the applicant is denied entrance to the ISW.

There are several processes that aid in determining if an individual’s health and safety needs can be met on the ISW. Initially, an individual is placed on the waitlist using a tool called the Developmental Disabilities Registration and Review (DDRR). This is a tool that scores an individual’s criticality in current life circumstances. It measures a variety of needs that could potentially indicate a need for supports greater than what the ISW can offer. Once an individual is drawn from the waitlist and offered the opportunity to apply for the ISW, the individual is required to submit an application package.

Detailed and contemporaneous evaluations are required as part of the application package. Often times these comprehensive evaluations discuss the level of support that is needed to ensure that health and safety needs are met. If an evaluation indicates a concern in terms of safety and/or compatibility with a cost limited waiver, SDS intake personnel address this with the SDS waiver review committee.

The review committee may decide to move to the assessment stage to gather more information, which may be used to update the DDRR. Updating the DDRR may allow the individual to be drawn for the IDD waiver, which has no cost limit.

The final process, which is often the most informative, is through the administration of the functional assessment tool for determining an ICF/IID level of care. In addition to the assessment for level of care the assessors collect collateral information in terms of the individual’s level of need and how that need translates in terms of appropriate supports. If the assessor has an indication that the individual has needs greater than what the ISW can meet, the application receives additional consideration. This could mean collecting more information, updating the DDRR with more current information, referring the individual to another waiver program or determining if there are other, more appropriate, supports that could be incorporated to meet the individual’s needs and complement the ISW.

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:

Participants may receive up to an additional $5,000 in services every three years in the form of an "emergency allocation" that is intended to address emergency needs related to a time-limited change in the participant's health, behavior or functional capacity, or a time-limited change in the participant's primary unpaid caregiver for a reason stated in 7 AAC 130.209 (a)(3)-(5). The emergency allocation can be received in one year or spread out over the three-year period.

Information about this emergency allocation is included in outreach materials that are directed at applicants, representatives, and caregivers, and in the training webinars and materials that care coordinators receive for this waiver.

A participant (or representative) will discuss with his/her care coordinator the need to pursue this emergency allocation funding, as part of regular care coordination duties that include additional communication when problems or issues arise. Together, using the person-centered process, the participant and care coordinator decide whether and which additional services, up to the $5,000 limit, would alleviate the health or safety issue. The care coordinator then submits an amendment to the support plan. SDS reviews the amendment according to regulations on expedited consideration of support plans, and within 10 days, notifies the participant's care coordinator of the approval or disapproval of the amendment. If the participant does not agree with the decision, the participant can appeal through the Fair Hearing process.

☒ **Other safeguard(s)**

Specify:

If there is a change in the participant's health, behavior, or functional capacity, or if there is a change in the participant's primary unpaid caregiver for a reason stated in 7 AAC 130.209 (a)(3)-(5) and his or her health and safety can no longer be assured on the ISW, he or she is referred another waiver.

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	620
Year 2	620
Year 3	620
Year 4	620
Year 5	620

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	600
Year 2	600
Year 3	600
Year 4	600
Year 5	600

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 considered for the ISW waiver, applicants must: 1) be determined to meet the definition of a person with a developmental disability as defined in AS 47.80.900(6), 2) request placement on the Developmental Disabilities Registration and Review ISW waitlist (DDRR-ISW), and 3) meet ICF/IID level of care.

Initially, an individual is placed on the ISW waitlist using a tool called the Developmental Disabilities Registration and Review, which is adopted by reference in regulation. This is a tool that scores an individual's criticality in current life circumstances. It measures a variety of needs that may potentially indicate an individual's support needs could be met within the ISW individual cost limit or, alternatively, potentially indicate an individual may have a need for supports greater than what the ISW can fund. The State's objective criteria for selecting ISW applicants is the applicant's DDRR score.

Applicants drawn from the DDRR-ISW are provided a list of agencies certified by SDS to provide care coordination services. The care coordinator then completes the application for waiver services, which includes gathering and submitting confirmation of a qualifying diagnosis and other documentation. The applicant is then assessed for eligibility for the ISW waiver using the Level of Care evaluation process which includes a case review and the use of the Inventory for Client and Agency Planning (ICAP) for all initial requests. The application and all documentation are reviewed by an SDS Qualified Intellectual Disabilities Professional (QIDP) 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 the applicant's support services are expected to remain within the scope of the waiver and the cost limit, the care coordinator is then authorized to complete and submit a support plan. Alternatively, if an applicant meets level of care but, based on a review of the level of care assessment or the developed support plan, SDS determines that the applicant does not have sufficient services and supports available from other sources that, in combination with the waiver, assure his/her health and welfare, the applicant is denied entrance to the waiver. If an individual is denied entrance to the waiver, SDS offers the individual the opportunity to request a Fair Hearing, as provided in Appendix F.

The DDRR-ISW is maintained when the ISW waiver is at capacity.

Appendix B: Participant Access and Eligibility

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

Waiver Phase-In/Phase-Out Schedule
Based on Waiver Proposed Effective Date: 07/01/18

a. The waiver is being (select one):

- (●) **Phased-in**
- ( ) **Phased-out**

b. Phase-In/Phase-Out Time Schedule. *Complete the following table:*

Beginning (base) number of Participants: 0

Phase-In/Phase-Out Schedule

Waiver Year 1
Unduplicated Number of Participants: 620

Month	Base Number of Participants	Change	Participant Limit
Jul	0	100	100
Aug	100	100	200
Sep	200	100	300
Oct	300	100	400
Nov	400	100	500

Waiver Year 2
Unduplicated Number of Participants: 620

Month	Base Number of Participants	Change	Participant Limit
Jul	600	0	600
Aug	600	0	600
Sep	600	0	600
Oct	600	0	600
Nov	600	0	600

Phase-In/Phase-Out Schedule

Month	Base Number of Participants	Change	Participant Limit
Dec	500	100	600
Jan	600	0	600
Feb	600	0	600
Mar	600	0	600
Apr	600	0	600
May	600	0	600
Jun	600	0	600

Month	Base Number of Participants	Change	Participant Limit
Dec	600	0	600
Jan	600	0	600
Feb	600	0	600
Mar	600	0	600
Apr	600	0	600
May	600	0	600
Jun	600	0	600

Waiver Year 3

Month	Base Number of Participants	Change	Participant Limit
Jul	600	0	600
Aug	600	0	600
Sep	600	0	600
Oct	600	0	600
Nov	600	0	600
Dec	600	0	600
Jan	600	0	600
Feb	600	0	600
Mar	600	0	600
Apr	600	0	600
May	600	0	600
Jun	600	0	600

Waiver Year 4

Unduplicated Number of Participants: 620

Month	Base Number of Participants	Change	Participant Limit
Jul	600	0	600
Aug	600	0	600
Sep	600	0	600
Oct	600	0	600
Nov	600	0	600
Dec	600	0	600
Jan	600	0	600
Feb	600	0	600
Mar	600	0	600
Apr	600	0	600
May	600	0	600
Jun	600	0	600

Waiver Year 5

Unduplicated Number of Participants: 620

Month	Base Number of Participants	Change	Participant Limit
Jul	600	0	600
Aug	600	0	600
Sep	600	0	600
Oct	600	0	600
Nov	600	0	600
Dec	600	0	600
Jan	600	0	600
Feb	600	0	600
Mar	600	0	600
Apr	600	0	600
May	600	0	600

Phase-In/Phase-Out Schedule

Month	Base Number of Participants	Change	Participant Limit
Jun	600	0	600

c. Waiver Years Subject to Phase-In/Phase-Out Schedule

Year One	Year Two	Year Three	Year Four	Year Five
☒	☐	☐	☐	☐

d. Phase-In/Phase-Out Time Period

	Month	Waiver Year
Waiver Year: First Calendar Month	**Jul**	
Phase-in/Phase-out begins	**Jul**	**1**
Phase-in/Phase-out ends	**Dec**	**1**

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. **1. State Classification.** The state is a *(select one)*:

- ○ **§1634 State**
- ◉ **SSI Criteria State**
- ○ **209(b) State**

2. Miller Trust State.
Indicate whether the state is a Miller Trust State *(select one)*:

- ○ **No**
- ◉ **Yes**

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

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

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

  Select one:

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

  Specify percentage:

- ☒ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**

☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**

☐ **Medically needy in 209(b) States (42 CFR §435.330)**

☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

☒ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

42 CFR
§435.110 Parents and other caretaker relatives. Sec 1925 Transitional Medical Assistance (TMA)
§435.115 Individuals Extended Medicaid due to increased spousal support.
§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.
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.
§435.145 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 Optional eligibility for individuals who meet the income and resource requirements of SSI or the State supplement program.
§435.222 Reasonable classification of children.
§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.

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 spend down 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 a 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: 1

ii. Frequency of services. The state requires (select one):

- (●) **The provision of waiver services at least monthly**
- ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- (●) **Directly by the Medicaid agency**
- ( ) **By the operating agency specified in Appendix A**
- ( ) **By a government agency 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:

Staff performing initial evaluations for needed supports will be Qualified Intellectual Disabilities Professionals (QIDP), defined as follows:

- A licensed psychologist (Master's prepared);
- A licensed physician (MD or DO);
- A social worker (Bachelor or Master's prepared);
- An occupational therapist;
- A physical therapist;
- A speech pathologist or audiologist;
- A Registered Nurse;
- Professional recreation staff (an individual with a Bachelor's in a recreation specialty (art, music, physical education);
- An individual with a Bachelor's in a human services field (sociology, special education, rehabilitation, counseling, psychology).

All must have at least one 1 year working as a profession directly with individuals with intellectual or other developmental disabilities.

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.

To be considered for the ISW waiver, an applicant must be determined to meet the definition of a person with a developmental disability as defined in AS47.80.900 (6), and have indicated an interest in being selected for the ISW waiver by applying for placement on the Developmental Disabilities Registration and Review ISW waitlist (DDRR-ISW).

Once an applicant has been drawn from DDRR-ISW waitlist and offered the opportunity to pursue the ISW waiver, the initial ICF/IID level of care process begins. SDS conducts a comprehensive review of the complete application submitted by a care coordinator, which includes updated diagnostic, medical, developmental, and functional evaluations and other records.

For participants under three years of age, the ICF/IID level of care is determined initially and reevaluated annually through a comprehensive review of current developmental assessments which includes a review of an evaluation completed as part of the Early Intervention/Infant Learning Program or an evaluation that was completed within the previous 12 months that 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.

For initial level of care assessments of participants ages three and older, SDS administers the Inventory for Community and Agency Planning (ICAP) process which includes interviews of one to three respondents and an observation of the participant. The respondents must be people who have known the participant for at least three months, see him/her on a regular basis, and are willing and able to provide information regarding the participant's current skills and behaviors.

The ICAP is administered annually for participants between the ages of three and seven. Participants over the age of seven receive an interim level of care assessment accompanied by an updated qualifying diagnosis certificate (QDC) or a comprehensive file review annually. The comprehensive file review includes 1) prior ICAP reviews, 2) functional assessments and 3) a qualifying diagnosis certificate (QDC). An ICAP may be administered if the interim level of care assessment or the comprehensive file review indicates a significant change in functioning has occurred or at the discretion of SDS.

The ICAP assessment is then scored by the ICAP Compuscore software. The level of care determination is made by a QIDP considering a combination of the applicant's diagnosis and ICAP score.

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 for level of care evaluation and reevaluation depends upon the applicant and/or participant's age.

Initial applicants and current waiver participants under three years of age receive a level of care evaluation or reevaluation through an annual comprehensive review of current developmental assessments.

Initial applicants and current waiver participants between the ages of three and seven, receive an ICAP to assess functional abilities and determine whether they meet ICF/IID level of care. The ICAP is used annually for level of care reevaluation for current waiver participants.

Initial applicants over the age of seven receive an ICAP. Participants over the age of seven receive an interim level of care assessment accompanied by an updated qualifying diagnosis certificate (QDC) or a comprehensive file review annually. The comprehensive file review includes 1) prior ICAP reviews, 2) functional assessments and 3) a qualifying diagnosis certificate (QDC). An ICAP may be administered if the interim level of care assessment or the comprehensive file review indicates a significant change in functioning has occurred or at the discretion of SDS.

When appropriate, the State conducts evaluations and reevaluations using telehealth technology.

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 SDS 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 QIDP 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.

Reevaluation timeliness is also tracked as an element of the unit manager's duties. Though SDS does not report on this measure to CMS, timeliness is evaluated and measured by the state to ensure adherence to eligibility processes.

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

Level of care evaluations and reevaluations are maintained in the participant's official file in the Anchorage office of the SDS 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 States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

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

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence

		Interval = Confidence Interval = 95%, +/- 5% and 50% distribution
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

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

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

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

Performance Measures

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

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

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

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval =

		Confidence Interval = 95%, +/- 5% and 50% distribution
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:

LOC 3: # and % of initial LOC determination criteria applied correctly. Numerator: # of initial and annual LOC determination criterion applied correctly. Denominator: # of participants who were included in the case review sample.

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

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

Data Aggregation and Analysis:

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

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

Quality improvement strategies are founded upon data-driven discovery activities. Task Committees focus on specific areas of performance and implement systems for data collection. The Level of Care Task Committee comprises managers of the IDD unit and CAT Intake and Assessment unit (co-chairs), Research and Analysis unit, Quality Assurance unit, Policy and Program Development unit and the CAT Review unit. These managers are the first line of discovery and are charged with identification of level of care problems within the waiver program through monitoring and evaluation of established performance measure data.

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

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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 SDS performance in determining level of care the managers of the CAT Intake and Assessment unit and the IDD unit are responsible for initiating remediation activities. As part of monthly discovery activities, the two unit managers review reports generated through the SDS information management system, DS3, which provides data on the appropriateness of initial level of care determinations, the timeliness of level of care re-determinations, the individual who performed the level of care determination and use of the approved forms in level of care determination. In addition, the managers review a sample of participant case records to determine if the level of care criteria have been applied correctly.

When the data reveals problems in level of care determination activities, the unit managers analyze the data to discover if the problem involves performance issues with individual assessors or systemic problems in the SDS level of care determination processes. For assessor performance issues such as lack of timeliness or incorrect application of level of care 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 level of care or the forms used by assessors are brought to the Level of Care Task Committee for analysis and development of recommendations for the Quality Assurance Workgroup. If remediation involves amendments to SDS regulations or policy and procedure improvements, responsibility falls to the Chair of the Policy Task Committee who facilitates changes through the State of Alaska regulation development process or the SDS policy and procedure development process as appropriate.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

After a participant is found eligible for the waiver, they and/or their legal representative, along with the participant's care coordinator, choose any combination of services available on ISW and complete a support plan.

Section IV of the support plan “Participant Choice of Services” requires that the participant or their legal representative 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 provides after a choice is made. Finally, the section requires the participant and/or their legal representative to indicate their choice. The support plan is signed by everyone involved in the planning effort. The "Participant Choice of Services" section of the support plan is updated and reviewed with the participant at least annually.

Participants and the team are referred to resources (web and hard copy) of all the services available through the waiver program.

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 support plans, 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 support plan 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):

The DHSS Division of Public Assistance (DPA) performs financial eligibility functions for home and community-based 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 support plan development and monitor waiver services for persons with limited English proficiency, are either bilingual or arrange for interpreters to perform these functions in the participant's language of origin.

When working with blind or deaf participants, SDS and care coordinators often rely on family members who act as interpreters. Those regions with Aging and Disability Resource Centers (ADRC) 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	**Intensive Active Treatment**		
Other Service	**Transportation**		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Care Coordination

HCBS Taxonomy:

Category 1: 01 Case Management

Sub-Category 1: 01010 case management

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

Care coordination services assist waiver participants in gaining access to needed waiver and other State plan serves, as well as medical, social, and educational services through development of an annual support plan and help with securing identified services. By means of a person-centered process led by the recipient and the planning team of his or her choosing, care coordinators assist eligible individuals to gain access to waiver and other state plan services, as well as medical, social, educational, and other services with funding sources other than Medicaid.

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 support plan. Care coordinators serving ISW participants are required to conduct at least one face-to-face contact quarterly, plus one telephone call in the two subsequent months. Care coordination services also assist with case terminations to ensure participants transitioning off a waiver have adequate community services and supports. These ongoing monthly services comprise waiver care coordination.

(Initial activities performed by care coordinators include providing assistance with waiver application documents, coordinating with SDS for the applicant to have a timely initial functional assessment and subsequent reassessments, developing of a person-centered support plan, and annually renewing that support plan. These services are covered under the Targeted Case Management State Plan Option; because waiver services cannot duplicate other Medicaid services, these are no longer waiver services.)

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 waiver care coordination services must be prior authorized.

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

One unit a month of on-going care coordination.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified care coordination agency
Individual	Care Coordinator

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Care Coordination

Provider Category:

Agency

Provider Type:

Certified care coordination agency

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

SDS Certified Agency under 7AAC 130.220, Provider certification and enrollment

Other Standard *(specify):*

SDS certified for Care Coordination Services under 7AAC 130.240

The Provider Conditions of Participation apply to all waiver home and community-based services:

Certification:

The provider must demonstrate readiness to provide services and comprehension of Medicaid regulations, home and community-based waiver services regulations, and pertinent service Conditions of Participations through documents describing provider operations.
The provider must submit, in a format provided by SDS, an application for certification or recertification; and if requesting an exception under 7 AAC 130.220 (j), an application to provide both care coordination and other home and community-based waiver services.

In addition to the required application forms, the provider must submit, depending on the services the provider elects to offer and as directed by SDS:
•policies and procedures that address the following: admissions to provider services; background; complaint management; confidentiality of protected health information, including a Notice of Privacy Practices; conflicts of interest; critical incident reporting; emergency response planning; evaluation of employees; financial accountability; medication management; quality improvement; restrictive interventions; termination of provider services; training;
•the following documents: State of Alaska business license; Certificate of Insurance or similar documentation of insurance coverage; licenses for assisted living homes and foster homes; building or use permits for site-based services, if required by state or local laws; vehicle permit for hire, if required by state or local laws; vehicle registration; food service permit; and verification that agency staff have attended and completed SDS training on critical incident reporting and settings requirements;
•personnel information, including organization chart, including names of individuals filling each position; list of names of board members; list of names of individuals with an ownership interest in the provider; list of names of personnel; and list of volunteers and contractors who work on-site and have unsupervised access to recipients or to protected health information;
•other information regarding requirements specified in the service Conditions of Participation;
•a quality improvement report for renewal of certification; and
•a provider self-assessment of settings where home and community-based waiver services are provided, when required and in a format provided by SDS.
The provider must implement and abide by all policies and procedures that were submitted for the purposes of gaining certification.
The provider must grant to SDS, for certification and oversight purposes, access to all service locations.

