Purpose

To clarify the circumstances under which a provider may initiate a request for an acuity designation for a qualified recipient.

To provide a process for care coordinators and providers to request an acuity designation for a qualified recipient.

Policy

Senior and Disabilities Services (SDS) will consider requests for an acuity designation for qualified recipients receiving residential supported living or group home habilitation services through the Home and Community Based Waiver Services Program. The acuity designation results in a payment for one-on-one staff dedicated to the recipient’s care 24 hours a day. An acuity payment, limited to 12 consecutive months, is a Medicaid service separate from and in addition to the Medicaid residential services noted above.

Based on a request from a provider, a care coordinator must request the acuity designation by submitting the required documentation in a Plan of Care (POC) or POC Amendment (APOC) for the qualified recipient. SDS will review the documentation and determine whether the request meets the criteria for authorization of the service based on 7 AAC 130.267.

SDS may authorize an acuity designation for a qualified recipient for no longer than twelve consecutive months. The authorization terminates if, at any time during the authorized period of coverage, the conditions or circumstances that justified the acuity designation are resolved. The provider must notify the care coordinator as soon as one-to-one, dedicated 24 hours a day staff are no longer needed, and the care coordinator must then notify SDS within 10 working days.

Authority

7 AAC 130.211 Screening;
7 AAC 130.213 Assessment and reassessment;
7 AAC 130.215 Level-of-care determination;
7 AAC 130.217 Plan of care development and amendment;
7 AAC 130.255 Residential supported living services;
7 AAC 130.265 Residential habilitation services;
7 AAC 130.267 Acuity payments for qualified recipients
Definitions

“Acuity payment” means an authorized payment code for additional services for qualified recipients receiving residential supported-living or group-home habilitation Home and Community Based waiver services

“Qualified recipient” means a recipient that needs services that exceed those authorized in the recipient's current Plan of Care because the recipient's physical condition or behavior needs direct one-to-one support from direct care workers who are dedicated solely to providing services to that one recipient 24 hours per day, seven days per week, in all environments in which the recipient functions.

“Home and Community Based Waiver Services Program” means the Medicaid program that includes the Adults with Physical and Developmental Disabilities waiver, the Children with Complex Medical Conditions waiver, the Intellectual and Developmental Disabilities waiver, and the Adults Living Independently waiver.

Responsibilities

1. The provider is responsible for
   a. identifying the need for an acuity designation and requesting that the care coordinator submit an Plan of Care or an Amended Plan of Care or a Renewal Plan of Care for the qualified recipient.
   b. providing justification and documentation as required in 7 AAC 130.267(c)(d)(e) to support the POC/APOC/Renewal POC (request for an acuity designation) for the qualified recipient to the recipient’s care coordinator,
   c. maintaining a daily record of the care provided under the acuity designation to the qualified recipient and a work schedule documenting the assignment of staff dedicated to the qualified recipient
   d. assisting the care coordinator to request, if needed, renewal of the acuity designation for a qualified recipient within the timeframe designated by SDS and
   e. identifying when the qualified recipient no longer needs an acuity designation; ending the additional staffing assignments for the qualified recipient and notifying the care coordinator that the qualified recipient no longer needs an acuity designation.

2. The care coordinator is responsible for
   a. the ongoing review of the need for an acuity designation for the qualified recipient with the qualified recipient and/or the qualified recipient’s representative and the qualified recipient’s provider
   b. completing and submitting a POC/APOC or Renewal POC requesting and justifying an acuity designation for qualified recipients,
   c. providing additional information to support the POC/APOC or Renewal POC to SDS when requested by SDS,
   d. completing and submitting Renewal POC when needed to request extension of the acuity
designation for qualified recipients, and
e. notifying SDS within 10 business days when the acuity designation for the qualified recipient is no longer needed.

2. **SDS** is responsible for
   a. determining eligibility for acuity designation based upon evidence submitted, and
   b. authorizing or denying requests for acuity designation in the POC/APOC or Renewal POC for qualified recipients.

**NOTE:** FOR POLICY AND PROCEDURES FOR COMPLETION OF PLANS OF CARE AND RENEWAL PLANS OF CARE SEE:

- SDS Approved Program Forms webpage at [http://dhss.alaska.gov/dsds/Pages/info/approvedforms.aspx](http://dhss.alaska.gov/dsds/Pages/info/approvedforms.aspx)