

Provider Conditions of Participation

I. Program operations

A. Service Principles.

The provider must integrate the following Senior and Disabilities Services Principles in its management and operations practices.

1. We and our partners are responsible and accountable for the efficient and effective management of services.
2. We and our partners foster an environment of fairness, equality, integrity and honesty.
3. Individuals have a right to choice and self-determination and are treated with respect, dignity and compassion.
4. Individuals have knowledge of and access to community services.
5. Individuals are safe and served in the least restrictive manner.
6. Quality services promote independence and incorporate each individual's culture and value system.
7. Quality services are designed and delivered to build communities where all members are included, respected and valued.
8. Quality services are delivered through collaboration and community partnerships.
9. Quality services are provided by competent and trained caregivers who are chosen by individuals and their families.

B. Operations requirements.

1. The provider must
 - a. grant to Senior and Disabilities Services, for certification and oversight purposes, access to all service locations and to locations where the provider proposes to render services;
 - b. implement and abide by all policies and procedures that were submitted to the department for the purpose of gaining certification;
 - c. comply with all training requirements for certification; and
 - d. practice open communications and cooperate with other providers of services.
2. No owner of a provider agency or provider employee or contractor who may provide services to participants if that individual
 - a. has been convicted of Medicaid fraud;
 - b. has been sanctioned under Medicaid regulations, or has been suspended or terminated from the Medicaid program, because of program abuse or abuse of a participant; or
 - c. has been convicted of a crime that would present a risk to the health, safety, and welfare of a participant.
3. Before hiring an employee or allowing a contractor or volunteer to work with participants, the provider must check the *List of Excluded Individuals* <http://oig.gov/fraud/exclusions.asp> and the *Excluded Parties List System* <https://www.epls.gov> to ascertain whether the individual is listed as excluded.

C. Financial accountability.

1. The provider must have available at all times a funding source sufficient to cover at least 90 days of its operating expenses.
2. The provider must carry insurance that
 - a. includes coverage for comprehensive general liability, commercial automotive liability, and professional liability, as is appropriate to the services the provider seeks to offer participants; and
 - b. names Senior and Disabilities Services, Provider Certification Section, 550 W. 8th Ave., Anchorage, AK 99501 as a certificate holder for that insurance; a copy of the Certificate of Insurance or similar document showing insurance coverage must be submitted with its application for certification or recertification.

3. The provider may charge fees for participant services at a rate no higher than those charged to private pay clients for comparable services.
4. The provider must
 - a. implement a financial system based on generally accepted accounting principles that ensures claims for payment are accurate;
 - b. maintain records that support claims for services;
 - c. report to the Medicaid fiscal agent, and voiding or adjusting, amounts identified as overpayments; and
 - d. cooperate with investigation and remediation activities.
5. The provider must report suspected Medicaid fraud, abuse, or waste to the Medicaid Fraud Control Unit by calling 1-907-269-6279 or sending a message to FAX number 1-907-279-6202.

D. Quality management.

1. Grievance process.

- a. The provider must develop and implement a protocol for handling and resolving written and oral complaints about services or personnel.
- b. The provider must analyze the complaints each calendar quarter to determine whether issues raised represent single incidents or a pattern, and take appropriate action to resolve issues brought to light by the quarterly analysis.

2. Quality improvement process.

- a. The provider must develop and implement a process that includes three elements: discovery, remediation, and continuous quality improvement.
- b. The provider must engage in monitoring and data collection activities related to the delivery of services and participant satisfaction with the services, analyze findings, and identify problems and opportunities for improvement.
- c. The provider must develop and implement a process for taking action to remedy problems whether the issues relate to a single individual or to systemic program operations.
- d. The provider must utilize its findings from data collection and analysis activities to engage in actions, e.g., policy development, management changes, staff training, or other system level interventions that lead to continuous improvements in its delivery of services

3. Self-assessment report.

- a. The provider must conduct a self-assessment of its quality improvement process annually, at a minimum, for each year of its certification period.
- b. The process must include evaluation of the findings from, and corrective actions taken in regard to,
 - i. the grievance process;
 - ii. critical incident reports, including reports of harm;
 - iii. analyses of medication errors;
 - iv. analyses of the use of restrictive interventions;
 - v. consumer satisfaction surveys; and
 - vi. internal reviews of the provision of services to determine they are provided in accordance with participant service plans and meet participant needs.
- c. The provider must summarize discovery activities, findings, and resulting corrective actions and program improvements in a quality improvement report for submission with its application for recertification; the report must be supported by data that must be made available to Senior and Disabilities Services upon the request.

E. Reporting changes in provider status.

1. The provider must report the following changes in provider status to the department within the timeframe specified:
 - a. ten days prior to a change in mailing address, email address, or telephone or fax number;
 - b. sixty days prior to a change of agency name, change in physical location, or change in the form of organization of its business;

- c. thirty days prior to a change of program administrator, or within one business day of an unplanned change of program administrator; and
 - d. ten days prior to termination of an association with an individual care coordinator or within one business day of an unforeseen termination of such an association.
2. The provider must give written notice to participants a minimum of 30 days prior to the effective date of an agency sale, closure, or change in ownership.
 3. The provider must notify Senior and Disabilities Services in writing, within 24 hours or one business day, of an owner, administrator, employee, volunteer, or agent of the agency who is charged with or convicted of a criminal offense or who is issued, as a respondent, a protective or restraining order.