Operations:
The provider must utilize the SDS secure electronic interface for submission of confidential and protected health information; subscribe to and review SDS electronic email, http://list.state.ak.us/mailman/listinfo/sds-e-news; maintain all records, required under 7 AAC 105.230, in English and in a form that is legible and understandable to a reviewer; comply with all training requirements; and practice open communications and cooperate with other providers of services.
No owner, executive director, board member, authorized agent, employee, or contractor of a provider agency may provide services to recipients if that individual has been convicted of Medicaid fraud; has been sanctioned under Medicaid regulations, or has been suspended or terminated from the Medicaid program, because of program abuse or abuse of a recipient; or has had either a valid criminal history check or variance revoked under 7 AAC 10.945.
The provider must comply with the criminal history checks requirements of 7 AAC 10.910 – 10.990.
In the event a dispute arises with another provider and is not resolved by discussion between them, the providers must agree to mediation; the providers must retain an alternate dispute resolution organization to mediate the dispute, and must share equally in the cost.
Personnel:
The provider must ensure that the employment and education history offered by a potential employee is verified, and resulted in the acquisition of the knowledge based and skills required for the position.
The provider must verify that any individual hired for a program administrator position meets the qualifications specified in the service Conditions of Participation. The provider may accept an applicant

whose education was completed in a country other than the United States if the applicant can show that his/her foreign education is comparable to that received in an accredited educational institution in the United States. The provider may accept a copy of a State of Alaska license issued under AS 08 as showing an applicant's foreign education is comparable to education in the United States. For applicants not licensed under AS 08, the provider must inform the applicant that the applicant is responsible for providing A) a foreign educational credentials evaluation report, from an evaluation service approved by the National Association of Credential Evaluation Services, that includes, at a minimum, a description of each course and semester or quarter hour credits earned for that course, and a statement of degree equivalency to education in the United States; and B) certified English translations of any document submitted as part of the application, if the original documents are not in English. The provider must keep documents showing a program administrator's foreign education comparability to that of the United States on file, and make them available to SDS upon request. The provider may employ an individual to serve as program administrator for more than one service if necessitated by the location of an agency office; and if, given the size of the recipient population served and the number of direct care workers employed by the provider, that administrator is capable of being actively engaged in the management of each service. The provider may use a term other than program administrator for this position (e.g., program director, program manager or program supervisor), but the individual filling the position must meet the requirements for program administrator that are specified in the Conditions of Participation for the services the provider offers.
The provider must identify the skill set needed by direct service workers to render the services the provider offers; the provider may use as a resource the Alaska Core Competencies for Direct Care Workers in Health and Human Services, http://www.trusttrainingcoop.org/training/akcc.html. The provider must develop and implement a performance evaluation based on the skill set determined to be needed by its direct service workers. The provider must assess the performance of direct service workers to ensure they have the ability to work effectively and to identify skills that need further development.
Training:
The provider must have on file, for each direct service worker, documentation showing successful completion of cardiopulmonary resuscitation (CPR) training, within the previous two years, that was taught by an individual who holds a valid CPR instructor credential in accordance with 7 AAC 26.985; and first aid training, within the previous two years, that was taught by an individual certified by the American Red Cross, the American Heart Association, or an equivalent organization approved by SDS. The provider must ensure that its direct service workers and individuals providing chore services, agency-based congregate meals, or transportation services provide documentation of attendance and successful completion of CPR and first aid training every two years; however, if that training is not periodically available within 100 miles of the workplace, the training requirement may be met by attendance and completion of the required course every three years. The provider must provide, and have on file, for all employees and volunteers, documentation of orientation to the agency and its relationship to the department; and training necessary to render services to recipients.
The provider must have on file, for all staff, documentation of attendance and completion of, at least every two years, training on how to report critical incidents to SDS.
Except for the staff of providers subject to the requirements of 7AAC 75.240, the provider must train all staff responsible for assisting recipients with self-administer medications, and have on file documentation of attendance and completion of the training.

In addition to the above, care coordination services providers must meet the requirements of 7 AAC 130.240 and operate in compliance with the Care Coordination Conditions of Participation:
The provider must designate a care coordination services program administrator who is responsible for the management of the program including the following: orientation, training, and supervision of care coordinators; implementation of policies and procedures; intake processing and evaluation of new admissions to the services; participation in the development of plans of care in collaboration with other providers of services; ongoing review of the delivery of services, including A) monitoring the amount, duration, and scope of services to assure delivery as outlined in the plan of care; B) assessing whether the services assist the recipients to attain the goals outlined in plans of care; and C) evaluating the quality of care rendered; development and implementation of corrective action plans for identified problems or deficiencies in delivery of care coordination services; and submission of required reports to SDS, including critical incident reports.

The provider must ensure that the individual in the program administrator position is certified as a care coordinator, and renews that certification as required under 7 AAC 130.238.
The program administrator must be at least 21 years of age, and qualified through experience and education in a human services field or setting. Required experience: one year of full-time or equivalent part-time experience providing services to individuals in a human services setting in a position with responsibility for planning, development, and management or operation of programs involving service delivery, fiscal management, needs assessment, program evaluation, or similar tasks. Required education and additional experience or alternatives to formal education: A) Bachelor of Arts or Bachelor of Science degree from an accredited college or university in social work, psychology, rehabilitation, nursing or a closely related human services field; or B) Associate of Arts degree from an accredited college or university in psychology, rehabilitation, nursing or a closely related human services field, and two years of full-time or equivalent part-time experience working with human services recipients; or C) four years of full-time or equivalent part-time experience working with human services recipients in social work, psychology, rehabilitation, nursing, or a closely related human services field or setting; or D) certification as a rural community health aide or practitioner, and one year of full-time or equivalent part-time experience working with human services recipients.
In addition to meeting education and experience requirements, the administrator must possess the knowledge base and skills necessary to carry out the care coordination services program. The administrator knowledge base must include: A) the medical, behavioral, habilitative, and rehabilitative conditions and requirements of the population to be served; and B) the laws and policies related to SDS programs. The administrator skill set must include: A) the ability to evaluate, and to develop a plan of care to meet, the needs of the population to be served; and the ability to supervise professional and support services staff.

Verification of Provider Qualifications

Entity Responsible for Verification:

SDS Provider Certification and Compliance Unit

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:

Individual

Provider Type:

Care Coordinator

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

SDS Certified Agency under 7AAC 130.220, Provider certification and enrollment

Other Standard *(specify):*

SDS certified Care Coordinator under 7AAC 130.238, Certification of care coordinators

SDS certified to provide "Care Coordination Services" under 7AAC 130.240

In addition to the Provider Conditions of Participation detailed in the Care Coordination Agency Qualifications above, a care coordination agency must ensure the following standards are met for its care coordinators:

A. Education and Experience
1. Care coordinators shall be at least 18 years of age, and qualified through experience and education in a human services field or setting.
2. Required education and additional experience or alternatives to formal education.
a. Bachelor of Arts , Bachelor of Science, or Associate of Arts 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, or equivalent part-time experience working with human services recipients; or
b. 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, or equivalent part-time experience working with human services recipients; or
c. three years of full-time or equivalent part-time experience working with human services recipients in social work, psychology, rehabilitation, nursing, or a closely related human services field or setting; or
d. certification as a rural community health aide or practitioner and one year of full-time or equivalent part-time experience working with human services recipients.
3. In addition to meeting education and experience requirements, care coordinators must possess, or develop before providing program services, the knowledge base and skills necessary to carry out the care coordination process.
a. The care coordination knowledge base must include:
i. the medical, behavioral, habilitative, and rehabilitative conditions and requirements of the population to be served by the care coordinator;
ii. the laws and policies related to Senior and Disabilities Services programs;
iii. the terminology commonly used in human services fields or settings;
iv. the elements of the care coordination process; and
v. the resources available to meet the needs of recipients.
b. The care coordination skill set must include:
i. the ability to evaluate, and to develop a plan of care to meet, the needs of the population to be served;
ii. the ability to organize, evaluate, and present information orally and in writing; and
iii. the ability to work with professional and support staff.
4. Senior and Disabilities Services may certify as care coordinator, under 7 AAC 130.238, an applicant whose education was completed in a country other than the United States if the applicant can show that his/her foreign education is comparable to that received in an accredited educational institution in the United States.
a. Applicants licensed under AS 08 may submit a copy of a State of Alaska license to show the applicant’s foreign education is comparable to education in the United States.
b. Applicants not licensed under AS 08 are responsible for providing to Senior and Disabilities Services the following with an initial application for certification:
i. a foreign educational credentials evaluation report, from an evaluation service approved by the National Association of Credential Evaluation Services, that includes, at a minimum, a description of each course and semester or quarter hour credits earned for that course, and a statement of degree equivalency to education in the United States; and
ii. certified English translations of any document submitted as part of the application, if the original documents are not in English.

B. Training.
1. An individual who seeks certification to provide care coordination services
a. must enroll in the Senior and Disabilities Services Beginning Care Coordination course;

b. demonstrate comprehension of course content through examination; and
c. provide proof of successful completion of that course not more than 365 days prior to the date of submission of an application for certification.
2. A certified care coordinator who wishes to renew his or her certification
a. must successfully complete
i. at least one Senior and Disabilities Services care coordination training course during the individual's first year of certification, and thereafter, every 24 months to qualify for certification renewal;
ii. 16 hours annually of continuing education that is relevant to a care coordinator's job responsibilities; and
b. when submitting an application for recertification, provide proof of successful completion of the Senior and Disabilities Services training course and 16 hours annually of continuing education.
3. The provider agency must document, for each care coordinator, attendance and successful completion of 16 hours of continuing education annually in the care coordinator's personnel file; the provider agency's in-service training may qualify as continuing education if
a. the training increases the knowledge, abilities, or skills of the care coordinator; and
b. the content of the in-service training, date, and time in attendance is documented.

Verification of Provider Qualifications

Entity Responsible for Verification:

SDS Provider Certification and Compliance Unit

Frequency of Verification:

Every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04020 day habilitation
Category 2:	**Sub-Category 2:**

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

Service Definition *(Scope):*

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

Day habilitation services assist recipients ages three and older to acquire, retain, and improve the self-help, socialization, and adaptive skills necessary to live successfully in home and community-based settings. These services must provide supervision and a secure environment for recipients, may be planned to reinforce skills or lessons taught in other settings, and may include both individual and group activities.

In addition, day habilitation services may be provided to assist recipients to participate in meaningful retirement activities, including hobbies, clubs, and other senior-related activities available in the community.

While day habilitation services may be offered in a variety of settings in the community and are not limited to fixed-site facilities, the environment in which they are provided must be appropriate for delivery of the services in a manner that will contribute to the recipient's accomplishing the outcomes and goals specified in the recipient's plan of care, and increasing participation in and access to community settings and resources. These services must be provided in non-residential settings separate from the recipient's private residence or another residential living arrangement, unless the provider is granted a waiver under 7 AAC 130.260 (d) regarding the setting.

All day habilitation services must be prior authorized and do not include vocational services.

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

Day habilitation is limited to 624 hours/year (an annualized amount based on 12 hours/week, but allowing for seasonal variation in utilization) for all recipients of the service, except in certain circumstances.

Requests for service amounts exceeding the yearly cap will be considered exceptions to the rule and should only be requested in extreme circumstances. These requests will be reviewed by SDS to determine whether a limited amount of additional day habilitation hours are necessary to protect a recipient's health and safety and to prevent institutionalization. Exception requests will be reviewed in the context of individual's entire service plan and person-centered goals.

When limits on amount to a waiver services is applied, the limit must not pose obstacles to the service achieving its stated purpose. Given the array of other services available, the reduction will not pose an obstacle to achieving the purpose of fostering the acquisition of skills, appropriate behavior, greater independence and personal choice. Waiver participants will still have access to other waiver and/or community services that can foster independence, such as:

- Waiver residential services
- Waiver supported employment
- Waiver respite
- Other state/federal initiatives (e.g. employment services through the Division of Vocational Rehabilitation (DVR))
- Natural supports and/or;
- Community volunteer supports.

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 waiver provider under 7AAC 130.220, Provider certification and enrollment

Other Standard *(specify):*

SDS certified to provide Day Habilitation Services under 7AAC 130.260

In addition to the Provider Conditions of Participation detailed in the Care Coordination Agency Qualifications above, the provider who chooses to offer day habilitation services must be certified as a provider of day habilitation services under 7 AAC 130.220, meet with the requirements of 7 AAC 130.260, and operate in compliance with the Provider Conditions of Participation and the following Conditions of Participation specific to day habilitation.

I. Program administration

A. Personnel.

1. Day habilitation services program administrator.
a. The provider must designate a day habilitation services program administrator who is responsible for day-to-day management of the program including the following:
i. orientation, training, and supervision of direct service workers;
ii. implementation of policies and procedures;
iii. intake processing and evaluation of new admissions to the services;
iv. participation in the development of plans of care in collaboration with care coordinators and other providers of services;
v. ongoing review of the delivery of services, including
(A) monitoring the amount, duration, and scope of services to assure delivery as outlined in the plan of care;
(B) assessing whether the services assist the recipients to attain the outcomes and goals outlined in plan of cares; and
(C) evaluating the quality of care rendered by direct service workers;
vi. development and implementation of corrective action plans for identified problems or deficiencies; and
vii. submission of required reports to Senior and Disabilities Services, including critical incident reports.
b. The provider may use a term other than program administrator for this position, e.g., program director, program manager, or program supervisor.
c. The program administrator must be at least 21 years of age, and qualified through experience and education in a human services field or setting.
i. Required experience: one year of full-time or equivalent part-time experience providing services to individuals in a human services setting in a position with responsibility for planning, development, and management or operation of programs involving service delivery, fiscal management, needs assessment, program evaluation, or similar tasks.
ii. Required education and additional experience or alternatives to formal education:
(A) Bachelor of Arts or Bachelor of Science degree from an accredited college or university in social work, psychology, rehabilitation, nursing or a closely related human services field; or
(B) Associate of Arts degree from an accredited college or university in psychology, rehabilitation, nursing or a closely related human services field, and two years of full-time, or equivalent part-time experience working with human services recipients; or
(C) four years of full-time or equivalent part-time experience working with human services recipients in social work, psychology, rehabilitation, nursing or a closely related human services field or setting; or
(D) certification as a rural community health aide or practitioner and one year of full-time, or equivalent part-time experience working with human services recipients.
d. In addition to meeting education and experience requirements, the administrator must possess the knowledge base and skills necessary to carry out the day habilitation services program.
i. The administrator knowledge base must include:
(A) the medical, behavioral, habilitative, and rehabilitative conditions and requirements of the population to be served; and
(B) the applicable laws and policies related to Senior and Disabilities Services programs.
ii. The administrator skill set must include:
(A) the ability to evaluate, and to develop a plan of care to meet, the needs of the population to be served; and

(B) the ability to supervise professional and support day habilitation services staff.

2. Day habilitation services direct service workers.

a. Direct service workers must be at least at least 18 years of age; qualified through education or experience; and possess, or develop before providing services, the skills necessary to meet the needs of the recipient population.

b. Required education and alternatives to formal education:

i. high school or general education development (GED) diploma; or

ii. demonstration to the program administrator of the ability to communicate in English, including reading and following written instructions and making appropriate entries regarding services in the recipient record or file.

c. Required skill set:

i. the ability to communicate with his/her supervisor, the recipient, and the primary caregiver;

ii. the ability to understand the needs of, and to work with, the recipient population;

iii. the ability to be guided by the plan of care; and

iv. the ability to respond in case of medical or community emergencies.

B. Training.

1. The provider must provide orientation and ongoing training to direct service workers to ensure they are qualified to perform day habilitation services for the recipient.

2. The provider must provide training to direct service workers in regard to the following at a minimum:

a. maintaining of a safe environment while providing services;;

b. universal precautions and basic infection control procedures;

c. cardiopulmonary resuscitation (CPR) and first aid; and

d. understanding the needs of the population to be served.

3. The provider must instruct direct service workers to notify the program manager, the supervisor, or the appropriate authority, when there is cause for concern about a recipient's health, safety, or welfare.

Verification of Provider Qualifications

Entity Responsible for Verification:

SDS Provider Certification and Compliance Unit

Frequency of Verification:

Every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

Residential habilitation services assist recipients to acquire, retain, and improve the self-help, socialization, and adaptive skills necessary to maximize independence and to live in the most integrated setting appropriate to the recipient's wishes and needs. Residential habilitation services available in the ISW are rendered as supported-living habilitation services or in-home support habilitation services based on the age of the recipient,

The activities provided as residential habilitation services must be planned with the objective of maintaining or improving the recipient's physical, mental, and social abilities rather than rehabilitating or restoring such abilities. These services must be individually tailored, and may include personal care and protective oversight and supervision, in addition to skills development.

Supported-living habilitation and in-home support services are provided, for the most part, in the recipient's residence, the home of a relative, a semi-independent or supported apartment or living arrangement.. If residential habilitation is furnished in a provider owned or leased facilities, the facility must be in compliance with the Americans with Disabilities Act and the CMS Final Rule on HCBS settings. SDS will ensure all ISW services are provided in settings that are compliant with SDS's settings regulations. Because some skills development may be enhanced by activities in community settings, services may be rendered in other environments provided the settings are appropriate for delivery of the services in a manner that will contribute the acquisition of skills necessary for daily living in the recipient's residence, and are approved in the recipient's plan of care.

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:

The department will not pay for more than 18 hours of supported living residential habilitation services from all providers combined, unless the recipient is unable to benefit from other waiver services or natural supports.

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

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:

Residential Habilitation Provider

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

SDS certified waiver provider under 7AAC 130.220, Provider certification and enrollment

Other Standard *(specify):*

SDS certified to provide Residential Habilitation Services under 7AAC 130.265

In addition to the Provider Conditions of Participation detailed in the Care Coordination Agency Qualifications above, the provider who chooses to offer residential habilitation services must be certified as a provider of residential habilitation services under 7 AAC 130.220, meet with the requirements of 7 AAC 130.265, and operate in compliance with the Provider Conditions of Participation and the following Conditions of Participation specific to residential habilitation.

I. Program administration

A. Personnel.

1. Residential habilitation services program administrator.
a. The provider must designate a residential habilitation services program administrator who is responsible for day-to-day management of the program including the following:
i. orientation, training, and supervision of direct service workers;
ii. implementation of policies and procedures;
iii. intake processing and evaluation of new admissions to the services;
iv. participation in the development of plans of care in collaboration with care coordinators and other providers of services;
v. ongoing review of the delivery of services, including
(A) monitoring the amount, duration, and scope of services to assure delivery as outlined in the plan of care;
(B) assessing whether the services assist recipients to attain the goals outlined in plans of care; and
(C) evaluating the quality of care rendered by direct care workers;
vi. development and implementation of corrective action plans for identified problems or deficiencies; and
vii. submission of required reports to Senior and Disabilities Services, including critical incident reports.
b. The provider may use a term other than program administrator for this position, e.g., program director, program manager, or program supervisor.
c. The program administrator must be at least 21 years of age, and qualified through experience and education in a human services field or setting.
i. Required experience: one year of full-time or equivalent part-time experience providing services to individuals in a human services setting in a position with responsibility for planning, development, and management or operation of programs involving service delivery, fiscal management, needs assessment, program evaluation, or similar tasks.
ii. Required education and additional experience or alternatives to formal education:
(A) Bachelor of Arts or Bachelor of Science degree from an accredited college or university in social work, psychology, rehabilitation, nursing or a closely related human services field; or
(B) Associate of Arts degree from an accredited college or university in psychology, rehabilitation, nursing or a closely related human services field, and two years of full-time or equivalent part-time experience working with human services recipients; or
(C) four years of full-time or equivalent part-time experience working with human services recipients in social work, psychology, rehabilitation, nursing, or a closely related human services field or setting; or
(D) certification as a rural community health aide or practitioner, and one year of full-time, or equivalent part-time experience working with human services recipients.
d. In addition to meeting education and experience requirements, the program administrator must possess the knowledge base and skills necessary to carry out the residential habilitation services program.
i. The administrator knowledge base must include:
(A) the medical, behavioral, and habilitative conditions and requirements of the population to be served; and
(B) the laws and policies related to Senior and Disabilities Services programs.
ii. The administrator skill set must include:
(A) the ability to evaluate, and to develop a plan of care to meet, the needs of the population to be

served;
(B) the ability to organize, evaluate, and present information orally and in writing; and
(C) the ability to supervise professional and support residential habilitation services staff.

2. Residential habilitation services direct service workers.

a. Direct service workers must be at least at least 18 years of age; qualified through education or experience; and possess, or develop before providing services, the skills necessary to meet the needs of the recipient population.
b. Required education and alternatives to formal education:
i. high school or general education development (GED) diploma; or
ii. demonstration to the provider of the ability to communicate in English, including reading written instructions and making appropriate entries regarding services in the recipient record or file.
c. Required skill set:
i. the ability to communicate with his/her supervisor and with the recipient and the primary caregiver;
ii. the ability to understand the needs of, and to work with the recipient population;
iii. the ability to be guided by the plan of care; and
iv. the ability to respond in case of household, medical, or community emergencies.

B. Training.

1. The provider must provide orientation and training to direct service workers to ensure they are qualified to perform the services planned for recipients.
2. The provider must provide training to direct service workers in regard to the following at a minimum:
a. maintaining a safe environment while providing services;
b. universal precautions and basic infection control procedures; and
c. understanding the needs of the population to be served.
3. The provider must instruct direct service workers to notify the program manager, the supervisor, or the appropriate authority, when there is cause for concern about a recipient's health, safety, or welfare.

C. Operations

1. Evaluation of capacity to provide services.
The provider must collaborate with the recipient and the recipient's care coordinator to determine whether, given the recipient's choices, diagnosis, and needs, its direct service workers have the capacity to provide residential habilitation services for that recipient.

