

STATE OF ALASKA DEPARTMENT OF HEALTH & SOCIAL SERVICES SENIOR AND DISABILITIES SERVICES POLICY & PROCEDURE MANUAL	SECTION: 4 MR/DD Waivers	Number: 4-2	Page: 1
	SUBJECT: ICF/MR Placement		
	APPROVED: /s/ <i>Rebecca J. Hilgendorf</i> Rebecca J. Hilgendorf, Director		DATE: 9/9/09

Purpose

To define a process for obtaining services in intermediate care facilities for people with developmental disabilities.

To delineate responsibilities for placements and, following discharge, for transitioning to other services.

Policy

Because the needs of people with developmental disabilities (DD) vary greatly, Medicaid funds a broad range of services, from home and community-based services to services in institutional settings. While the needs of most individuals can be met in the home and community, SDS recognizes that, at times, the level of support available in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) makes this setting the best option for services. When needs cannot be met in the home and community, SDS works to locate placements for Alaska residents who choose to receive services in ICF/MRs.

Individuals seeking ICF/MR placement must meet Medicaid financial requirements, in addition to DD eligibility and level of care requirements. The Division of Public Assistance (DPA) determines financial eligibility and authorizes payment for services. SDS determines DD eligibility and need for ICF/MR level of care, coordinates care, and maintains oversight of the services provided in ICF/MR placements.

Recipients of MR/DD services funded by the Home and Community-Based Waiver (HCBW) Services program are eligible for ICF/MR services. Waiver coverage is suspended when a recipient is admitted to an ICF/MR, but resumes upon return to his/her home or community in Alaska. Applicants for ICF/MR placement who are not waiver recipients must apply to DPA for Medicaid coverage and to SDS for eligibility and level of care determinations.

Authority

7 AAC §43.075 Out-of-state covered services; 7 AAC §43.240 Payment for out-of-state facilities; 7 AAC §§43.300 – 43.335 ICF/MR; 7 AAC §§43.502, 43.503, 43.509 Transportation and escort.

Definitions

“Care coordinator” means an SDS employee who assists the recipient/representative, participates in care planning, and monitors and evaluates treatment.

“Liaison” means an SDS employee who facilitates placement in, and serves as the state contact with, the admitting ICF/MR.

“Representative” means a parent, guardian, or other individual with legal authority to act on behalf of a recipient.

Responsibilities

1. The **SDS liaison** is responsible for
 - a. mediating admission to ICF/MRs,
 - b. notifying relevant parties of admission and transfer or discharge,
 - c. conducting an exit interview, and
 - d. preparing a report for the recipient record.

STATE OF ALASKA DEPARTMENT OF HEALTH & SOCIAL SERVICES SENIOR AND DISABILITIES SERVICES POLICY & PROCEDURE MANUAL	SECTION: 4 MR/DD Waivers	Number: 4-2	Page: 2
	SUBJECT: ICF/MR Placement		
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2. The **SDS care coordinator** is responsible for
 - a. helping the recipient/representative with the admission process,
 - b. facilitating communications,
 - c. participating in the development of care plans,
 - d. continuing oversight of the services provided by the ICF/MR, and
 - e. assisting the recipient/representative with the discharge process and transition to waiver services.
3. The **ICF/MR** is responsible for
 - a. enrolling as a Medicaid vendor in Alaska,
 - b. determining whether it can meet the needs of the recipient,
 - c. contacting the recipient/representative regarding its admission process,
 - d. securing authorizations for services,
 - e. developing a care plan,
 - f. including the care coordinator and representative in planning,
 - g. providing written notice of transfer or discharge, and
 - h. participating in an exit interview with the SDS liaison.
4. The **recipient/representative** is responsible for
 - a. maintaining eligibility for services,
 - b. meeting admission requirements,
 - c. participating in care planning, and
 - d. notifying SDS regarding critical incidents and concerns about quality of care.

Procedures

A. ICF/MR placement requirements.

1. Recipient eligibility. The liaison confirms the recipient
 - a. qualifies for DD services,
 - b. requires the level of care provided by an ICF/MR, and
 - c. is financially eligible for Medicaid funding of services.
2. ICF/MR qualifications. The liaison verifies that the facility under consideration for placement
 - a. is certified and licensed as an ICF/MR in the state where it is located,
 - b. meets all requirements for participation in the Alaska Medicaid program,
 - c. is enrolled as a Medicaid vendor with the Alaska fiscal intermediary, and
 - d. has a daily rate established by the DHSS Office of Rate Review.
3. Discussion of options. The liaison meets with the recipient/representative to
 - a. discuss recipient needs and the right to choose services ranging from home and community-based services to ICF/MR placement,
 - b. explain requirements for ICF/MR placement and Medicaid funding of services, and
 - c. identify facilities for possible placement.
4. Confirmation of choice. The recipient/representative confirms ICF/MR placement is his/her choice for services by signing
 - a. Section IX of the Plan of Care, and
 - b. a Release of Information form permitting SDS to exchange information with the ICF/MR.