II. Program administration

A. Personnel.

1. Program administrator.

- a. The provider may employ an individual to serve as program administrator for more than one service
 - i. if necessitated by the location of an agency office; and
 - ii. if given the size of the participant population served and the number of direct care workers employed by the provider, that administrator is capable of being actively engaged in the day-to-day management of each service; except that the program administrator for care coordination services may not be employed or act as program administrator for any other service.
- b. 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.

2. Direct care workers.

- a. The provider must identify the competencies needed by direct care workers to render the services the provider offers; the provider may use *Alaska Core Competencies for Direct Care Workers in Health and Human Services* [link] as a resource.
- b. The provider must develop and implement a performance evaluation based on the core competencies determined to be needed by its direct care workers.
- c. The provider must assess the performance of direct care workers to ensure they have the ability to work effectively and to identify skills that need further development.
- d. The provider must require on-the-job training or continuing education courses to further development of the core competencies in its direct care workers.

B. Training.

1. CPR and first aid training.

- a. The provider must have on file, for each direct care worker, documentation showing successful completion of
 - i. cardiopulmonary resuscitation (CPR) training, within the previous two years, that
 - (A) was taught by an individual who holds a valid CPR instructor credential in accordance with 7 AAC 26.985; and
 - (B) was offered through the American Red Cross; the American Heart Association (CPR for Family and Friends Training Program or a more advanced program); or an equivalent organization approved by Senior and Disabilities Services; and
 - ii. first aid training, within the previous three years, that was taught by an individual certified by the American Red Cross, the American Heart Association, or an equivalent organization approved by Senior and Disabilities Services.
- b. The provider must ensure that its direct care workers attend 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.

2. Orientation and training.

The provider must provide, for all direct care workers and volunteers,

- a. orientation to the agency and its relationship to the department;
- b. training necessary to render services to recipients; and c. coaching and feedback regarding performance of services, as needed; and
- d. all information necessary to perform the services for which the individual is responsible, including pertinent health information, and contact information for assistance and emergencies.

C. Supervision.

1. The provider must monitor direct care workers and volunteers
 - a. to ensure the health, safety, and welfare of recipients; and
 - b. to provide training to upgrade the skills needed to work with recipients.
2. In the event of an allegation of abuse neglect, or exploitation made against a direct care worker or a volunteer, the provider shall bar that individual from contact with recipients until the investigation is complete or the allegation is found to be unsubstantiated.

III. Participant relationships**A. Conflicts of interest.**

The owners, employees, agents, and associates of a provider may not

1. exploit a relationship with any participant for personal or business benefit;
2. engage in or allow any financial transaction with, or on the behalf of, any participant;
3. solicit as clients any participants known to be receiving services from another provider;
4. seek to influence the eligibility determination process by providing false or misleading information about an applicant or participant; or
5. represent a participant during any hearing or appeal process if the decision could result in a personal or financial benefit.

B. Participant health, safety, and welfare.

1. The provider must report any changes or concerns regarding a participant's emotional, physical, or psychological condition to the participant's care coordinator and participant representative, and, as appropriate, to other providers of services.
2. In the event a participant experiences a medical emergency, an injury that requires medical attention or an event that that creates a risk to the participant or to others, the provider must
 - a. contact the appropriate emergency responder, and provide emergency care and support until the responder arrives; and
 - b. cooperate with the responder as requested, including providing current health, diagnostic, and medication information as needed and as available on-site or accessible through a data base or contact known to the provider.
3. The provider must communicate and cooperate with other providers to prevent placing participants at risk; if disagreements or disputes regarding a participant arise, the participant's health, safety, and welfare must be the primary factor in reaching a resolution.

C. Participant rights.

The provider must

1. treat all participants respectfully;
2. encourage participant involvement in planning care;
3. cooperate with participants who elect to change service providers;
4. collaborate with other providers to deliver an integrated program of services;
5. provide information regarding fees for services to participants;
6. address participant complaints about services;
7. evaluate whether services are effective for achieving participant goals; and
8. render quality care by employing competent, trained staff.

D. Participant services termination.

The provider must implement a termination or discharge procedure for ending involvement with a participant that

1. factors in the health, safety, and welfare of the participant;
2. requires documentation that shows failure to cooperate with the delivery of services or risks of physical injury to the provider's employees;
3. includes supervisory review to determine whether
 - a. reasonable accommodation measures have been considered and tried, and
 - b. termination is appropriate;
4. provides written notice of the reasons for termination to the participant;
5. informs the participant regarding the provider's process for appealing a decision to terminate services, and other possible sources for the services being terminated.