Verification of Provider Qualifications

Entity Responsible for Verification:

SDS Provider Certification and Compliance Unit

Frequency of Verification:

Every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

Respite care services may be provided for primary unpaid caregivers and providers of family home habilitation services that are in need of relief or will be unable to provide care for recipients for limited periods of time, if those caregivers provide the oversight, care, and support needed to prevent the risk of institutionalization of a recipient by assisting with basic personal activities or with activities related to independent living. These services may be provided in the recipient's private residence, in the private residence of the respite care services provider, in specified licensed facilities, and at community locations that contribute to furthering the goals of the recipient.

Respite care services may be family directed for recipients in specified waiver categories. With the assistance of a certified respite care services provider, the recipient's primary unpaid caregiver may train and supervise the individuals chosen to care for a recipient while that caregiver is away or unable to provide care.

Per regulation, hourly respite can be provided in the recipient's home; the private residence of the respite care provider; a licensed facility including a nursing facility, a general acute care hospital, or an intermediate care facility for individuals with intellectual or developmental disabilities (ICF/IID); another community setting if the setting is appropriate for the needs of the recipient and the recipient's health, safety, and welfare will not be placed at risk. Per regulation, daily respite can be provided in the recipient's home; a licensed facility including a nursing facility, a general acute care hospital, or an intermediate care facility for individuals with intellectual or developmental disabilities (ICF/IID); or a licensed assisted living home or foster home, if that home is not the recipient's residence.

Because the intent of respite care services is to offer relief to caregivers, units of respite care services authorized in the recipient's plan of care may not be used to substitute for, or to supplement the number of personnel providing, other home and community-based services or personal care services.

Federal financial participation is not to be claimed for the cost of room and board except when provided as part of a respite care furnished in a facility approved by the state that is not a private residence.

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

Alaska regulations at 7 AAC 130.280(c) states that the department will not pay for respite care services that exceed the following duration limits:
(1) 520 hours of hourly respite care services per year, unless the department approves more hours because the lack of additional care or support would result in risk of institutionalization, and the department will not pay more than the daily rate for respite care services provided to a recipient in the adults with physical disabilities category;
(2) 14 days of daily respite care services per year.

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

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):*

n/a

Other Standard *(specify):*

SDS Certified waiver provider under 7AAC 130.220, Provider certification and enrollment

Certified by SDS to provide Respite Care Services under 7AAC 130.280

In addition to the Provider Conditions of Participation detailed in the Care Coordination Agency Qualifications above, the provider who chooses to offer respite services must be certified as a provider of respite services under 7 AAC 130.220, meet with the requirements of 7 AAC 130.280, and operate in compliance with the Provider Conditions of Participation and the following Conditions of Participation specific to respite care.

I. Program administration
A. Personnel.
1. Respite care services program administrator.
a. The provider must designate a respite care services program administrator who is responsible for day-to-day management of the program.
b. The provider may use a term other than program administrator for this position, e.g., program director, program manager, or program supervisor.
c. The program administrator must be at least 21 years of age, and qualified through experience and education in a human services field or setting.
i. Required experience: one year of full-time or equivalent part-time experience providing services to individuals in a human services setting in a position with responsibility for planning, development, and management or operation of programs involving service delivery, fiscal management, needs assessment, program evaluation, or similar tasks.
ii. Required education: high school or general education development (GED) diploma.
d. In addition to meeting education and experience requirements, the program administrator must possess the knowledge base and skills necessary to carry out the respite care services program.
i. The program administrator knowledge base must include:
(A) the medical, behavioral, habilitative, and rehabilitative conditions and requirements of the population to be served; and
(B) the laws and policies related to Senior and Developmental Disabilities programs.
ii. The program administrator skill set must include:
(A) the ability to evaluate, and to develop a service plan to meet, the needs of the population to be served;
(B) the ability to organize, evaluate, and present information orally and in writing; and
(C) the ability to supervise professional and support respite care services staff.
2. Respite care services direct service workers.
a. Direct service workers must be at least at least 18 years of age; qualified through education or experience; and possess, or develop before providing services, the skills necessary to meet the needs of the recipient population.
b. Required education and alternatives to formal education:
i. high school or general education development (GED) diploma; or
ii. demonstration to the provider of the ability to communicate in English, including reading written instructions and making appropriate entries regarding services in the recipient record or file.
c. Required skill set:
i. the ability to communicate with his/her supervisor and with the recipient and the primary caregiver;
ii. the ability to understand the needs of, and to work with the recipient population;
iii. the ability to be guided by the service plan; and
iv. the ability to handle household and medical emergencies.
B. Training.
1. The provider must provide orientation and training to direct service workers to ensure they are qualified to perform the services planned for recipients.
2. The provider must provide training to direct service workers in regard to the following at a minimum:
a. safety in the workplace, and proper use of tools and equipment required to meet the recipient's needs;
b. maintenance of a clean, safe and healthy home environment;
c. universal precautions and basic infection control procedures;

d. understanding the needs of the population to be served; and
e. safe food handling and storage, nutritious meal preparation, and the special dietary or nutrition requirements of the recipient.
3. The provider must instruct direct service workers to notify the program manager, the supervisor, or the appropriate authority, when there is cause for concern about a recipient's health, safety, or welfare.

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: Division of Senior and Disabilities Services, Provider Certification and Compliance 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: 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:

Agency

Provider Type:

Certified home and community-based service agency

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

SDS Certified waiver provider under 7AAC 130.220, Provider certification and enrollment

Other Standard *(specify):*

Certified by SDS to provide Respite Care Services under 7AAC 130.280

In addition to the Provider Conditions of Participation detailed in the Care Coordination Agency Qualifications above, the provider who chooses to offer respite services must be certified as a provider of respite services under 7 AAC 130.220, meet with the requirements of 7 AAC 130.280, and operate in compliance with the Provider Conditions of Participation and the following Conditions of Participation specific to respite care.

I. Program administration
A. Personnel.
1. Respite care services program administrator.
a. The provider must designate a respite care services program administrator who is responsible for day-to-day management of the program.
b. The provider may use a term other than program administrator for this position, e.g., program director, program manager, or program supervisor.
c. The program administrator must be at least 21 years of age, and qualified through experience and education in a human services field or setting.
i. Required experience: one year of full-time or equivalent part-time experience providing services to individuals in a human services setting in a position with responsibility for planning, development, and management or operation of programs involving service delivery, fiscal management, needs assessment, program evaluation, or similar tasks.
ii. Required education: high school or general education development (GED) diploma.
d. In addition to meeting education and experience requirements, the program administrator must possess the knowledge base and skills necessary to carry out the respite care services program.
i. The program administrator knowledge base must include:
(A) the medical, behavioral, habilitative, and rehabilitative conditions and requirements of the population to be served; and
(B) the laws and policies related to Senior and Developmental Disabilities programs.
ii. The program administrator skill set must include:
(A) the ability to evaluate, and to develop a service plan to meet, the needs of the population to be served;
(B) the ability to organize, evaluate, and present information orally and in writing; and
(C) the ability to supervise professional and support respite care services staff.
2. Respite care services direct service workers.
a. Direct service workers must be at least at least 18 years of age; qualified through education or experience; and possess, or develop before providing services, the skills necessary to meet the needs of the recipient population.
b. Required education and alternatives to formal education:
i. high school or general education development (GED) diploma; or
ii. demonstration to the provider of the ability to communicate in English, including reading written instructions and making appropriate entries regarding services in the recipient record or file.
c. Required skill set:
i. the ability to communicate with his/her supervisor and with the recipient and the primary caregiver;
ii. the ability to understand the needs of, and to work with the recipient population;
iii. the ability to be guided by the service plan; and
iv. the ability to handle household and medical emergencies.
B. Training.
1. The provider must provide orientation and training to direct service workers to ensure they are qualified to perform the services planned for recipients.
2. The provider must provide training to direct service workers in regard to the following at a minimum:
a. safety in the workplace, and proper use of tools and equipment required to meet the recipient's needs;
b. maintenance of a clean, safe and healthy home environment;
c. universal precautions and basic infection control procedures;
d. understanding the needs of the population to be served; and
e. safe food handling and storage, nutritious meal preparation, and the special dietary or nutrition

requirements of the recipient.
3. The provider must instruct direct service workers to notify the program manager, the supervisor, or the appropriate authority, when there is cause for concern about a recipient's health, safety, or welfare.

Verification of Provider Qualifications

Entity Responsible for Verification:

SDS Provider Certification and Compliance Unit

Frequency of Verification:

Every two years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

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:

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: Service Specification

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

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

03 Supported Employment

Sub-Category 1:

03021 ongoing supported employment, individual

Category 2:

Sub-Category 2:

03 Supported Employment	03022 ongoing supported employment, group

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

Service Definition *(Scope):*

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

Supported employment services may be provided to assist recipients to acquire and maintain the work-related skills necessary to become self-employed or for employment in an integrated work setting in the general workforce, at or above minimum wage with the level of benefits paid by the employer for the same or similar worked performed by individuals who are not recipients. These services focus on activities that will meet the recipient's personal and career goals; lead to an appropriate job match for the recipient and the employer; and may include vocational or job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, and career advancement activities. In addition, the services may include benefits support, training, planning, and asset development. Following job placement, the provider may offer intensive, ongoing supports, including supervision, job coaching, and additional training, to enable recipient to perform in the workplace.

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

All supported employment services must be prior authorized.

Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: 1. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or 2. Payments that are passed through to users of supported employment services.

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

The department will not pay for more than three months of supported employment services if the services prepare a recipient for work; assist a recipient to develop the skills needed to obtain or maintain employment; or develop a job for the recipient or assist the recipient to locate suitable employment, unless provider demonstrates that the recipient needs additional preparation for employment or is preparing for a new job placement.

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 waiver provider under 7AAC 130.220, Provider certification and enrollment.

Other Standard *(specify):*

SDS certified to provide Supported Employment Services under 7AAC 130.270

In addition to the Provider Conditions of Participation detailed in the Care Coordination Agency Qualifications above, the provider who chooses to offer supported employment services must be certified as a provider of supported employment services under 7 AAC 130.220, meet with the requirements of 7 AAC 130.270, and operate in compliance with the Provider Conditions of Participation and the following Conditions of Participation specific to supported employment.

I. Program Administration

A. Personnel.

1. Supported employment program administrator.
a. The provider agency must designate a supported employment program administrator who is responsible for day-to-day management of the program.
b. The provider may use a term other than program administrator for this position, e.g., program director, program manager, or program supervisor.
c. The program administrator must be at least 21 years of age, and qualified through experience and education in a human services field or setting.
i. Required experience: one year of full-time or equivalent part-time experience providing services to individuals in a human services setting in a position with responsibility for planning, development, and management or operation of programs involving service delivery, fiscal management, needs assessment, program evaluation, or similar tasks.
ii. Required education and additional experience or alternatives to formal education:
(A) Bachelor of Arts or Bachelor of Science degree from an accredited college or university in social work, psychology, rehabilitation, nursing or a closely related human services field; or
(B) Associate of Arts degree from an accredited college or university in psychology, rehabilitation, nursing or a closely related human services field, and two years of full-time, or equivalent part-time experience working with human services recipients; or
(C) four years of full-time or equivalent part-time experience working with human services recipients in social work, psychology, rehabilitation, nursing, or a closely related human services field or setting; or
(D) certification as a rural community health aide or practitioner and one year of full-time, or equivalent part-time experience working with human services recipients

d. In addition to meeting education and experience requirements, the administrator must possess, or develop before providing program services, the knowledge base and skills necessary to carry out the supported employment services program.
i. The administrator knowledge base must include:
(A) the medical, behavioral, and habilitative conditions and requirements of the population to be served;
(B) supported employment philosophy, state regulations and emerging service delivery techniques;
(C) the applicable laws, regulations and policies related to governing services for individuals with disabilities.
ii. The administrator skill set must include:
(A) the ability to evaluate, and to develop a plan of care to meet the needs of the population to be served; and
(B) the ability to supervise and support supported employment services worker.

2. Supported employment services direct care workers.

a. Direct care workers must be at least 18 years of age, qualified through education or experience, and possess, or develops before providing services, the skills necessary to perform the tasks included in the supported employment services plan.
b. Required education:
i. high school or general education development (GED) diploma or
ii. demonstration to the provider of the ability to communicate in English, including reading written instructions and making appropriate entries regarding services in the recipient record or file.

c. Required skill set:
i. vocational exploration and discovery for individuals with disabilities;
ii. benefits counseling, including the impact of wages on state and federal disability benefits;
iii. researching employment opportunities;
iv. job development and job matching;
v. identifying and teaching required employment-related skills; and
vi. job coaching and support.

B. Training.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

SDS Provider Certification and Compliance Unit

Frequency of Verification:

Every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Chore

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

Chore services may be provided for a recipient only when the recipient, or anyone else in the household, is not capable of performing or financially responsible for the tasks required to maintain a clean, sanitary, and safe home environment. These tasks include routine household chores as well as work necessary to maintain safe access and egress for the recipient's residence.

Chore services may not be authorized, or may be time limited when a relative who is a caregiver and lives in the home of the recipient, a caregiver, a landlord, a community/volunteer agency, or a third-party payer is capable of, or responsible for, the tasks.

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

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 waiver provider under 7AAC 130.220, Provider certification and enrollment

Other Standard *(specify):*

SDS certified to provide Chore Services under 7AAC 130.245

In addition to the Provider Conditions of Participation detailed in the Care Coordination Agency Qualifications above, the provider who chooses to offer chore services must be certified as a provider of chore services under 7 AAC 130.220, meet with the requirements of 7 AAC 130.245, and operate in compliance with the Provider Conditions of Participation and the following Conditions of Participation specific to chore services.

I. Program administration

A. Personnel.

1. Chore services program administrator.
a. The provider must designate a chore services program administrator who is responsible for day-to-day management of the program.
b. The provider may use a term other than program administrator for this position, e.g., program director, program manager, or program supervisor.
c. The program administrator must be at least 18 years of age, and qualified through experience and education in a human services field or setting.
i. Required experience: one year of full-time or equivalent part-time experience providing services to individuals in a human services setting in a position with responsibility for planning, development, and management or operation of programs involving service delivery, fiscal management, needs assessment, program evaluation, or similar tasks.
ii. Required education: high school or general education development (GED) diploma.
2. Chore service workers.
a. Chore service workers must be at least at least 18 years of age; qualified through education or experience; and possess, or develop before providing services, the skills necessary to perform, as requested by the recipient, the tasks included in the chore services plan.
b. Required education and alternatives to formal education:
i. high school or general educational development (GED) diploma; or
ii. demonstration to the provider of the ability to communicate in English, including reading and following written instructions and making appropriate entries regarding services in the recipient record or file.

B. Training.

1. The provider must
a. provide orientation and training to chore service workers to ensure they are qualified to perform, and to maintain a safe environment while performing, assigned tasks; and
b. instruct chore service workers to notify the program manager, the supervisor, or the appropriate authority, when there is cause for concern about a recipient's health, safety, or welfare.

2. The provider must provide training to chore service workers in regard to the following:
a. safety in the workplace, and proper use of tools and equipment;
b. maintenance of a clean, safe, and healthy home environment;
c. universal precautions and basic infection control procedures;
d. understanding the needs of the population to be served; and
e. for those who provide food preparation and shopping services, safe food handling and storage, nutrition requirements, and nutritious meal preparation

Verification of Provider Qualifications

Entity Responsible for Verification:

SDS Provider Certification and Compliance Unit

Frequency of Verification:

Every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Intensive Active Treatment

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

Intensive Active Treatment (IAT) assist participants who need immediate intervention to treat a medical or decelerate behavior regression that, if left untreated, would place the recipient at risk of institutionalization. This waiver service is only provided to individuals age 21 and over. All medically necessary IAT services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit IAT is provided by a professional licensed under AS 08, a paraprofessional supervised by that professional and licensed under AS 08 if required, or an individual certified under AS 14.20.010 with a special education endorsement under 4 AAC 12.330. Providers of IAT 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 possess 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.

IAT services are provided in the offices of the professionals providing the interventions, so the setting is the same as the setting for services provided to the greater community of non-disabled people, with occasional service provided in the recipient's natural setting to ensure skills are being transferred appropriately.

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):*

If not licensed (above), AS 14.20.010 with a special education endorsement under 4 AAC 12.330.

Other Standard *(specify):*

SDS certified provider under 7AAC 130.220, Provider certification and enrollment.

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: If not licensed (above), Department of Education and Early Development teaching certificate; SDS Provider Quality Assurance Unit, Provider Certification Section

Frequency of Verification:

Every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Transportation

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

Transportation services may be provided to recipients when natural supports are not available to provide transportation, and the services are necessary to enable recipients to travel to and return from locations where waiver or grant services are provided, or to other community services and resources. These services may not be used for medical services transportation that is available for recipients under 7 AAC 120.405 – 120.490.

The department will not make separate payment for transportation services for providers of family home residential habilitation services. The department will authorize a separate payment for transportation services for providers of licensed residential habilitation services.

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

The department will not pay for transportation to destinations that are over 20 miles from the recipient's residence, unless approved by the department in the recipient's plan of care.

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Certified home and community-based service agency

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

SDS certified provider under 7AAC 130.220, Provider certification and enrollment.

Other Standard *(specify):*

SDS certified to provide Transportation Services under 7AAC 130.290

In addition to the Provider Conditions of Participation detailed in the Care Coordination Agency Qualifications above, the provider who chooses to offer transportation services must be certified as a provider of transportation services under 7 AAC 130.220, meet with the requirements of 7 AAC 130.290, and operate in compliance with the Provider Conditions of Participation and the following Conditions of Participation specific to transportation services.

I. Program administration: Agency-based transportation services providers

A. Personnel.

1. Transportation services program director.
a. The provider must designate a transportation services program director who is responsible for day-to-day management of the program.
b. The director must be 18 years of age or older, have education or management experience sufficient to direct the program, and have the capacity to facilitate communications between staff and recipients.

2. Drivers.

a. Drivers must be 18 years of age or older, have a current Alaska driver license with a class designation appropriate to the type of vehicle operated, and have a safe driving record.
b. The provider must ensure that all drivers are physically capable and willing to assist recipients.

B. Training.

1. The provider must have on file for staff drivers and volunteers written verification of attendance at, and successful completion of, training regarding safe transportation and the needs of the recipient population.
2. The provider must require all drivers and volunteers to attend the PASS (Passenger Assistance Safety and Securement) course offered by the Community Transportation Association of America, or an equivalent course that addresses
a. professional customer service;
b. use of securement systems for mobility devices and individuals, including requirements regarding child safety;
c. lift operation procedures;
d. Americans with Disabilities Act;
e. universal precautions and basic infection control procedures;
f. service animals;
g. emergency and evacuation procedures;
h. awareness of inappropriate behaviors;
i. disability awareness
j. incident and accident protocols in case of accidents, or of medical or weather emergencies; and
k. the provider's policy, incorporating the requirements of 7 AAC 130.229, on the use of restrictive interventions

Verification of Provider Qualifications

Entity Responsible for Verification:

SDS Provider Certification and Compliance Unit

Frequency of Verification:

Every two 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.*

☐ **As a primary care case management system service under a concurrent managed care authority.** *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:

Case management functions provided on behalf of each waiver recipient include completing and submitting an initial application for services, developing and submitting an initial support plan, and annually developing and submitting the renewal support plan. The person performing these case management functions must be certified as a care coordinator. Ongoing case management in the waiver is referred to as care coordination. Please see Appendix C-3 for care coordination service and provider specifications.

Appendix C: Participant Services

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

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

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

◉ **Yes. Criminal history and/or background investigations are required.**

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

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

The DHCS, Section of Residential Licensing and Background Check Program conducts the background check, which includes review of records from both Alaska and those states the individual has lived in for the prior 10 years, to search for "barrier crimes" that would make the applicant unsuitable for direct care service employment. Fingerprints are processed by both the Alaska Department of Public Safety and the Federal Bureau of Investigation for a national criminal history record check. Regulations at 7 AAC 10.905 define barrier crimes as a criminal offences inconsistent with the standards of licensure, certification, approval or eligibility to receive [Medicaid] payments, and list those crimes that are permanent, 10, five, three and one year barrier crimes. In addition, state and federal records searched include:

- Alaska Public Safety Information Network (APSIN) - APSIN serves as a central repository for Alaska criminal justice information. This information is also known as an "Interested Persons Report;"
- Alaska Court System/Court View and Name Index - Provides civil and criminal case information and is used to assist in determination of disposition for cases in APSIN;
- Juvenile Offender Management Information System (JOMIS) – JOMIS is the primary repository for juvenile offense history records for the State of Alaska, Division of Juvenile Justice;
- Certified Nurses Aide (CNA) Registry -Professional registry listing those individuals certified to perform duties as a CNA;
- National Sex Offender Registry (NSOR)- The NSOR provides centralized access to registries from all 50 states, Guam, Puerto Rico and the District of Columbia; and
- Office of Inspector General (OIG) - a database which provides information relating to parties excluded from participation in the Medicare, Medicaid and all Federal health care programs;
- Any other records/registries the Department deems are applicable.

Applicants for certification and recertification (every two years) as home and community-based waiver service providers must submit a copy of the "Final Authorization" letter issued by the background check unit, or SDS can independently verify the background check information. In addition, applicants assure SDS by affidavit that their employees and volunteers will comply with the background check requirements.

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

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

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

Appendix C: Participant Services

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

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

- ◉ **No. Home and community-based services under this waiver are not provided in facilities subject to**

§1616(e) of the Act.

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

Appendix C: Participant Services

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

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

◉ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**

○ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

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

☐ **Self-directed**

☐ **Agency-operated**

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

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

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

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

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

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

State regulations at 7 AAC 130.202(2) allows the State to make payments for waiver services furnished by a legal guardian who is the spouse, adult child, parent or sibling of the participant, if a court has authorized the guardian to provide those services under AS 13.26.145(c). The court must determine that any potential conflict of interest is insubstantial and that the appointment would clearly be in the best interests of the participant. Controls employed to ensure that payments are made only for services rendered include monthly monitoring by care coordinators, documentation by SDS certified agencies of services rendered and identification of who was paid for the services; certified agencies are required to document services, to maintain the records for seven years and are subject to audit requirements.

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

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

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

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

○ **Other policy.**

Specify:

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

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

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
QP 12: # and % of providers who meet state certification or licensure requirements prior to providing waiver services. Numerator: # of providers who meet initial state certification or licensure requirements. Denominator: Sample of currently active waiver service providers who were enrolled in Medicaid during the reporting period.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence

		Interval = Confidence Interval = 95%, +/- 5% and 50% distribution
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
QP 13: # and % of providers who continue to meet state certification or licensure requirements while providing waiver services. Numerator: # of providers who continue to meet state re-certification or licensure requirements. Denominator: Sample of currently active providers who are enrolled in Medicaid

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

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

Data Aggregation and Analysis:

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

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

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

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

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

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

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

Performance Measure:
QP 14: # and % of care coordinators in compliance with required SDS training. Numerator: # of care coordinators that are in compliance with required SDS training, and that are currently certified within the reporting period. Denominator: Sample of care coordinators that are currently certified within the reporting period.

Data Source (Select one):
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):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = Confidence Interval = 95%, +/- 5% and 50% distribution
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☒ **Monthly**

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

Performance Measure:
QP 15: # and % of provider agencies that are in compliance with critical incident report training requirements. Numerator: # of provider agencies that are in compliance with the state's critical incident report training requirements and that are currently certified within the reporting period. Denominator: Sample of provider agencies that are currently certified within the reporting period.

Data Source (Select one):
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):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = Confidence Interval = 95%, +/- 5% and 50% distribution
☐ **Other**	☐ **Annually**	☐ **Stratified**

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

Data Aggregation and Analysis:

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

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

Quality improvement strategies are founded upon data-driven discovery activities. Task Committees have been developed to focus on specific areas of performance and to implement systems for data collection. The "Qualified Providers Review" Task Committee comprises the Provider Certification and Compliance unit manager (Chair), Provider Certification and Compliance staff, Operations and Training unit manager, Training Coordinator, Policy and Program Development unit manager, and the Grants unit manager. These individuals are the first line of discovery and are charged with identification of problems with provider certification and performance through monitoring and evaluation of established performance measure data.

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

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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 Provider Certification and Compliance 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 Provider Certification and Compliance unit 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 unit to assist the provider complete an application or reapplication for certification.

As part of monthly discovery activities, the Provider Certification and Compliance 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 on-site surveys including document reviews and participant or provider staff interviews. SDS then monitors remediation requirements through review and analysis of provider reports, participant information and complaint reviews. SDS continues to review progress until the deficiencies are corrected, and reports on the performance of SDS certification and oversight process activities to the departmental Quality Improvement Steering Committee on a quarterly basis.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

◉ **Applicable** - The state imposes additional limits on the amount of waiver services.

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

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

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

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

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

The State established an individual cost limit of $28,928 that applies to all waiver participants during the first year of the waiver period, and which will be indexed to service rate inflation the following years the waiver is in effect. The individual budget limit within the individual cost limit (the individual budget limit can be no higher than the individual cost limit) is $19,285 and the State's Medicaid Management Information System (MMIS) applies a geographic differential to waiver services listed in the Department of Health and Social Services, Chart of Personal Care Attendant and Waiver Services Rates, found here: http://dhss.alaska.gov/dsds/Pages/info/costsurvey.aspx. The geographic differential addresses the regional differences in the cost of doing business across the state.

A participant's support plan is developed and approved up to the $19,285 individual budget limit. Participants may calculate the total cost of their support plans up to the individual cost limit by multiplying the cost of the plan built up to the $19,285 individual budget limit by the geographic differential assigned to the region in which the participant's service provider operates. The State's Medicaid Management Information System (MMIS) automatically applies the assigned geographic differential to waiver service claims based on the geographic region in which the service provider operates. Individual budget limits may vary by participant according to the provider's geographic region.

The application of the geographic differential rate at claims payment allows all ISW participants a fair and equitable opportunity to receive the same amount of services regardless of where they live in the state, and also ensures that providers will be fairly compensated for services, as the geographic differential reflects the cost of doing business across the state.

The individual budget limit applies to all waiver services offered in this waiver (as evidenced in Appendix C-1/C-3): care coordination, day habilitation, residential habilitation, respite, supported employment, chore, intensive active treatment, and transportation.

The method for determining the $19,285 individual budget limit was based on analysis of utilization data of the most comparable program, a State grant serving people with intellectual and developmental disabilities, adjusted to reflect unit costs based on Medicaid waiver rates for the same services. The amount of the individual budget limit was based on the cost of services received by grant recipients, excluding out-of- home residential services (those services are not included in this waiver).

The processes that are used to determine how much service a recipient will receive on this waiver start with the person-centered planning process, during which the recipient identifies goals to be achieved via use of waiver services and natural supports. The recipient and care coordinator use a cost calculator provided by the State to calculate the cost of waiver services. The care coordinator documents services in the support plan, and State reviews the justification for the requested services and approves and approves the plan.

The amount of the individual budget limit is adjusted during the five year waiver period to account for rate increases that reflect inflation. The State will periodically re-evaluate the methodology used to set the individual budget limit in light of service and safeguards utilization patterns, and may amend the waiver to reflect the results of this analysis.

Recipients can adjust support plans (within the individual budget limit) to meet their health and welfare or other needs at any time during a plan year via the support plan amendment process. Amendments are submitted by care coordinators who are trained using the State's clear and explicit instructions on how to submit amendments.

If the recipient cannot be served safely in the community under the individual budget limit, the recipient can access emergency allocation funding in certain circumstances (presented in Appendix B-2-c "Participant Safeguards") for short term needs, or move onto the State's other waiver that serves people with intellectual and developmental disabilities by accessing a reserve capacity slot. Access to both of these can be expedited in case of emergency.

Individuals who are initially assessed for the waiver and are determined to fall within the individual cost limit,

but whose health and safety needs cannot be met within the budget limit will be denied entry to the waiver. The individual may choose to apply for the State's other waiver that serves people with intellectual and developmental disabilities.

A participant (or representative) will discuss with his/her care coordinator the need to pursue the emergency allocation funding, as part of regular care coordination duties that include additional communication when problems or issues arise. Together, using the person-centered process, the participant and care coordinator decide whether and which additional services, up to the $5,000 limit, would alleviate the health or safety issue. The care coordinator then submits an amendment to the support plan. SDS reviews the amendment according to regulations on expedited consideration of support plans, and within 10 days, notifies the participant's care coordinator of the approval or disapproval of the amendment. If the participant does not agree with the decision, the participant can appeal through the Fair Hearing process.

Potential waiver participants are notified of the individual budget limit through the following mechanisms: 1) the individual budget limit is include in descriptions of the waiver on the State's website and outreach materials; 2) individuals contacting the State-funded Aging and Disability Resource Centers and Short-Term Assistance & Referral agencies are informed about the individual budget limit when they are provided with the choice of waivers; and 3) care coordinators inform individuals about the individual budget limit during the application and support plan development processes. This discussion will inform participants that the actual amount paid to service providers in some parts of the state may be higher than the individual budget limit due to the geographic differential applied to waiver services during claims payment.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

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

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

As of February 23, 2018, all providers of the Individualized Supports Waiver (ISW) services received a final certificate of Full Compliance from the State.

ISW review and remediation timeline:

- November 17, 2017: Remediation plans due from those potential providers of ISW services
- November 30, 2017: The State notified potential providers if their remediation plans were approved or not
- December 10-20, 2017: All providers entered active remediation
- January 15, 2018: Provider attestation deadline
- January 15-February 22, 2018: The State issued certificates of full compliance with Final Rule
- February 23, 2018: The State concluded remediation work for all settings. All signed Attestations had been received. All potential ISW providers (83 of 83) received a final certificate of Full Compliance from the State.
- Ongoing: All settings subject to monitoring of ongoing compliance with HCBS criteria.

The setting types involved in the ISW assessment, review and remediation process are:

- site-based day habilitation,
- site-based supported employment, and
- provider-operated or controlled supported-living services.

Each federal home and community-based standard was described in a self-assessment tool that providers in each setting were required to complete. Upon receipt of each self-assessment, the State performed a focused desk review or an onsite visit using standardized tools to assess consistency, completeness, and evidence of compliance with the settings requirements. During the onsite visits, Provider Certification and Compliance (PCC) Unit staff interviewed residents, managers and staff, and conducted physical observations to determine compliance with each home and community-based settings requirement. The State then identified and discussed any emerging issues that may have precluded full compliance, and assigned the setting to one of four compliance categories ranging from non-compliant to fully compliant.

Findings from the onsite visit or focused desk review were outlined in a “Notice of Review Status” for each setting. The Notice included a timeline for the provider to submit a remediation plan and a timeline for the State to review that plan. If the remediation plan was not approved, the provider was notified that revised plan needed to be submitted.

Initially, most ISW settings were initially rated “emerging compliant," with some issues still be be resolved. Approximately 20% of the ISW settings accepted the State’s offer to provide guidance and technical assistance in developing remediation plans. Evidence submitted by providers was reviewed by the State using a Remediation Plan Review Key and the Evidence Grading System Key for Determining Final Settings Rule Provider Compliance. This enabled the State to assess type of evidence, quality of evidence, and probability that it would move a provider into fully compliant status. The potential providers of ISW services submitted sufficient evidence and attestations to the State verifying that they had taken the specific steps necessary by the attestation deadline.

All settings under the new waivers are required to meet the federal home and community-based settings requirements under 42 CFR 441.301 (c)(4)-(5).The State assessed each ISW setting for alignment with the following criteria designed to meet the core elements of the Settings Final Rule as follows:

State Criteria:
- The provider intends to comply with all requirements of the HCBS Settings Rule.
- The setting does not intentionally or inadvertently segregate individuals with disabilities from the broader community.
- The setting supports individuals receiving Medicaid HCBS in seeking and maintaining employment in competitive integrated settings.
- The setting supports individuals in engaging in community life to the same degree of access as individuals not receiving Medicaid HCBS.
- The setting supports and encourages individuals’ control of personal resources.
- The setting is selected by the individual from among setting options including non-disability specific settings and an option of

a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.

- The setting ensures individuals' rights of privacy, dignity and respect.
- The setting ensures individuals the freedom from coercion and restraint.
- The setting optimizes but does not regiment individual initiative, autonomy and independence in making life choices, including but not limited to daily activities, physical environment, and with whom to interact.
- The setting facilitates individual choice regarding services and supports and who provides them.
- The setting provides a specific physical place that can be owned, rented or occupied under a legally enforceable agreement (rental lease or service/admission written agreement) with the same responsibilities and protections from eviction that tenants have under the landlord/tenant law.
- The setting is physically accessible to the individual and offers privacy in sleeping or living unit, lockable doors, choice of roommates, freedom to furnish and decorate within the lease or other agreement, freedom to control their own schedules and activities, have access to food at any time, and have visitors of their choosing at any time.

Criteria: Provider intends to comply with all HCBS Setting Rule Requirements:

No provider participating in the ISW delivers services in a publicly or privately operated facility that provides inpatient institutional treatment, nor are any providers located in a building on the grounds of or immediately adjacent to a public institution. This information was verified by map and grid searches of the community, internal knowledge within Senior and Disabilities Services (SDS), provider assurance, and, for some settings, onsite visits.

Criteria: Setting does not intentionally or inadvertently segregate individual with disabilities from the broader community:

The assessment and review process with site-based day habilitation providers revealed two primary challenges to integration and access: the abandonment of reverse integration and the adoption of documentation and tracking procedures to evidence the presence of the broader community in the setting. There were some settings that found it necessary to revise staffing to allow for more recipient choice between community-based and site-based activities.

Provider-operated or controlled Supported Living services were found to be mostly compliant with the Settings Final Rule. The most common area requiring change for Supported Living providers was the language in governing documents (i.e. house rules, resident rights, or service/lease/admission agreements) that reflected limitations or restrictions not supported by the Plan of Care. Providers were required to modify business practices and governing documents to ensure that rights were observed unless a limitation or restriction was clearly documented in the Plan of Care. Because the State of Alaska had successfully transitioned to conflict-free care coordination and person-centered care models, supported living providers were well positioned for compliance with the Settings Final Rule.

Criteria: Setting supports individuals receiving Medicaid HCBS in seeking and maintaining employment in competitive integrated settings:

Site-based employment settings had two primary findings related to integration of settings and competitive employment.

To assess how well the setting supports individuals in seeking and maintaining employment in competitive settings, the State considered factors such as standard employee practices governing performance, upward mobility, and decreasing supports with increased independence in job performance, location of worksite, and fair wage distribution scales.

Integration was assessed and remediated by adjusting factors such as the composition of the work teams/place, hours worked compared to business open hours, inclusive hiring/solicitation processes, community interaction during work performance, and location of worksite.

Some settings were found to have work crews comprised solely of individuals experiencing disabilities who were not paid a competitive wage and were isolated from interaction with the greater community. Agencies with this type of service successfully remediated by eliminating the agency-specific work crew and integrating into the fully integrated, competitive team of maintenance services.

Criteria: Setting supports the individual in engaging in community life to the same degree of access as individuals not receiving Medicaid HCBS:

Each setting and service type presents with unique characteristics to be considered as part of the evaluation, including factors such as community norms for access and lifestyle. Alaskans have access to a wide variety of lifestyles and communities specific to recreation or remote living. The unique characteristics of each community and the underlying reasons recipients choose services in the specific setting were considered for each location. The State reviewed the types of activities/services available to any resident in the community as well as community norms for transportation.

Transportation: Many residential providers offer transportation as a service for recipients in their care. Agencies that did not offer transportation beyond medical appointments identified the methods of transportation utilized by recipients in the community. These included transport services specifically designed for individuals who require assistance, such as provider or service vans, taxis if available, natural supports, and, in line with the community norm of certain rural or remote locations, the use of all-terrain vehicles or snow machines.

Some challenges inherent in rural or remote living may limit the availability of a wide variety of services such as multiple barber or hairdresser choices, banking providers, shopping vendors, or a wide variety of community amenities such as gyms or theaters. In these instances, review of the setting was based on whether or not recipients had the same access and opportunities as other community residents to participate in the activities, events and life choices as manifested in their chosen home community.

Criteria: Setting supports and encourages individuals' control of personal resources:

The State found that among site-based day habilitation and supported employment settings, there was a need for clearer processes supporting the right of residents to access and use personal resources. The State required clear disclosure of the process used to assist the recipient to access and control their personal resources.

Criteria: Setting is selected by the individual from among setting options including non-disability specific settings and an option or a private unit in a residential setting.

The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preference, and, for residential settings, resources available for room and board. The previous adoption of the conflict-free care coordination and person-centered care approaches supported compliance in this area. As a result, provider compliance was strong with clear evidence reflected in the recipients' Plans of Care. The robust care planning process strengthens assurances that this requirement is met.

Criteria: Setting ensures individuals' rights of privacy, dignity, and respect:

Many elements were reviewed in order to determine compliance with this requirement. Observation during onsite reviews and review of governing documents during focused reviews provided initial information for assessing compliance. Evidence beyond statements of assent was required, such as house rules, resident rights, resident handbooks, policy statements, and service/lease/admission agreements to assess meeting rights of privacy, dignity and respect.

The State reviewed a setting's governing documents, training programs, and follow-up monitoring of staff for adherence to the processes supporting recipients' rights in the area. Policies related to the personal health information and the safeguarding of that information were reviewed and any observations or concerns were remediated. Access to communication devices and space for privacy was assessed in each setting. Further, settings that chose to use video monitoring or cameras in or around the setting were required to disclose the policies and protocols in place that identify who has access to the information, how it is used and stored, how it is communicated to recipients and guardians, and how privacy of visitors and recipients is protected. The provider's policies and protocols on video monitoring and use of cameras are required to assure that the technology is used for security purposes and is not a substitute for direct staff supervision.

Criteria: The Setting ensures individuals' freedom from coercion and restraint:

Each setting was assessed for sufficiency in staffing, provider policies related to the use of restrictive interventions and required associated training, and complaints/grievance policies utilized in the setting. Policies were required to have clear protections from consequences or retaliation regarding Complaints/Grievances. Settings had to show evidence of an established process to communicate the information in a way the recipient understands.

Providers were also required to have an approved restrictive intervention policy with certification and evidence that this policy and required training were delivered to the staff and are practiced in the setting.

Evidence of potential insufficient staffing was reviewed if indicators were present such as the same schedule for all recipients, compulsion to attend external events with no choice to remain home, multiple incident reports resulting in recipient harm by another recipient in resident or a staff member, or any other related information.

Criteria: The Setting optimizes but does not regiment individual initiative, autonomy, and independence in making life choices, including, but not limited to, daily activities, physical environment, and with whom to interact:

Providers were tasked with communicating established processes used by the setting to support recipients in exercising personal and civil rights. Most settings returned clear processes supporting individuals who want to vote, attend church or other cultural events as well as assisting the recipient with obtaining transportation as required.

A setting was assessed to ensure that no rigid schedule or structure was in place that would usurp a participant's ability to choose preferred daily activities and scheduled in preferred locations. Residential/service/lease agreements, residents rights, and/or house rules/schedules were required, if used, and were assessed for the ability for recipients to exercise choice in their daily schedules and routines including laundry, hygiene and self-care, planned and leisure activities, access to foods and cooking as appropriate, with required ADA supports as indicated, free of movement or physical barriers and restrictions not clearly documented in the recipients' Plan of Care.

Further, providers were required to demonstrate through evidence, observation or other documentation that recipients who do not require a limitation or restriction are not passively restricted by another recipient's need for limitations or restrictions imposed through the care planning process and reflected in the support plan.

Restrictions imposed via curfew required remediation. Quiet hours can be observed as is normal in any situation of aggregate living as long as they are disclosed prior to admission choice, but lights out and curfew restrictions not clearly documented in a recipient's support plan are not acceptable.

Restrictions to visiting hours, time and place of visits, or the need for the visitor to visit by appointment did not align with the Final Rule, and required remediation. Providers successfully remediated by changing governing documents such as House Rules, Resident Rights, Resident Handbooks, policy/procedures documents, and lease/admission/service agreements.

Criteria: The Setting facilitates individual choice regarding services and supports, and who provided them:

Providers were required to identify the established process they use to support individuals in gaining access to the generic community services and supports available to them. Many forms of evidence arose including daily/weekly/monthly calendars from a variety of activity or service providers as well as community specific information for barbers, banks, grocery and convenience stores, sources of safety or help such as the police department or hospital, and other information captured and provided to the recipient upon admission, in the resident handbook, handouts/advertisements/flyers posted on bulletin boards, and guidance, information, and direction provided by staff.

Criteria: Setting provides a specific physical place that can be owned, rented or occupied under a legally enforceable agreement (rental lease or service/admission written agreement) with the same responsibilities and protections from eviction that tenants have under the landlord/tenant law:

Providers were required to provide evidence that they were meeting this requirement. Providers utilized legal and other advice to ensure alignment with the Alaska Landlord/Tenant Act. The State ensured that the responsibilities and protections from eviction were documented in the agreement.

Criteria: The setting is physically accessible to the individual and offers privacy in sleeping or living unit, lockable doors choice of roommates, freedom to furnish and decorate within the lease or other agreement, freedom to control own schedules and activities and have access to food at any time, have visitors of their choosing at any time:

Many providers were required to make changes to restrictions for curfew, visitation, locking doors, and access to the kitchen and snacks of choice. Providers responded by providing evidence such as pictures, revised service/lease/admission agreement, house rules, resident rights, resident handbook and policies/procedures. This evidence was reviewed to ensure that restrictions or limitations are not imposed on recipients unless clearly documented and supported by the support plan. Because of the implementation of the conflict-free care coordination and the person-centered care planning process, the process for making modifications to an individual's person-centered plan is an established practice in Alaska. This includes processes for emergency requests, modifications due to significant changes, quarterly reviews, and annual assessments/reviews.

Monitoring

All potential ISW providers have been determined fully compliant and the State is now moving into the monitoring phase of settings compliance. Any new ISW providers will need to complete a certification application that includes proof of settings compliance.

SDS is required by Statute AS 47.05.010 and 7 AAC 160.140 to regularly monitor providers certified for personal care services or home and community-based waiver services. All settings will be reviewed for settings compliance every two years at a minimum. Reviews will verify that providers continue to meet all of the settings criteria under 441.301(c)(4)(i)-(v). The State will ensure ongoing compliance by using a coordinated approach that includes SDS Provider Certification and Compliance, DHCS Residential Licensing, advocacy groups, and care coordinators.

SDS' Provider Certification and Compliance Unit (PCC) conducts desk reviews and on-site reviews in response to any complaints or concerns, including settings violations. In addition, a monthly sample of providers will be randomly selected for review. The State assures that this monthly random sample is representative of the larger pool of settings.

SDS has partnered with DHCS Residential Licensing and developed a Residential Licensing Settings Compliance Tool designed to supplement the work of Residential Licensing (RL) staff and ensure critical settings compliance indicators are observed and documented while their staff conducts onsite inspections and investigations. Once an investigation/inspection is complete, RL forwards the completed residential settings compliance tool to the PCC Unit for further review. SDS retains the documentation in the provider record for consideration at recertification.

The PCC Unit and SDS partners are working to ensure compliance with the Settings Final rule by incorporating a settings compliance review component into existing monitoring processes as follows:

- Compliance of settings is required by new Alaska regulations and policies
- All settings must have program administrators and all program administrators must be trained in settings to ensure compliance
- Onsite reviews that are necessitated for reasons other than settings compliance will include concomitant review of settings compliance.
- Both certification reviewers and compliance reviewers will participate in pre-certification reviews.
- To broaden capacity for ongoing monitoring, the SDS IDD Unit will commence site reviews as needed.
- SDS will mobilize other groups to conduct settings compliance monitoring activities as needed, including SDS grant managers who visit congregate meals sites as part of grant oversight duties, and care coordinators, who are required to visit every recipient in every setting contained in the recipient's support plan at least once a year. SDS grant managers' visits are provided through the Nutrition, Transportation, and Support Services Grant program funded through Title III C1 under the Older American's Act, CFDA #93.045 and provided through the Adult Day program grant funded with 100% state funds. Because both waiver and grant recipients participate in the adult day and congregate meal settings, the grant managers will be able to observe setting compliance while conducting on-site reviews of grantees.

- SDS will request and encourage advocacy groups such as the Governor's Council on Disabilities and Special Education, the Office of the Long Term Care Ombudsman, and the Alaska Commission on Aging to volunteer for training to evaluate settings compliance. Members of these groups often have reason to be present in HCBW services settings in the regular course of their duties. Those that volunteer will be trained to evaluate settings compliance and report issues of non-compliance through Central Intake for possible investigation or remediation with providers.
- SDS will continue collaborating with advocacy groups, providers, and other stakeholders to assure that recipients fully understand their opportunities to participate in the community, and continue to know their other freedoms and protections (knowledge also supported by SDS Alaska HCBS website)
- Recipients of waiver services (or their guardians) will complete a person-centered questionnaire focusing on satisfaction with services received, and including settings questions, as part of submitting a support plan for SDS approval
- SDS will continue to update trainings and monitoring tools to assure a consistent and current knowledge base
- All new providers of waiver services will need to complete a certification application that requires settings compliance.

The recipient's support plan provides another avenue for ongoing monitoring. Support plans are reviewed annually by SDS staff. Under Alaska regulation 7 AAC 130.218, the recipient leads the planning process that results in the support plan and its revisions, and the plan must identify the individuals responsible for monitoring it. Typically a care coordinator or case manager facilitates this process unless otherwise directed by the recipient.

The support plan should describe what the year looked like for the recipient, including any change in services/service providers, choice of friends/activities/hobbies, employment opportunities, integration into the community, and restrictions/limitations and interventions tried.

The care coordinator is responsible for making one in-person contact at least once every three months, and one telephone contact in each of the subsequent two months. These contacts are intended to monitor recipient experiences with their services and discuss modifications when needed. If any part of the support plan is altered to decrease the recipient's rights under the Final Rule, the care coordinator must submit a modification plan about the specific condition the recipient experiences that creates a need for restriction, plan for ending restriction, and statement of no harm signed by the recipient and their legal representative. The following requirements must be documented in the person-centered service plan:

(A) Identify a specific and individualized assessed need.
(B) Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
(C) Document less intrusive methods of meeting the need that have been tried but did not work.
(D) Include a clear description of the condition that is directly proportionate to the specific assessed need.
(E) Include a regular collection and review of data to measure the ongoing effectiveness of the modification.
(F) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
(G) Include informed consent of the individual.
(H) Include an assurance that interventions and supports will cause no harm to the individual."

Alaska presumes private homes, those that are not provider owned or controlled, to be the least restrictive setting available and to be chosen by the individual. Alaska utilizes care coordinators to identify, coordinate and monitor service delivery to each recipient. Services are reviewed and support plans are renewed or amended annually, or more frequently if there is a change in condition or need. Care coordinators receive training on all settings elements and work with individuals to explore choice and educate individuals on their rights throughout the person-centered support planning process. Discovery of issues in private settings through case monitoring may also result in a report to central intake that would be addressed through established investigative teams such as Adult Protective Services, Provider Certification and Compliance, or Quality Assurance.

Care coordinators will be trained on settings compliance and will work with individuals and their families on strategies for identifying and mitigating risks, restrictions in settings, and documenting goals through the person centered plan. Issues with settings would require submission of a report to central intake.

Individuals who seek certification to provide care coordination services and those seeking to renew certification are required to complete care coordination training. Care coordinators play a key role in monitoring the well-being of Medicaid recipients and the settings in which they live. Alaska regulations require ongoing care coordination services to include routine monitoring and support and monitoring quality of care. (7 AAC 130.240(c). Care coordination services).

Program staff also review and approve planned services annually, or through the amendment process, and may work with care coordinators when inconsistencies or suspected setting issues arise. Program staff also are trained to report through central intake. If there is a critical incident involving a recipient, all providers are required to report it not later than one business day after observing or learning of it. (7 AAC.224 (a)).

SDS' new database called Harmony serves as an additional method to ensure ongoing compliance. Used by the State, care coordinators, and providers, it will include data on whether or not each setting is fully compliant. Care coordinators can use this information when developing a support plan with a participant, to ensure that only settings-compliant services will be included. Settings compliance staff will share updates on providers and settings internally. Additional reviews of settings-compliance will occur during SDS staff review of all (100%) HCBS support plans, which include all services and settings, as well as when individual services are prior authorized. These methods will ensure that all settings where individuals receive services will continue to meet HCB settings compliance.

Providers failing to participate or cooperate in a timely manner with any of the mandated requirements for continued compliance with certification will be subject to the decertification and sanction processes, up to and including disenrollment from the Medicaid program per 7 AAC 130.220.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Person-Centered Support Plan ("Support Plan")

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:

Case management functions are provided on behalf of each waiver recipient include completing and submitting an initial application for services, developing and submitting an initial support plan, and annually developing and submitting the renewal support plan. The person performing these case management functions must be certified as a care coordinator. Ongoing case management in the waiver is referred to as care coordination. Care coordinators conducting TCM case management functions require the following specified qualifications.

A care coordination agency must ensure the following standards are met for its care coordinators.

A. Education and Experience

1. Care coordinators shall be at least 18 years of age, and qualified through experience and education in a human services field or setting.

2. Required education and additional experience or alternatives to formal education.
a. Bachelor of Arts , Bachelor of Science, or Associate of Arts degree from an accredited college or university in social work, psych ology, rehabilitation, nursing or a closely related human services field, and one year of full-time, or equivalent part-time experience working with human services recipients; or
b. 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, or equivalent part-time experience working with human services recipients; or
c. three years of full-time or equivalent part-time experience working with human services recipients in social work, psychology, rehabilitation, nursing, or a closely related human services field or setting; or
d. certification as a rural community health aide or practitioner and one year of full-time or equivalent part-time experience working with human services recipients.

3. In addition to meeting education and experience requirements, care coordinators must possess, or develop before providing program services, the knowledge base and skills necessary to carry out the care coordination process.
a. The care coordination knowledge base must include:
i. the medical, behavioral, habilitative, and rehabilitative conditions and requirements of the population to be served by the care coordinator;
ii. the laws and policies related to Senior and Disabilities Services programs;
iii. the terminology commonly used in human services fields or settings;
iv. the elements of the care coordination process; and
v. the resources available to meet the needs of recipients.
b. The care coordination skill set must include:
i. the ability to evaluate, and to develop a plan of care to meet, the needs of the population to be served;
ii. the ability to organize, evaluate, and present information orally and in writing; and

iii. the ability to work with professional and support staff.

4. Senior and Disabilities Services may certify as care coordinator, under 7 AAC 130.238, an applicant whose education was completed in a country other than the United States if the applicant can show that his/her foreign education is comparable to that received in an accredited educational institution in the United States.
a. Applicants licensed under AS 08 may submit a copy of a State of Alaska license to show the applicant’s foreign education is comparable to education in the United States.
b. Applicants not licensed under AS 08 are responsible for providing to Senior and Disabilities Services the following with an initial application for certification:
i. a foreign educational credentials evaluation report, from an evaluation service approved by the National Association of Credential Evaluation Services, that includes, at a minimum, a description of each course and semester or quarter hour credits earned for that course, and a statement of degree equivalency to education in the United States; and
ii. certified English translations of any document submitted as part of the application, if the original documents are not in English.

B. Training.

1. An individual who seeks certification to provide care coordination services
   a. must enroll in the Senior and Disabilities Services Beginning Care Coordination course;
   b. demonstrate comprehension of course content through examination; and
   c. provide proof of successful completion of that course not more than 365 days prior to the date of submission of an application for certification.

2. A certified care coordinator who wishes to renew his or her certification
   a. must successfully complete
      i. at least one Senior and Disabilities Services care coordination training course during the individual's first year of certification, and thereafter, every 24 months to qualify for certification renewal;
      ii. 16 hours annually of continuing education that is relevant to a care coordinator's job responsibilities; and
   b. when submitting an application for recertification, provide proof of successful completion of the Senior and Disabilities Services training course and 16 hours annually of continuing education.

3.The provider agency must document, for each care coordinator, attendance and successful completion of 16 hours of continuing education annually in the care coordinator's personnel file; the provider agency's in-service training may qualify as continuing education if
   a. the training increases the knowledge, abilities, or skills of the care coordinator; and
   b. the content of the in-service training, date, and time in attendance is documented.

☐ **Social Worker**
Specify qualifications:

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

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

Effective July 1, 2016, SDS amended State regulations to ensure compliance with federal conflict free care coordination requirements, including a process for allowing exceptions in rural areas when a provider of waiver and care coordination services is the only willing and qualified entity responsible for the person-centered support plan. SDS has developed and instituted safeguards to protect against conflict of interest and to ensure that support plans are developed in the best interests of the participants.

Because Alaska is largely rural and sparsely populated, in remote regions there may be only one or two service providers offering direct services as well as employ the area's only care coordinator(s). In such situations, the State may award that agency an exception to the requirement that care coordination be conflict-free. At no time, however, can a care coordinator also be a provider of direct services; this is a requirement statewide regardless of the conflict-free exceptions awarded in certain census areas, and all care coordinators must attest to being conflict-free at the individual level, even if the agency he or she is employed by has an exception. In other words, all care coordinators, regardless of location (urban or rural and remote) are always prohibited from providing any other direct (non-care coordination) home and community-based service on a participant's support plan.

Each entity must complete a conflict of interest form for each affiliated care coordinator, attesting that each individual care coordinator is conflict-free and will not unduly influence a participant in their choice of waiver service providers.
Individual care coordinators, responsible for developing the support plan, may not provide other direct (non-care coordination) waiver services to the participant. Individual care coordinators may not have an interest in or be employed by a provider (entity) of home and community-based services except when the conflicted entity is the only willing and qualified provider in the area.

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

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

Exceptions to conflict-free care coordination were awarded to agencies that provided both direct services and care coordination for a three year period beginning July 1, 2016, based on a close analysis of the number of direct service providers, care coordinators, and recipients in each census area of the state at a point in time (March, 2016). The State reviewed the March 2016 data, the locations of providers, care coordinators and recipients to determine whether each census area would meet one of four situations. One such situation was that a census area had no recipients, no service providers, and no care coordinators at that point in time.

In March 2016, there were two census areas (Aleutians East and Bristol Bay) that met all three conditions of having no providers, no care coordinators, and no recipients. If recipients are identified in these census areas during the three year period that the exception is awarded (until July, 2019), they can be served by any agency and care coordinator that can expand services to that census area, including an agency with a conflict-free exception. To build capacity during the three year period, the State did not restrict providers from entering census areas that were awarded exemptions.
Safeguards that address potential and mitigate actual problems are as follows:

At any time during the three-year exception period, conflict-free care coordinators are allowed to enter a census area where providers have been awarded a conflict-free exception. This will allow participants additional choice in care coordinators while building capacity during the exception period.

Through the State's central intake system, a participant may file a complaint or grievance about the State's awarding a conflict-free care coordination exception to a particular provider/agency or file a complaint about the participant

experience in attempting to select a different care coordinator. As part of completing the “Appointment for Care Coordination Services” form, each participant is informed about the provider’s grievance procedures, the State’s central intake process, and receives copies of the “Recipient Rights and Responsibilities” and the “Notice of Adverse Action and Fair Hearing Rights” forms. Each complaint, grievance, and report made to central intake is investigated by the appropriate unit within SDS.

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

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

Participants sign the "Recipient Rights" form at time of initial application. They also sign annual support plans and support plan amendments.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

By regulation at 7 AAC 130.230, prior to developing the support plan, 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 participate.

The care coordinator takes the lead in developing the support plan 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 up to the individual cost limit. The support plan identifies the providers responsible for providing each service to the participant.

As part of the planning process, the participant and the team are referred to resources (web-based and hard copy) of all the services available through the waiver program.

By SDS policy, the support plan must be submitted no later than 60-days after the initial determination of ICF/IID level of care. A new support plan must be submitted annually that reflects changes in the participant's health, life plans and goals no later than 30 days before expiration. 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 support plan 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 support plan prior to submission for the SDS's review. IDD staff review the support plan and communicate with care coordinators to resolve any conflicts noted. The IDD unit reviews the support plan prior to issuance of authorizations for billing. In addition, the participant must initial and sign the "Program Participant Rights" form that outlines participant's rights regarding the right to make choices about their care, the right to participate in the care planning process, the right to receive a copy of their support plan, the right to change providers at any time, and the right to submit a complaint through a grievance procedure established by the service provider.

By signing the support plan, each provider acknowledges the responsibility of each agency to provide the services in the support plan. The care coordinator is responsible for coordination of all the waiver services on the support plan, as well as documenting regular Medicaid services, community resources, and natural supports utilized.

Under 7 AAC 125 Personal Care Assistance, a participant of both home and community-based waiver and PCA services will establish coordinated support plans using the same support plan dates, and coordinating services to avoid any duplications.

Monitoring the support plan is the primary responsibility of the care coordinator. Concerns are discussed with the participant or the participant's legal representative during the monthly telephone contacts or the quarterly face-to-face visits.

The support plan 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 ICF/IID level of care. The care coordinator convenes the person-centered planning team, and follows the same process as outlined above for initial support plan development. By SDS policy, the care coordinator must submit a new support plan within 30 business days of the determination that the participant has met ICF/IID level of care. Amendments to the support plan are submitted by the care coordinator 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 the waiver 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 support plan.

Appendix D: Participant-Centered Planning and Service Delivery

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

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan

development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

As part of the care planning team, care coordinators identify and address potential risks to the applicant and their families as one part of the planning process. The SDS assessor administering the ICAP also identifies risks. Applicant needs and preferred service providers are incorporated into the support plan. Each service is reviewed to determine the relevance of the service and the risks that may be encountered with delivery. Prior to enrolling onto the ISW, IDD staff will review the assessment or the potential participant's support plan to ensure applicant health and safety can be assured within service scope of the waiver and the individual cost limit.

The care planning team develops an "Emergency Response and Backup System Plan" (ERBUSP) as a section of the participant's support plan. Each backup and contingency plan is unique to meet the needs and circumstances of the participant. The participant's ERBUSP provides a summary of the emergency plan that will be used for the participant in the event of an unplanned event, such as a provider failing to show up, natural disaster, or other emergency event. The ERBUSP 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 support plan 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. The provider is required to outline and summarize who will maintain participant contacts to notify in case of an emergency, how the provider will handle the failure of staff to show at service settings, what the agency will do in the event of a medical emergency, natural disaster, or an emergency involving the service setting, e.g., fire, gas leak, etc. A copy of the ERRP is filed in each provider's file at SDS.

Emergency allocation funding is available up to $5,000 in addition to the individual cost limit. This funding may be accessed one time during any three-year period. A participant may request the funding by submitting a support plan amendment for services and supports to needs related to a time-limited change in the participant's health, behavior, or functional capacity, or a time-limited change in the participant's primary unpaid caregiver for a reason stated in 7 AAC 130.209 (a)(3)-(5).

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 as 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 participant or the participant's representative, and identifies potential issues with service delivery. These strategies are incorporated into the support plan.

If there is a change in the participant's health, behavior, or functional capacity, or if there is a change in the participant's primary unpaid caregiver for a reason stated in 7 AAC 130.209 (a)(3)-(5) and his or her health and safety can no longer be assured on the ISW, he or she will be referred to another waiver.
.

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 support plan and have the capacity to serve them. In addition, the support plan document includes a Participant Choice of Service section in which the participant confirms that their care coordinator has given them a list of certified providers in their community from which they may choose a provider. If the care coordinator works for an agency that provides other types of waiver services under an SDS-awarded exception to the CMS requirement that care coordination be conflict-free, the care coordinator is required to disclose this conflict of interest and ensure that the participant understands that they still have the right to choose a provider other than from the care coordinator's agency.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

SDS exercises routine oversight of support plans to ensure that plans are developed according to State policy and that participants' health and welfare are protected.

Every support plan is reviewed and signed by the participant or the participant's legal representative before being submitted to SDS for review. Each support plan is reviewed and approved by IDD unit staff for suitability and adequacy and confirmed to be within the individual cost limit 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 prior authorizes service and confirms support plan is within the individual cost limit.

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:

The care coordinator provides a copy of the completed support plan to all waiver service providers identified in the support plan and to the participant.

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 support plan. Care coordinators must make one in-person contact with the participant at least once every three months and one telephone contact in each of the subsequent two months.

Using in-person and telephonic contacts, the care coordinator ensures that services are provided as identified in the support plan, monitors the effectiveness and quality of services received from providers, evaluates the need for specific services or changes in services and, with the participant, amends the support plan 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 provider must implement procedures for reporting to the recipient's care coordinator information regarding how the provider's activities are contributing to the recipient's progress toward meeting service goals and whether alternative activities would be more effective if progress is limited.

The State also takes a role in monitoring implementation of the support plan through a review of the care coordinator's efforts. After each visit with a participant, the care coordinator completes a provider "record of service" that includes annotated case notes signed and dated by the care coordinator. The SDS Quality Assurance (QA) 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.

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 support plan implementation. Rural exceptions to conflict-free care coordination may allow a care coordinator to work for an agency that provides direct waiver services to the participant when the agency is the only willing and qualified entity responsible for the person-centered support plan, but the care coordinator may not provide any direct waiver services to a participant while that care coordinator is providing ongoing care coordination services.

Care coordinators must complete mandatory training that addresses their responsibilities to monitor support plans, 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 other than from 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 support plan, and that SDS staff will investigate complaints regarding support plans. The applicant initials and signs the form indicating they have been informed.

When the participant's support plan 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.

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 States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

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

participants who were included in the case review sample.

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

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

Performance Measure:
SP 5: # and % of participants who have documented personal goals identified in the service plan. Numerator: # of participants whose service plans had documented personal goals. Denominator: # of participants who were included in the case review sample.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
SP 6: # and % of participants who indicate progress made towards goals identified in their service plan. Numerator: # of participants who indicate they made progress towards their goals Denominator: # of participant who were included in the case review sample

Data Source (Select one):

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
SP 7: # and % of waiver participants whose service plans address health and safety risks. Numerator: # of participants whose service plans addressed health and safety risks during the PCP process. Denominator: # of participants who were included in the case review sample.

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the

method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

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

Performance Measures

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

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

Performance Measure:
SP 8: # and % of renewal service plans or amendments received by SDS prior to the set annual redetermination date. Numerator: # of renewal service plans or amendments received by SDS prior to the set annual redetermination date that are due within the reporting period. Denominator: Sample of renewal service plans due for receipt within the reporting period.

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the

method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid**	☐ **Weekly**	☐ **100% Review**

Agency		
☐ **Operating Agency**	☒ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = Confidence Interval = 95%, +/- 5% and 50% distribution
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
SP 11: # and % of participant records with documentation that the participant reviewed a list of qualified providers and was provided a choice of providers Numerator: # of service plans that included evidence that the participant reviewed a list of providers and was provided a choice in providers. Denominator: # of participants who were included in the case review sample.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Quality improvement strategies are founded upon data-driven discovery activities. Task Committees have been developed to focus on specific areas of performance and to implement systems for data collection. The Service Plan Task Committee comprises managers of the Intellectual and Developmental Disability unit and the CAT Review unit manager (Co-Chairs), QA unit manager, Operations and Training manager, Research and Analysis Unit manager and CAT Intake and Assessment unit manager.

These managers are the first line of discovery and are charged with identification of support plan problems within the waiver program through monitoring and evaluation of established performance measure data.

Initial discovery is the responsibility of the Service Plan Task Committee Co-Chairs who perform 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 on-site visits that include document reviews and participant and provider staff interviews.

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The care coordinator is responsible for a participant's support plan development and implementation.

When discovery activities reveal that a support plan has not been submitted in a timely fashion, is inadequate to meet the participant's needs identified in the level of care 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 QA is responsible for remediation activities.

The QA manager identifies the care coordinator who submitted the support plan and prepares a "report of findings" outlining support plan 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 support plan 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 QISC on a quarterly basis.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

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

c. Timelines

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

○ **No**

◉ **Yes**

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

On January 16, 2018, Phase 2.1 of the new Harmony Data System went into production. This part of the system involves three components: Provider Certification, Consumer Programs, and a Web Resource. Taken together, these components constitute the largest part of the new system and meet basic agency business needs. The go-live of Harmony has required extensive staff time and commitment. Reports, including those built to report on CMS-approved HCBS performance measures, have been delivered by the vendor and approved by the State.

At the time of this waiver application, the Harmony project team of state agency staff and contractors are engaged in remediation of issues found since the system entered production, including evaluation of new change requests. Planning is also underway to phase in use of Harmony by service providers and care coordinators; extensive training is taking place prior to phase-in. Progress on the remaining phases of the project continues.

A large part of the success in the Harmony system is dependent on the provisioning of external users such as care coordinators, personal care agency service coordinators, and hospital staff, to enter information directly into Harmony. At this time the State does not expect to be able to fully provision external users until September, 2018. Once external users are in the system, the State expects to provide a large amount of technical assistance before Harmony can be considered fully functional. The State expects to be operating at full capacity with external providers by January 1, 2019.

Amending the quality measures at this time will impact the State's ability to remediate immediate issues that must be addressed in order to ensure that the State's business needs are met. For example, when data was converted from the legacy system, some providers were duplicated within the Harmony system. State staff and Harmony production are working to identify these duplicates and remediate the duplication. Developing new quality measures, building the data collection and reporting of those measures, and incorporating these new measures into the state's quality improvement model is a large task and is done by the same team of research analysts responsible for provisioning and remediation of system issues. While the State agrees that the quality measures may need some improvement, making those changes at this time has the potential to negatively impact the successful implementation of the new Harmony database and lessens the state's ability to build meaningful measures.

The State's four existing waivers were approved under the same assurances and sub-assurances in July, 2016. The State proposes for consistency that it seek to submit an amendment effective July, 2021.

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 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, they are not given the choice of home and community-based services as an alternative to institutional care, they are denied the service(s) of their choice or the provider(s) of their choice, or, their 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 "Notice of Adverse Actions, Hearings and Appeals" information sheet. SDS ensures that the applicant receives the "Notice of Adverse Action" by requiring the Program Recipient Rights" form as part of the complete application. The form requires the applicant to read and initial 18 statements attesting to the fact that they understand their rights under the program. The final statement confirms that they have received a copy of the "Notice of Adverse Actions, Hearings and Appeals" information sheet.

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

A request for a hearing must be made in writing by the applicant, 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 Conduent, 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 Conduent for appropriate processing. Individuals who want to file for a Fair Hearing who are non-English speaking or illiterate are assisted by either their care coordinator or their agency representative who will develop the request in writing and ensure that it is delivered to Conduent.

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 (ALJ). Fair Hearing Representatives within the SDS Quality Assurance 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 Department's Division of Health Care Services (DHCS) will provide assistance in obtaining representation, preparing the case, and gathering witnesses and/or documents to be used in presenting the claim.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates an additional dispute resolution process**

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

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

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

Procedures and Timeframe: Participants (or care coordinators of behalf of participants) who have requested a Fair Hearing are automatically scheduled for an informal mediation session. OAH sends a notice to the appellant with a date and time for the informal mediation session, generally 10 days from the time OAH receives the case referral. The OAH schedules the mediation at the earliest time slot available. Participants may reschedule the mediation to suit their availability and may also decline mediation. A Calendar Call (a short scheduling conference to set a date and time for the Fair Hearing if the case is not settled in mediation) is also identified within this notice. The notice also states that the mediation is voluntary, is not a pre-requisite or substitute for a Fair Hearing, and that the appellant retains the right to a Fair Hearing if the disputes are not resolved during the mediation, as set forth in 7AAC 49.010, Chapter 49 Hearings.

Each mediation is scheduled for one hour with the mediator (the lawyer contracted by OAH) acting as a neutral party, an SDS Fair Hearing Representative (there are two SDS hearing representatives who are available for this process), and an SDS professional with the ability to make changes to the existing authorization of services. Appellants have the opportunity to have care coordinators and others assist and advise on their behalf, without representing the appellant. Care coordinators may assist participants in retrieving and forwarding new records or information for the mediation. They may also assist in explaining complex ideas as a result of the mediation. The participant has a choice to include or not include a care coordinator in their mediation. During the mediation session, the mediator sets forth basic mediation rules and directs the communication. Disagreements are discussed in a highly informal manner, and additional information, including new records, can be considered. The parties may reach a total or partial resolution. Resolutions are voice recorded during the mediation session, and an order dismissing the case is issued by OAH if resolution is reached.

After a partial resolution, the State will record the portion of the agreement that was reached and inform the ALJ of the terms of the partial resolution. Once there is a final decision from the ALJ on any remaining issues, SDS authorizes the services and informs the participant and the service agency.

Appellants can let the OAH know at any time up to and during the mediation session that they do not want to pursue settlement through mediation, and that they wish to proceed to Fair Hearing. If the parties do not reach an agreement, the case goes on to a Calendar Call and a Fair Hearing is scheduled.

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

Types of Disputes: During both the informal and formal mediation sessions, the parties may discuss new information including medical documentation and other potential environmental changes, and how these affect the appellant's eligibility for level of care or specific services. The types of disputes addressed through this mediation process include initial waiver denial, material improvement and waiver termination decisions, eligibility for services such as chore, respite, and day habilitation, determination of developmental disability decisions, denials of enhanced payments for acuity, and any disagreements stated by the appellant which are addressed in the State's notice authorizing or denying services. Any matters discussed during mediation remain confidential. Partial resolutions are allowable, if documented, and remaining unresolved issues can proceed to Fair Hearing.

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

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

○ **No. This Appendix does not apply**

◉ **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

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

SDS has a complaint management policy and procedure outlining a system that offers a number of approaches to resolve problems and issues with program operations or services. This system, which includes provider grievance processes as well as State agency processes, fosters the identification of problems that, when remediated, lead to improvement in the quality of program operations and to the health, safety, and welfare of participants.

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

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

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

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

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

If the complaint is about the behavior of an SDS employee or an SDS administrative process (e.g., conduct considered negligent, rude, or discourteous, timeliness of actions, request for unreasonable or unnecessary documentation or clarification, and treatment different than others without reasons related to regulations) the complaint is routed to the appropriate SDS program unit manager within three business days. Deficiencies in SDS operations are addressed with changes in process or policy, clarification of policy or regulations, individual, unit or division-wide training, and in cases of grievous misconduct, referral to Human Resources.

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

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

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

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

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

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

All waiver service providers are mandatory reporters for abuse, neglect or exploitation and are required to report these types of incidents in accordance with AS 47.17.010 for children and AS 47.24.010 for adults. For incidents of abuse, neglect or exploitation in an assisted living home, service providers are required to report these incidents to the Division of Health Care Services, Certification and Licensing Unit pursuant to AS 47.24.013.

Regulations at 7 AAC 130.222 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 support plan, the provider agency or the incident reporter is required to file an SDS critical incident report. 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.

Critical 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 participant;
- Accident, injury, or another unexpected event that affected the recipients health, safety, or welfare to the extant evaluation by or consultation with medical personnel was needed;
- A medication error resulting in the need for evaluation by or consultation with medical personnel including failure to document administration of a medication, failure to administer a medication at a scheduled time, and administration of a medication at a time other than when it was scheduled, other than by the prescribed route, not intended for the recipient, intended for the recipient but given to another person, and other than the correct dosage;
- An event that involved the participant and a response from a peace officer.

The Central Intake unit (CI), is responsible for receiving and processing voluntary reports, required reports and/or complaints relative to vulnerable adults, persons living in assisted living homes and persons receiving services managed by SDS. The reports may pertain to physical and sexual abuse, neglect, self-neglect, exploitation, including financial exploitation, and abandonment as well as critical incidents involving waiver participants.

CI unit staff are well versed and crossed trained on Adult Protective Services (APS), Quality Assurance (QA), and the Division of Health Care Services' (DHCS) Section of Residential Licensing and Background Check Programs (RL) policies and procedures. Providers, participants, care coordinators, family members, advocates or any citizen may submit a report through the SDS-sponsored "Centralized Reporting" electronic portal accessed through SDS Harmony data base system web at http://dhss.alaska.gov/dsds/Pages/CentralizedReporting.aspx.

The CI unit reviews all reports within 24 hours of receipt and routes the report to the pertinent unit: APS, QA, or the RL section. The CI unit may route the same report to multiple units, depending on the nature of the report.

If a report involves a participant who resides in a licensed assisted living home, the CI unit refers the case to the RL section for investigation and they may collaborate with the SDS Provider Certification and Compliance (PCC) unit and/or the QA unit on shared investigations. All information received from the RL section is recorded in a database shared by the CI unit, APS, QA and the RL section.

When the RL section receives a report of abuse or neglect in an assisted living home and plans a site visit, they inform the CI unit in the event that a waiver participant might be displaced from the home. In addition, the RL section performs site inspections when immediate risks to the health and safety of the participants exist. APS may be present at these inspections to facilitate protective placement at a new facility if residents wish to accept assistance.

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

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

As part of the initial application process and during the annual reassessment process applicants and participants and/or their legal representatives are informed on reporting abuse, neglect and exploitation, and document that they have been informed by initialing and signing the SDS "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 are received by the Central Intake Unit through the SDS- sponsored “Centralized Reporting” electronic portal. Within 24 hours or one business day of receipt, Central Intake reviews the report to determine if there are indications of past harm or risk for or suspected abuse, neglect, exploitation that requires referral to APS, the Alaska Office of Children’s Services, the DHCS RL Unit, or to law enforcement/emergency services.

The timeline for Office of Chidren's Services, the Division of Health Care Services, Residential Licensing Unit and Adult Protective Services are as follows:

- Office of Children’s Services: 24 hours, 72 hours, or five days, based on priority level of the report made.
- DHCS Residential Licensing Unit: 48 hours, five days, or 14 days (mostly phone contact with collateral information gathering), with a fourth category that just logs the report when it doesn’t require follow-up questions or response.
- Adult Protective Services: 24 hours, 10 days, or 10 days (to provide information and/or referrals via phone contact)

The QA Unit is responsible for reviewing the provider agency response to the incident to determine whether circumstances to mitigate any risks to health, safety and welfare and reduce the risk of reoccurrence have been adequately addressed. For an adequate response, SDS takes no further action. For an inadequate response, the QA Unit staff will 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 Corrective Action Plan, and may copy the Provider Certification and Compliance Unit on the notice that a plan has been requested.

The provider agency develops and submits to SDS a Corrective Action 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. QA 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 DHCS Residential Licensing Unit for investigation, record of the action taken is entered in the shared database. The information is then a part of the participant’s and the provider’s files and may be used in discovery of trends in provider performance and participant needs.

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

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

The QA unit oversees the critical incident report 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 device 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, and ongoing monitoring activities. 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, but does not require, the use of time limited positive behavioral support plans that use the least restrictive methods needed to manage behaviors and eliminate the circumstances in which restraints or seclusion would be necessary. A behavior support plan may be initiated when 1) 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, 2) a participant’s behavior is reoccurring and requires the use of restraints two or more times in a six month period, or 3) the behavior that required restraint has caused an imminent risk to the participant or others. SDS requires that, in cases where behavior is impacting the service request or design, support teams note in the recipient’s support plan the type of interventions implemented. Support teams are free to address behaviors using a prescribed method in which they are trained, such as positive behavioral supports or a nonviolent crisis program like Crisis Prevention Intervention.

All support plans must be in accordance with 7 AAC 130.220 (p) (1)-(7)), which mandates the support plan must include the following when a restrictive intervention is used:

- Identification of a specific and individualized assessed need.
- Documentation of the positive interventions and supports used prior to any modifications to the person-centered service plan.
- Documentation that less intrusive methods of meeting the need have been tried but did not work
- Description of the condition that is directly proportionate to the specific assessed need.
- Collection and analysis of behavioral data to measure the ongoing effectiveness of the modification.

- Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
- Informed consent of the individual regarding the use of restraints is documented in the recipient's support plan.
- Assurances from the provider of the service that the interventions and supports will cause no harm to the individual.

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

For participants without a behavioral support plan, the participant's care coordinator is trained to come up with solutions when a person has a problem accessing services or the community due to behavior issues, including assessing the need for restrictive interventions and working with the service providers to amend the support plan in accordance with 7 AAC 130.220 (p) (1)-(7) . The support plan will identify a specific and individualized assessed need; document the positive interventions and supports used prior to any modifications; document that less intrusive methods of meeting the need were tried but did not work; describe the condition that is directly proportionate to the specific assessed need; establish time limits for periodic reviews to determine if the modification is still necessary or can be terminated; and monitor the service delivery including the restrictive intervention through collection and analysis of behavioral data to measure the ongoing effectiveness of the modification, and works with the service provider to amend the support plan when changes are needed.

All agency direct care workers must meet the following qualifications and have received the required trainings: 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, Critical Incident Reporting training, Restrictive Intervention training, and, for direct service workers that assist with self-administration of medications, Assistance with Self-Administration of Medications 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, the event or circumstances,, the outcomes; and the debriefing
- 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;
- make a "Critical Incident Report" to 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, and analyze the collected information and take corrective action for identified problem areas.

- document other interventions applied or attempted prior to use of any restraint, and the use the less restrictive interventions prior to the implementation of restraints or time out including but not limited to: 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 and incentives; incentives; teaching and encouraging; canceling an activity; controlling access to medications and hazards; physically blocking without holding a participant for protective purposes; requesting a participant leave an area or room; use of medical alert devices;; use of door and window alarm or alert system 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.

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.

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, support plan processing, critical incident reporting management, and quality assurance reviews.

The SDS QA and APS units in cooperation with the RL section 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 RL section is responsible for the licensure of assisted living homes, offers 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 quarterly face-to-face contact and two subsequent months of telephone calls, 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 support plan 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 support plan. During each of the quarterly face-to-face contact and the monthly telephone calls, 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 a 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 support plan processing, if the use of restraints or seclusion is a contingency, the IDD unit verifies either that a positive behavioral support plan has been developed and included in the support plan, or if not included, contacts the care coordinator regarding the need for a behavior support plan. The IDD unit approves the support plan 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 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 QA 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 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 QISC, 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.

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, develops 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 support plan 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 support plan. During each of the quarterly face-to-face contacts and the monthly telephone calls, 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 a 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, telephone calls, 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 support plan. 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.

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 the 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, support plan 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 on-site 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 the RL section. 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 RL section 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 RL section, responsible for the licensure of assisted living homes, offers 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 quarterly face-to-face contacts and monthly telephone calls, 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 QA 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 evaluates the information for possible individual remediation, patterns or trends in use of restrictive intervention and makes a monthly quality report to the 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 QISC, 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 on-site 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 RL section. Use of seclusion may result in a provider sanction or enforcement action up to and including termination from the Medicaid program.

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

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

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

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

Appendix G: Participant Safeguards

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

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

a. Applicability. Select one:

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

◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

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

Medication management is provided for recipients of home and community-based residential habilitation services; these services may be provided in licensed assisted living homes only. SDS specifies that home and community-based waiver regulations regarding medications are superseded by assisted living home regulations, 7 AAC 130.227 (i)(1).

Health-related services, including medication management, are allowed in assisted living homes, AS 47.33.020. Under 12 AAC 44.965, a registered nurse may delegate the administration of medication to a residential habilitation services provider. In an assisted living home, residents may self-administer their own medications.

The assisted living plan must address the need for health-related services and how that need will be met, AS 47.33.230 (b)(8). A physician's statement regarding the medication regimen must be included in the plan. The plan must be evaluated at three-month intervals if an assisted living home provides or arranged for such services. In addition to evaluation of the over-all plan by the resident or the resident's representative, and the assisted living home administrator, a registered nurse must review the portion of the plan that that describes how the resident's need for health-related services will be met. The registered nurse monitors the appropriateness of medications with particular attention paid to behavior-modifying medications; usage pattern; potential risks and side-effects associated with the medications; and possible medication interactions. The registered nurse must report adverse findings to the physician, and based on evaluation of the medication process in the assisted living home, may revise the plan to stipulate more frequent provider monitoring or additional training to direct care staff, if 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 RL section monitors assisted living homes on a bi-annual basis to determine compliance with regulations. It is responsible for oversight of medication management practices within assisted living homes, including monitoring medication regimens. The bi-annual evaluation includes review of resident assisted living plans to ensure that medication management activities have been completed by a registered nurse at three-month intervals, and that that any concerns or problems with a medication regimen, type of medication, or usage patterns have been documented, addressed, and resolved.

The RL section responds to complaints or incidents involving medication management with an investigation of the circumstances that led to a medication error and takes action to correct the practices contributing to the error. If an investigation reveals medication management deficiencies that indicate imminent risks to recipients, the RL section requires immediate corrective action. For other deficiencies, the RL section requires the assisted living homes to develop and submit a Plan of Correction for approval, specifying the timeframe within which the plan must be submitted (generally 30 days from the date of issuance, depending upon the deficiencies noted). Once the deficiencies have been corrected, a report of compliance is submitted to and reviewed by the RL section which may conduct a follow-up investigation or inspection to determine compliance. If the provider does not comply with the plan, the RL section has authority to convert a standard ALH license to a probationary license until the deficiencies are corrected, 7 AAC 75.020 – 75.070, or may suspend or revoke the assisted living homes license.

The RL section regularly consults with the Alaska Board of Nursing regarding medication questions, and clarification of nurse delegation responsibilities. The RL section reports any substantiated findings or concerns regarding the performance of a nurse or nurse's aide directly to the Board of Nursing. The mission of the Board of Nursing 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's aides in Alaska. It makes final licensing decisions and takes disciplinary action against those who violate the licensing laws.

If a completed assisted living home's report of inspection or investigation may affect its certification, the RL section sends the completed report to the PCC 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).

State policies that apply to the administration of medications to waiver participants or to assist with participant self-administration of medications distinguish between situations in which a nurse has delegated these duties to a home and community-based service provider, and those in which delegation of these duties arises from another licensed health care provider, the participant or the participant's legal representative. SDS regulations regarding medications, 7 AAC 130.227, were developed in view of the fact that the participant or the participant's legal representative may delegate medication administration or assistance with self- administration to waiver providers.

SDS requires specified waiver providers to administer, or assist a participant to self-administer, medications when needed or requested by a participant or participant's representative if no other individual otherwise responsible for medication for the participant is available at the time the participant requires medication. The provider must have a written delegation from the participant, participant's representative, a registered nurse, or another health care professional in accordance with statutes or regulations applicable to that professional.

The provider must develop and implement written policies and procedures that address medication administration while participants are in the care of and receiving services from the provider; documentation of all medications in an individual participant record; the name of the medication; the dosage administered; the time of administration; the name of the individual who assists with self-medication or who administers a medication to the recipient; monitoring and evaluation of medication administration; medication error reporting requirements; and medication administration training requirements.

A provider agency seeking certification must create and implement a medication management policy to be submitted and reviewed by the State at the initial certification stage and it is reviewed at certification renewal if the agency's policy or guiding state/federal regulations have changed.

The provider may assist a recipient to self-administer medication provided the assisting employee is supervised as necessary. Assisted living home staff, as residential habilitation services providers, may assist with self-administration by reminding the participant to take medication; opening a medication container or pre-packaged medication for a participant; reading a medication label to a participant; observing a participant while the participant takes medication; checking a participant self-administered dosage against the label of the medication container; reassuring a participant that the participant is taking the dosage as prescribed; and directing or guiding, at the request of the participant, the hand of a participant who is administering his or her own medications, AS 47.33.020.

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

The medication management policy addresses training for non-medical waiver providers in both the administration of medication and assistance with self-administration of medication. The provider's policy must comply with AS 08.68.805 Delegation of Nursing Functions, 7 AAC 130.227 Administration of medication and assistance with self-administration of medication, and 12 AAC 44.965 Delegation of the administration of medication.

To administer medication to participants, agencies must determine that the participant requires medication administration as part of the service. If yes, a licensed nurse must formally delegate medication administration and train non-medical waiver providers who will be administering

medication to the participant. The nurse must train non-medical providers using the current medication administration curriculum that has been approved by the Alaska Board of Nursing.

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

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

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

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

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

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

Whether a medication is self-administered with assistance or administered by the provider under delegation, the provider must record and document the following medication errors that might occur while the participant is in the care of or receiving services from, the provider:

1) failure to document medication administration;
2) failure to administer medication administration at, or within one hour before or one hour after, the scheduled time;
3) the delivery of medication
a. at a time other than when a medication was scheduled, if the time was outside the acceptable range in (2);
b. other than by the prescribed route;
c. other than in the prescribed dosage;
d. not intended for the participant; or
e. intended for the participant, but given to another person.

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

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

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

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

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

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

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

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

i. Sub-Assurances:

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

Performance Measures

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

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

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

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

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

		Sample Confidence Interval = Confidence Interval = 95%, +/- 5% and 50% distribution
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
HW 17: # and % of central intake reports involving possible A/N/E of adults providers submitted w/in required timeframe. Numerator: # of central intake reports involving possible A/N/E of adults providers submitted w/in required timeframes and reporting period. Denominator: Sample of central intake reports involving possible A/N/E of adults providers submitted w/in the reporting period.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
HW 18: # and % of central intake reports involving critical incidents referenced in 7AAC 130.224 that providers submitted w/in required timeframe. Numerator: # of central intake reports involving critical incidents submitted by provider w/in required timeframes and reporting period. Denominator: Sample of critical incident reports submitted to SDS by provider w/in reporting period.

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

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

☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = Confidence Interval = 95%, +/- 5% and 50% distribution
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
HW 19: # and % of deaths reported by providers. Numerator: # of participant deaths recorded by Vital Statistics that were reported to SDS by providers within the reporting period. Denominator: Sample of participant deaths recorded by Vital Statistics within the reporting period.

Data Source (Select one):
Mortality reviews
If 'Other' is selected, specify:

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

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

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

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
HW 20: # and % of central intake reports involving possible A/N/E of adults reviewed w/in one business day of receipt. Numerator: # of central intake reports involving possible A/N/E of adults reviewed w/in one business day of receipt and submitted w/in reporting period. Denominator: Sample of central intake reports involving possible A/N/E of adults submitted w/in reporting period.

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

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

☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = Confidence Interval = 95%, +/- 5% and 50% distribution
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW 21: # and % of alleged non-waiver victims involved in founded A/N/E central intake reports. Numerator: # of alleged non-waiver victims involved in A/N/E central intake reports and were founded within the reporting period. Denominator: Sample of alleged non-waiver victims involved in founded A/N/E central intake reports that were founded within the reporting period.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:
HW 22: #/% of critical incidents reporting restrictive intervention that was

prohibited/inappropriate/ resulted in need for med intervention. Numerator: # of critical incidents reporting restrictive intervention that was prohibited/inappropriate/resulted in need for med intervention. Denominator: Sample of critical incidents reporting restrictive intervention w/in the reporting period.

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

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

Data Aggregation and Analysis:

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

Performance Measure:
HW 23: # and % of critical incident reports reporting provider medication errors that resulted in the need for medical intervention. Numerator: # of critical incident reports reporting provider medication errors that resulted in the need for medical intervention. Denominator: Sample of critical incident reports submitted to SDS within the reporting period.

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

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

☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = Confidence Interval = 95%, +/- 5% and 50% distribution
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW 24: # and % of waiver central intake reports involving med intervention that resulted in an investigation. Numerator: # of waiver central intake reports submitted during the reporting period involving med intervention that resulted in an investigation. Denominator: Sample of waiver central intake reports involving med intervention submitted by providers during the reporting period.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Quality improvement strategies are founded upon data-driven discovery activities. Task Committees have been developed to focus on specific areas of performance and to implement systems for data collection. The Health and Welfare Task Committee comprises managers of the Quality Assurance unit (Co-Chair), Adult Protection Services manager, (Co-Chair), IDD unit, CAT Intake and Assessment unit, Research and Analysis unit, CAT Review unit, Grant manager, and Policy and Program Development unit. These managers are the first line of discovery and are charged with identification of support plan 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 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 on-site visits that include document reviews and participant and provider staff interviews.

The Health and Welfare Committee prepares standardized monthly reports for the QIW based on the Health and Welfare measures approved by the 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 States 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 QA 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 QA 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 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 on-site 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 QA 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 and Procedure Task Committee who facilitates changes through the State of Alaska regulation development process or the SDS policy and procedure development process as appropriate.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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

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.

On January 16, 2018, Phase 2.1 of the new Harmony Data System went into production. This part of the system involves three components: Provider Certification, Consumer Programs, and a Web Resource. Taken together, these components constitute the largest part of the new system and meet basic agency business needs. The go-live of Harmony has required extensive staff time and commitment. Reports, including those built to report on CMS-approved HCBS performance measures, have been delivered by the vendor and approved by the State.

At the time of this waiver application, the Harmony project team of state agency staff and contractors are engaged in remediation of issues found since the system entered production, including evaluation of new change requests. Planning is also underway to phase in use of Harmony by service providers and care coordinators; extensive training is taking place prior to phase-in. Progress on the remaining phases of the project continues.

A large part of the success in the Harmony system is dependent on the provisioning of external users such as care coordinators, personal care agency service coordinators, and hospital staff, to enter information directly into Harmony. At this time the State does not expect to be able to fully provision external users until September, 2018. Once external users are in the system, the State expects to provide a large amount of technical assistance before Harmony can be considered fully functional. The State expects to be operating at full capacity with external providers by January 1, 2019.

Amending the quality measures at this time will impact the State's ability to remediate immediate issues that must be addressed in order to ensure that the State's business needs are met. For example, when data was converted from the legacy system, some providers were duplicated within the Harmony system. State staff and Harmony production are working to identify these duplicates and remediate the duplication. Developing new quality measures, building the data collection and reporting of those measures, and incorporating these new measures into the state's quality improvement model is a large task and is done by the same team of research analysts responsible for provisioning and remediation of system issues. While the State agrees that the quality measures may need some improvement, making those changes at this time has the potential to negatively impact the successful implementation of the new Harmony database and lessens the state's ability to build meaningful measures.

The State's four existing waivers were approved under the same assurances and sub-assurances in July, 2016. The State proposes for consistency that it seek to submit an amendment effective July, 2021.

Appendix H: Quality Improvement Strategy (1 of 3)

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; and
- 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 3)

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. The Quality Improvement Workgroup (QIW) comprises of SDS unit managers and the Division's Executive Team. Activities of the QIW are overseen by the DHSS Quality Improvement Steering Committee (QISC) led by the department's Commissioner and Deputy Commissioner.

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

The QIS and Task Committees perform discovery and remediation activities for all Medicaid waivers. Data is separately aggregated and analyzed for each waiver.

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

Mortality Review Team. The Mortality Review Team identifies and reviews all deaths reported throughout the centralized intake reporting system. Membership includes the Quality Assurance unit manager (Chair) and SDS staff including a Qualified Intellectual Disability Professional (QIDP), a Registered Nurse (RN), the SDS Mortality Review Coordinator, an Adult Protective Services (APS) unit representative, a DHCS Residential Licensing and Certification unit representative and an Office of Long Term Care Ombudsman representative. The Committee reviews information on participant deaths obtained through the SDS critical incident reporting process, medical records, vital statistics, Medical Examiner's office and law enforcement reports and determines if the death is the result of an action or omission (or inaction) on the part of a provider agency or SDS. The Committee also compares SDS findings with information obtained from the Bureau of Vital Statistics to discover additional deaths not reported by providers. Untimely deaths or deaths involving unusual circumstances of waiver participants are vetted carefully by the committee and may trigger an investigation.

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

Qualified Providers Review. The Qualified Providers Task Committee gathers and reviews data from SDS performance measures regarding provider qualifications to determine whether certification standards, including required training, are met. Membership includes the managers of the Provider Certification and Compliance unit (Chair), Provider Certification and Compliance unit staff, SDS Training Coordinator, Quality Assurance unit Staff, Policy and Program Development unit, and the Grants unit. 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 support 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 unit and CAT Review unit manager (Co-Chairs), Quality Assurance unit, a Research and Analysis Team and the CAT Intake and Assessment unit manager. The Committee reviews results of monthly support plan record reviews and reports findings to the manager of the applicable waiver unit. The manager identifies and initiates remediation activities needed to cure identified deficiencies. The Committee also submits reports on remediation completed to the QA unit for inclusion in the monthly QIW meetings and makes system improvement recommendations to QIW.

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

Health and Welfare Review Task Committee. The Health and Welfare Review Task Committee monitors performance measures related to reports of harm and other critical incidents. Membership includes the managers of the Quality Assurance unit and Adult Protective Services (Co-Chairs), IDD unit, CAT Intake and Assessment unit, Operations unit, CAT Review unit, Central Intake unit, Grants unit and Policy and Program Development unit. The Committee reviews reports of harm, critical incident and complaint reports, discovers deficiencies and plans and conducts individual and system remediation.

Information Technology Task Committee. The Information Technology (IT) Task Committee monitors the coordination and integration of SDS information technology and supports data collection and analysis activities of all the Task Committees. Membership includes the DHSS Finance Management Systems/IT Project manager (Chair), Research and Analysis unit manager, SDS Deputy Director, SDS Chief of Programs, SDS Chief of Quality, Administrative Operations manager, a representative of the DHSS IT Business Analysis unit and IT Programming contractor representative. 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 comprises CAT Review unit manager (Chair), Quality Assurance unit manager, Policy and Program Development unit manager, and representatives from DHCS 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 DHCS to discover deficiencies in provider billing compliance. The committee addresses deficiencies that can be remediated at the SDS level, and supports DHSS efforts to recoup overpayments and sanction providers as needed to maintain the financial integrity of waiver programs.

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

Under Alaska Statute, home and community-based 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, home and community-based service providers are expected to perform an internal evaluation including client satisfaction surveys, which are reviewed by QA staff and considered when the agency seeks recertification.

ii. System Improvement Activities

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

b. System Design Changes

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

Quality Improvement Steering Committee (QISC)

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

While the Commissioner of the Department of Health and Social Services holds ultimate responsibility for quality improvement activities of SDS, the Deputy Commissioner for Medicaid and Health Care Policy/State Medicaid Director has been delegated by the Commissioner as the individual responsible to oversee the QISC functions.

QISC Committee Membership includes:

- Deputy Commissioner for Medicaid and Health Care Policy/State Medicaid Director, Committee Chair
- Director, SDS
- Deputy Director, SDS
- Chief of Quality, SDS
- Chief of Programs, SDS
- Program Integrity Manager, Performance and Quality Assurance,
- 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 and assist with DHSS-level activities to reduce duplication of effort and to streamline processes;
- Advise Commissioner of DHSS on the status of quality improvement measures;
- Evaluate the composition of the QISC; and
- Coordinate efforts and exchange information with external stakeholders.

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

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

The Quality Improvement Steering Committee (QISC) provides oversight to SDS's continuous quality improvement activities. This is a multi-divisional group within DHSS that includes, at a minimum:

- Deputy Commissioner for Medicaid and Health Care Policy/State Medicaid Director, Committee Chair
- Director, SDS
- Deputy Director, SDS
- Chief of Quality, SDS
- Chief of Programs, SDS
- Program Integrity Manager, Performance and Quality Assurance
- Additional division or department staff at the invitation of the committee.

As the Committee Chair, the Deputy Commissioner for Medicaid and Health Care Policy 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 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 participants and the provision of quality services to these participants. The QISC monitors, recommends, and implements changes in the Quality Improvement Strategy to assure the health, safety and welfare of waiver participants and improve the quality of services provided to participants. 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 participants. 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 H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- (●) **No**
- ( ) **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ( ) **HCBS CAHPS Survey :**
- ( ) **NCI Survey :**
- ( ) **NCI AD Survey :**
- ( ) **Other** *(Please provide a description of the survey tool used):*

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, home and community-based service providers are subject to the following independent audit schedule:

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

For audits conducted under the State statute AS 47.05.200, the original sample used during the desk review process is the one sample that is utilized for both the desk and on- site portions of the audit. If the contracted audit firm plans on performing onsite sampling, the sampled list of individual records does not change.

In addition to audits conducted under State statute, a waiver provider may also be selected for audit under the new Unified Program Integrity Contractor (UPIC) audit process. While the Western Region UPIC contractor has yet to transition into Alaska, the Office of Medicaid Program Integrity expects to begin working with them shortly. If a provider is suspected of fraudulent behavior, a fraud probe sampling technique may be employed as part of an audit. In that case, a primary sample is transmitted to the provider so they may begin pulling records in response to the audit notification and a subset of the overall sample is presented to the provider at the time of the field visit. This approach is useful to compare the documentation pulled and submitted in advance of the audit to the documentation received while on-site, to help ensure the agency is keeping appropriate, contemporaneous records consistent with regulatory requirements.

In rare instances a fraud probe sampling technique may be used in which a subset of the original sample is not given to the provider as part of the desk review information request. The documentation supporting the small subset of the original sample is reviewed in the field typically at the provider's business location, and documentation received in the field examination can be compared to documentation received as part of the desk review to gather assurances that the documentation is authentic.

Upon completion of an onsite or desk audit, a preliminary detailed audit report is drafted by the contract audit firm. This preliminary report is sent to the Department of Health and Social Services for review prior to being released to the provider. After review by the Department, the report is released to the provider. The provider has a minimum of 30 days to review the report and submit a response to the contract audit firm. This response may include additional documentation to support any contested findings. The provider's response and all documentation submitted is reviewed by the auditor and any necessary changes are made to the detail report. The contract auditor will issue an audit report and narrative summary to the department, which in turn issues the findings to the provider. A provider then has a minimum of 30 days to request a reconsideration of the results of the audit and/or request an administrative appeal. A provider may first seek reconsideration and subsequently appeal the results of the reconsideration if they choose to. Appeals are heard in front of Alaska's Office of Administrative Hearings. A provider may appeal the results of an administrative hearing to the Superior court.

For Single Audit Act of 1984 and the US OMB A-133 audit requirements, these audits are conducted every year through the single state audits performed by the Division of Legislative Audit for the State's financial statements and a contractor or the federal program requirements. These audits include all of the department's federal programs. These audits are posted online and via this link: http://legaudit.akleg.gov/audits/statewide/

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

Additional Detail:

Desk Procedures: Desk procedures are performed at the auditor's location, on-site procedures are conducted at the agency's location. All audits start as desk reviews. Approximately 33% of audits then move on to an on-site review based on the results of the desk review. Providers are selected for on-site review based on the results of the desk review.

Onsite reviews are conducted on those providers where it is believed the onsite review will be the most productive. A productive on-site audit is not measured only in terms of overpayments found but also in terms of resolution of complex issues that may have surfaced during the desk review. A provider may be selected for on-site procedures based on a number of analytical review procedures and testing procedures performed on the documentation submitted as part of the desk review.

The analytical review procedures include comparing provider claims to inpatient hospital and long term care claims, testing for potential duplicate claims, testing for services after date of death and testing for large volumes of claims billed on any particular date of service for a single recipient. Detail testing includes ensuring clinical documentation provided during the desk review process supports the units and procedure codes billed, ensuring documentation meets the standards required under 7 AAC 105.230 and ensuring medical necessity exists for the services billed. Those providers with higher apparent error rates are generally the ones where on-site reviews are conducted.

A Contract Audit Sample Selection Methodology is used, and an excerpt of that is provided here:

"Sample Selection Methodology

The methodology used in sample selection process took into consideration a variety of goals:

- *Use of risk-based selection protocols such that desk reviews and field examinations are focused on providers with a higher risk for Medicaid overpayments.*
- *Geographic diversity.*
- *Provider-type diversity.*
- *Primary focus on providers with higher levels of Medicaid payments.*
- *Some element of randomness.*

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

Risk factors used in the determination of a risk score which factors into sample selection include both general and provider type specific risk factors. The general factors include:

- *Provider type payment level; a factor specific to provider type that represents the relative level of Medicaid payments to that provider type as a ratio of total Medicaid payments to all provider types.*
- *Provider Specific Payment Level; a logarithmically adjusted factor that represents Medicaid payments relative to all other Medicaid providers.*
- *Provider Specific Payment Level Relative to Provider Type; a logarithmically adjusted factor that represents Medicaid payments relative to all other Medicaid providers of the same type.*
- *Average claim amount; a logarithmically adjusted factor that represents the relative payment amount per claim compared to other Medicaid providers of the same type.*
- *Average payments per recipient; a logarithmically adjusted factor that represents the relative payment per Medicaid recipient compared to other Medicaid providers of the same type.*

The Waiver specific risk factors include:

- *Waiver and Personal Care Services Unit Analysis; a factor that measures the relative frequency of services provided to each Medicaid recipient by home and community based waiver, care coordinator, residential living and personal care*

attendant providers.

Scope of Review: The scope of review is the providers' universe of Medicaid claims for a one year period. A statistically valid random sample is chosen from the universe of claims. The State anticipates conducting between 5 and 10 post payment review audits of these waiver providers annually. Documentation supporting the paid claims is requested from the provider for desk review testing procedures. The following details are taken from the Agreed Upon Procedures (AUP) for on-site reviews:

Continued at Main B. Optional/Additional Needed Information (after Appendix D-1-b Additional Information)

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

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

Performance Measures

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

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

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

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

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

		Review
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *Confidence Interval = 95%, +/- 5% and 50% distribution*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

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

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
	☒ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

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

Quality improvement strategies are founded upon data-driven discovery activities. Task Committees 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 CAT Review unit, Chair, Provider Certification and Compliance unit, Quality Assurance unit, Policy and Program Development unit as well as representatives from the Division of Health Care Services and the DHSS Program Integrity Office. These individuals are the first line of discovery and are charged with identification of problems with participant health and welfare through monitoring and evaluation of established performance measure data.

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

The Financial Accountability Task Committee prepares standardized monthly reports for the QIW based on the Service Plan performance measures approved by the Department of Health and Social Service 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 States 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 SDS discovery activities reveal problems with the State's performance in financial accountability, the Chair of the Financial Accountability Task Committee is responsible for bringing the issue to committee, initiating remediation activities with program and quality assurance managers, and monitoring the issue through resolution.

If discovery activities originate with the Division of Health Care Services (DHCS), which oversees the Surveillance and Utilization Review System (SURS), DHCS will refer the issues to the manager of the QA unit for remediation discussions. The QA unit manager will make the appropriate referral to the SDS unit managers and review the issues with the Financial Accountability Task Committee Chairs for ongoing monitoring.

If the data reveals a possible overpayment, it is referred to the Chair of the Financial Accountability Task Committee for review. For provider billing issues such as automatic rebilling, the issue is referred to the SDS QA unit who works with the provider to seek recovery and refer to provider billing training. If the provider does not cooperate with attempts to seek a refund or demonstrate billing practice improvements, the overpayments are referred to the DHSS Program Integrity unit.

If SDS discovers any systemic problems regarding the MMIS, they are brought to the QIW who will report any issues to the Director of DHCS, the State Medicaid Agency and alert the DHCS contract managers who oversee the MMIS contract.

If remediation involves amendments to SDS regulations or policy and procedure improvements, responsibility falls to the Chair of the Policy Task Committee who facilitates changes through the State of Alaska regulation development process or the SDS policy and procedure development process as appropriate.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☒ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☒ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

c. Timelines

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

◉ ***No***

○ ***Yes***

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

Appendix I: Financial Accountability

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

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

The Department of Health and Social Service's Office of Rate Review (ORR) is responsible for setting and reviewing Medicaid rates for home and community-based waiver services.

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

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

Medicaid reimbursement rates for home and community-based waiver services are rebased at least every four years, and are annually adjusted for inflation in non-rebase years. The inflation factor is determined using the CMS Home Health Agency Market Basket in Global Insight's Healthcare Cost Review. For state fiscal year 2018, the payment rates were not adjusted for inflation due to the State's budget situation.

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

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

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

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

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

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

follow the application of the adjustment. The process starts over in the next rebasing.

The methodology to set care coordination rates established wages, fringe benefits, administrative and general costs and caseload size using public sources such as the Alaska Bureau of Labor Statistics, the Internal Revenue Services, and other States' approved 1915(c) waivers. The rate for ISW care coordination presumes a caseload of 40 participants.

On or after January 1, 2018, the department will establish new rates for home and community based waiver services. The department will use a method that sets rates based on comprehensive cost surveys and financial audits from providers of the highest volume of Medicaid services in a given year. While reported costs from the high-volume providers is the most efficient starting point for establishing these rates, the costs will be adjusted upwards so that the final rates are accessible to all providers, large and small, in a manner that ensures that quality of care and services are available to Medicaid participants to the extent that such care and services are available to the general public. Additionally, to protect providers and participants of home and community-based waiver services and personal care attendant services from dramatic rate swings when rates are reestablished, reestablished rates or aggregate costs cannot increase or decrease more than 5% from the rates or costs that are in effect at the time the rates are reestablished. Rates that are capped at 5% can self-correct on an annual basis through enhanced or reduced inflation adjustments, and every four years when the rates are again reestablished.

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

The State's Office of Rate Review utilizes the list and guidelines for unallowable costs outlined in 7 AAC 150.170, which follow CMS PUB 15-1, chapter 21 guidelines. In response to the new rate methodology for these providers, Alaska has also recently revised regulations specific to this provider type, that once published will also include the list of unallowable costs. The new regulation citation is 7 AAC 145.533; these regulations became effective March 1, 2018, so are only available in final adopted form via this link: https://aws.state.ak.us/OnlinePublicNotices/Notices/View.aspx?id=188634

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 support plan. Based on this document, service authorizations are requested by SDS limiting frequency, scope and duration to that documented on the support plan.

The home and community-based agency provides service to the recipient on the service authorization and documents that the service was actually rendered on the date shown on the provider billing.

The home and community-based agency requests reimbursement for service on an invoice that includes the service authorization number, number of units and total dollars.

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

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

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

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

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

- (●) ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ( ) ***Payments for some, but not all, waiver services are made through an approved MMIS.***

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

- ( ) ***Payments for waiver services are not made through an approved MMIS.***

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

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

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

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

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

- [ ] ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***
- [x] ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***
- [ ] ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

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

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

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

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

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

- (●) ***No. The state does not make supplemental or enhanced payments for waiver services.***
- ( ) ***Yes. The state makes supplemental or enhanced payments for waiver services.***

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

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

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

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

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

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

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

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

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

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

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment *(6 of 7)*

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

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

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

Appendix I: Financial Accountability

I-3: Payment *(7 of 7)*

g. Additional Payment Arrangements

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

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

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

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

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

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

iii. Contracts with MCOs, PIHPs or PAHPs.

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

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

- ○ ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***

Appendix I: Financial Accountability

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

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

- ☒ ***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:*

Do not complete this item.

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	11249.05	11078.46	22327.51	317940.55	1626.77	319567.32	297239.81
2	18206.00	11344.34	29550.34	326524.94	1665.81	328190.75	298640.41
3	18643.88	11616.61	30260.49	335341.12	1705.79	337046.91	306786.42
4	19091.61	11895.41	30987.02	344395.33	1746.73	346142.06	315155.04
5	19547.84	12180.90	31728.74	353694.00	1788.65	355482.65	323753.91

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	620	620

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 2	620	620
Year 3	620	620
Year 4	620	620
Year 5	620	620

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.*

The Average Length of Stay calculation for waiver year one is 288 days. The Average Length of Stay calculation for waiver years two-five is 335 days. Individual days were counted for all waiver participants based on the expected beginning and ending dates associated with their Medicaid waiver eligibility status. The sum of the individual days is divided by the number of participants on the waiver during a particular waiver year.

The Average Length of Stay estimates for year one is lower than waiver years two-five because of the phase-in schedule. The Average Length of Stay estimates for waiver years two–five is based on the PIDD waiver (AK.02060) which serves a similar population.

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 and methodology for these estimates is as follows:*

For estimates of the initial year, the State utilized the IDD waiver and the developmental disabilities grant services as a starting point. IDD waiver services from SFY17 were used as the basis for establishing costs for individual services for the ISW. In addition, the State examined the range of per participant costs using IDD waiver data from SFY 2017. These analyses identified a large number of waiver participants with substantially lower costs. This finding supported the concept of having two separate waivers, one targeting individuals with more intensive services and the other providing a more modest benefit.

The State also analyzed utilization data from the developmental disabilities grants in SFY 2017. Because the rates for services for these grants are negotiated by the grantees and differ by grantee, The State used the units of service and attached costs to these services using the Medicaid IDD waiver rates. The State analyzed monthly utilization for each of the grantees and attached costs as if these services were paid for using the Medicaid rate. These analyses were used to establish the individual cap and the amount available for emergency allocations.

In developing the actual cost estimates, the State recognized that actual costs would be lower than the caps because: 1) each participant will have a plan based on their assessed needs and the services authorized in this plan will, in many cases, fall below the cap; and 2) historically, waiver participants do not use all of their authorized services.

The State developed estimates of actual cost using historical usage of services under the State- funded grants. A floor for spending was established by assuming that, at a minimum, participants would use the same amount of services under the ISW as they do under the grants unless this use is limited by the spending cap. The State calculated this floor by applying waiver service rates to the units of service used by each grant recipient in SFY 2017. Because care coordination is a mandatory service, a fixed amount for this service was added for every participant (i.e., the cost of care coordination is not included in the $17,500 individual cost limit). The ceiling for spending is the actual cap plus the cost of care coordination. The State assumed that actual spending would be 80% of the way from the floor to the ceiling.

For Waiver Year 2, a 2.4% increase was applied to each subsequent year to reflect inflation. Inflation Rates: The State provides as evidence for using a 2.4% inflation rate annually the CMS Home Health Agency Market Basket contained in the most recent quarterly publication of IHS Global Insight's Healthcare Cost Review. Documentation of the estimated 2.4% annual inflation rate is the 2nd Quarter 2017IHS Global Insight's Healthcare Cost Review, CMS Home Health Agency Market Basket for the quarters2016:1 through 2019:4 on pages 56-57/95.

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:*

The Factor D' estimate used FY17 Medicaid claims data from the IDD waiver to calculate an average per capita utilization of Medicaid state plan services. The State provided claims data used to develop the WY 1 Factor D' estimate in Appendix J as an attachment emailed to CMS on the day of resubmittal of this waiver application.

- *All claims with the following parameters were retrieved for all 2,014 individuals who received IDD Waiver services during FY 2017*
- *All paid claims, that are original, void, credit or debit of adjustment*
- *For services rendered between 7/1/2016 and 6/30/2017*

For estimates of the initial year, the average cost per participant receiving IDD waiver services and/or developmental disabilities grant services were utilized as the starting point. A 2.4% increase was applied to each subsequent year to reflect inflation. Inflation Rates: The State provides as evidence for using a 2.4% inflation rate annually the CMS Home Health Agency Market Basket contained in the most recent quarterly publication of IHS Global Insight's Healthcare Cost Review. Documentation of the estimated 2.4% annual inflation rate is the 2nd Quarter 2017IHS Global Insight's Healthcare Cost Review, CMS Home Health Agency Market Basket for the quarters2016:1 through 2019:4 on pages 56-57/95.

Prescribed Drugs: The SDS Research and Analysis Unit set up the MMIS query to estimate factor D'. The query for the calculation of D' was set up to exclude the costs of prescribed drugs by excluding the claims with the category of services and procedure codes designated as prescribed drugs. In this manner, only non- waiver claims (excluding prescribed drugs) were utilized in D' calculation and estimates.

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:*

The State of Alaska Office of Rate Review (ORR) developed a rate model that incorporated estimated capital and operating costs that would likely be included in an Alaska-based ICF/IID. The model allowed for Division of Senior & Disabilities Services (SDS) staff to include the variables reflecting a variety of staffing needs and patterns. The Division used this model along with estimated service needs to update the Factor G estimates. For Factor G, the result is a daily rate of $871.07 for FY19. This new base rate will be increased 2.7% per year, to align with the inpatient hospital weighted inflation factor granted to hospitals whose fiscal year began on July 1, 2018.

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:*

The Factor G' estimate uses Medicaid claims data from the comparable population of Medicaid recipients who were receiving institutional care out of state in FY17 to calculate an average per capita utilization of Medicaid state plan services.

For estimates of the initial year, the average cost per participant receiving IDD waiver services and/or developmental disabilities grant services were utilized as the starting point. A 2.4% increase was applied to each subsequent year to reflect inflation. Inflation Rates: The State provides as evidence for using a 2.4% inflation rate annually the CMS Home Health Agency Market Basket contained in the most recent quarterly publication of IHS Global Insight's Healthcare Cost Review. Documentation of the estimated 2.4% annual inflation rate is the 2nd Quarter 2017IHS Global Insight's Healthcare Cost Review, CMS Home Health Agency Market Basket for the quarters2016:1 through 2019:4 on pages 56-57/95.

The State uses actual Medicaid claims data to estimate future Medicaid expenses for Factor G' and Factor D'. The forecasting of Factor D' (regular Medicaid expenses for waiver participants) being lower than G' (regular Medicaid expenses for the comparison institutionalized population) reflects that people who remain in their homes and communities do not use as many regular medical services as people who reside institutions.

Appendix J: Cost Neutrality Demonstration

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

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

Waiver Services	
Care Coordination	
Day Habilitation	
Residential Habilitation	
Respite	
Supported Employment	
Chore	
Intensive Active Treatment	
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:						803423.30
Care Coordination	1 month	491	10.00	163.63	803423.30	
Day Habilitation Total:						1905266.52
Individual Day Habilitation	15 minutes	204	621.00	11.78	1492337.52	
Group Day Habilitation	15 minutes	129	388.00	8.25	412929.00	
Residential Habilitation Total:						1520102.43
Residential Habilitation	15 minutes	119	1089.00	11.73	1520102.43	
Respite Total:						980849.93
Respite	15 minutes	179	683.00	6.89	842350.73	
Daily Respite	Daily	70	6.00	329.76	138499.20	
Supported Employment Total:						1446209.80
Individual Supported					925261.96	

GRAND TOTAL:	6974412.15
Total Estimated Unduplicated Participants:	620
Factor D (Divide total by number of participants):	11249.05
Average Length of Stay on the Waiver:	288

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Employment	15 minutes	67	1036.00	13.33		
Group Supported Employment	15 minutes	42	1328.00	9.34	520947.84	
Chore Total:						4864.20
Chore	15 minutes	2	330.00	7.37	4864.20	
Intensive Active Treatment Total:						271213.92
Intensive Active Treatment	15 minutes	24	459.00	24.62	271213.92	
Transportation Total:						42482.05
Transportation-less than 20 miles	Per trip	10	25.00	16.21	4052.50	
Transportation-more than 20 miles	Per trip	5	237.00	32.43	38429.55	
				GRAND TOTAL:		6974412.15
				Total Estimated Unduplicated Participants:		620
				Factor D (Divide total by number of participants):		11249.05
				Average Length of Stay on the Waiver:		288

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:						1246572.00
Care Coordination	1 month	620	12.00	167.55	1246572.00	
Day Habilitation Total:						3117413.30
Individual Day Habilitation	15 minutes	258	785.00	12.06	2442511.80	
Group Day Habilitation	15 minutes	163	490.00	8.45	674901.50	
Residential Habilitation Total:						2478864.00
Residential					2478864.00	
				GRAND TOTAL:		11287685.00
				Total Estimated Unduplicated Participants:		620
				Factor D (Divide total by number of participants):		18206.00
				Average Length of Stay on the Waiver:		335

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Habilitation	15 minutes	150	1376.00	12.01		
Respite Total:						**1583022.62**
Respite	15 minutes	226	863.00	7.05	**1375017.90**	
Daily Respite	Daily	88	7.00	337.67	**208004.72**	
Supported Employment Total:						**2351108.44**
Individual Supported Employment	15 minutes	84	1309.00	13.65	**1500899.40**	
Group Supported Employment	15 minutes	53	1678.00	9.56	**850209.04**	
Chore Total:						**6296.70**
Chore	15 minutes	2	417.00	7.55	**6296.70**	
Intensive Active Treatment Total:						**438654.00**
Intensive Active Treatment	15 minutes	30	580.00	25.21	**438654.00**	
Transportation Total:						**65753.94**
Transportation-less than 20 miles	Per trip	12	31.00	16.60	**6175.20**	
Transportation-more than 20 miles	Per trip	6	299.00	33.21	**59578.74**	
				GRAND TOTAL:		**11287685.00**
				Total Estimated Unduplicated Participants:		**620**
				Factor D (Divide total by number of participants):		**18206.00**
				Average Length of Stay on the Waiver:		335

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:						**1276480.80**
Care Coordination					**1276480.80**	
				GRAND TOTAL:		**11559206.20**
				Total Estimated Unduplicated Participants:		**620**
				Factor D (Divide total by number of participants):		**18643.88**
				Average Length of Stay on the Waiver:		335

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	1 month	620	12.00	171.57		
Day Habilitation Total:						3192121.00
Individual Day Habilitation	15 minutes	258	785.00	12.35	2501245.50	
Group Day Habilitation	15 minutes	163	490.00	8.65	690875.50	
Residential Habilitation Total:						2538720.00
Residential Habilitation	15 minutes	150	1376.00	12.30	2538720.00	
Respite Total:						1621174.84
Respite	15 minutes	226	863.00	7.22	1408174.36	
Daily Respite	Daily	88	7.00	345.78	213000.48	
Supported Employment Total:						2407848.74
Individual Supported Employment	15 minutes	84	1309.00	13.98	1537184.88	
Group Supported Employment	15 minutes	53	1678.00	9.79	870663.86	
Chore Total:						6446.82
Chore	15 minutes	2	417.00	7.73	6446.82	
Intensive Active Treatment Total:						449094.00
Intensive Active Treatment	15 minutes	30	580.00	25.81	449094.00	
Transportation Total:						67320.00
Transportation-less than 20 miles	Per trip	12	31.00	17.00	6324.00	
Transportation-more than 20 miles	Per trip	6	299.00	34.00	60996.00	
			GRAND TOTAL:			11559206.20
			Total Estimated Unduplicated Participants:			620
			Factor D (Divide total by number of participants):			18643.88
			Average Length of Stay on the Waiver:			335

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:						1307133.60
Care Coordination	1 month	620	12.00	175.69	1307133.60	
Day Habilitation Total:						3269652.70
Individual Day Habilitation	15 minutes	258	785.00	12.65	2562004.50	
Group Day Habilitation	15 minutes	163	490.00	8.86	707648.20	
Residential Habilitation Total:						2598576.00
Residential Habilitation	15 minutes	150	1376.00	12.59	2598576.00	
Respite Total:						1659437.94
Respite	15 minutes	226	863.00	7.39	1441330.82	
Daily Respite	Daily	88	7.00	354.07	218107.12	
Supported Employment Total:						2466577.94
Individual Supported Employment	15 minutes	84	1309.00	14.32	1574569.92	
Group Supported Employment	15 minutes	53	1678.00	10.03	892008.02	
Chore Total:						6596.94
Chore	15 minutes	2	417.00	7.91	6596.94	
Intensive Active Treatment Total:						459882.00
Intensive Active Treatment	15 minutes	30	580.00	26.43	459882.00	
Transportation Total:						68943.60
Transportation-less than 20 miles	Per trip	12	31.00	17.41	6476.52	
Transportation-more than 20 miles	Per trip	6	299.00	34.82	62467.08	
				GRAND TOTAL:		11836800.72
				Total Estimated Unduplicated Participants:		620
				Factor D (Divide total by number of participants):		19091.61
				Average Length of Stay on the Waiver:		335

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:						1338530.40
Care Coordination	1 month	620	12.00	179.91	1338530.40	
Day Habilitation Total:						3347184.40
Individual Day Habilitation	15 minutes	258	785.00	12.95	2622763.50	
Group Day Habilitation	15 minutes	163	490.00	9.07	724420.90	
Residential Habilitation Total:						2660496.00
Residential Habilitation	15 minutes	150	1376.00	12.89	2660496.00	
Respite Total:						1699780.78
Respite	15 minutes	226	863.00	7.57	1476437.66	
Daily Respite	Daily	88	7.00	362.57	223343.12	
Supported Employment Total:						2525307.14
Individual Supported Employment	15 minutes	84	1309.00	14.66	1611954.96	
Group Supported Employment	15 minutes	53	1678.00	10.27	913352.18	
Chore Total:						6755.40
Chore	15 minutes	2	417.00	8.10	6755.40	
Intensive Active Treatment Total:						471018.00
Intensive Active Treatment	15 minutes	30	580.00	27.07	471018.00	
Transportation Total:						70588.86
Transportation-less than 20 miles	Per trip	12	31.00	17.83	6632.76	
Transportation-more than 20 miles	Per trip	6	299.00	35.65	63956.10	

GRAND TOTAL:	12119660.98
Total Estimated Unduplicated Participants:	620
Factor D (Divide total by number of participants):	19547.84
Average Length of Stay on the Waiver:	335