STATE OF ALASKA DEPARTMENT OF HEALTH & SOCIAL SERVICES SENIOR AND DISABILITIES SERVICES POLICY & PROCEDURE MANUAL	SECTION: 4 MR/DD Waivers	Number: 4-2	Page: 3
	SUBJECT: ICF/MR Placement		
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B. Locating ICF/MR services.

1. Referrals.

- a. The liaison
 - i. contacts the ICF/MR to inquire about possible placement;
 - ii. sends records necessary for the ICF/MR to assess its capacity to provide active treatment for the recipient, including, but not limited to,
 - A) level of care information,
 - B) most recent Plan of Care, and
 - C) recent incident reports; and
 - iii. contacts the ICF/MR within five days to confirm receipt of information and to inquire whether additional information is needed.
- b. The ICF/MR
 - i. reviews referral materials,
 - ii. determines whether it can meet the needs of the recipient, and
 - iii. if admission within 10 days is feasible, contacts the liaison by telephone and email.

2. Notifications.

- a. Admission.

The liaison notifies, by telephone or by email, the following of possible admission:

 - i. the recipient/representative,
 - ii. the care coordinator (CC),
 - iii. DPA, and
 - iv. the SDS Quality Assurance Unit.
- b. Determination by ICF/MR that recipient needs cannot be met.
 - i. The liaison notifies the recipient/representative by telephone or by email.
 - ii. The CC continues to work with the recipient/family to find services.

C. Pre-admission process.

- 1. ICF/MR. The ICF/MR sends the recipient/representative an admission packet indicating the date by which return is required.
- 2. Care coordination. The CC
 - a. collects and sends any additional information/documentation requested by the ICF/MR; and
 - b. facilitates and coordinates
 - i. teleconferences between the recipient/representative and the ICF/MR,
 - ii. communications between ICF/MR and provider agency personnel,
 - iii. communications between the recipient/representative and agencies associated with the ICF/MR (e.g., school services or local medical services), and
 - iv. when requested, in-person interviews/meetings between the ICF/MR and the recipient/representative before the admission decision.

STATE OF ALASKA DEPARTMENT OF HEALTH & SOCIAL SERVICES SENIOR AND DISABILITIES SERVICES POLICY & PROCEDURE MANUAL	SECTION: 4 MR/DD Waivers	Number: 4-2	Page: 4
	SUBJECT: ICF/MR Placement		
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3. Authorization for services.

a. Long Term Care authorization.

i. The ICF/MR

(A) completes Sections I and IV of the *Long Term Care Authorization* form, and

(B) sends the form to the liaison.

ii. The liaison

(A) arranges for completion of Section II by the attending, Alaska-licensed physician, psychiatrist, or psychologist;

(B) secures the signature of the recipient/representative on the *Request for Long Term Care Authorization* form;

(C) completes the *ICF/MR Level of Care Determination* form; and

(D) submits the three forms to the Long Term Care Authorization (LTCA) Unit

iii. The LTCA Unit

(A) reviews the forms;

(B) completes Section III of the *Long Term Care Authorization* form, indicating a decision regarding admission to the ICF/MR; and

(C) notifies the liaison by sending a copy of the completed form.

b. Travel authorization.

i. The recipient/ representative

(A) makes travel arrangements with the Alaska Medicaid travel office;

(B) pays for all travel expenses not covered by Medicaid; and

(C) informs the ICF/MR and CC of the departure date and expected date for arrival.

ii. The CC

(A) assists the recipient/representative with travel arrangements and with finding sources for travel expenses not covered by Medicaid;

(B) notifies DPA by email of travel and arrival dates, and

(C) verifies that the ICF/MR has been informed of the expected date of arrival.

D. **ICF/MR services.**

1. ICF/MR.

a. Individualized Program Plan (IPP). The ICF/MR

i. develops an Individualized Program Plan (IPP) with the participation of the recipient/representative, and the CC;

ii. provides a copy of the IPP to the CC within 30 days of completion; and

iii. includes the CC in all subsequent planning meetings.

b. Incident reports. The ICF/MR notifies SDS of critical incidents involving the recipient by submitting reports in accordance with the requirements of *SDS Policy 15-1 Critical Incident Reporting and Management*.

STATE OF ALASKA DEPARTMENT OF HEALTH & SOCIAL SERVICES SENIOR AND DISABILITIES SERVICES POLICY & PROCEDURE MANUAL	SECTION: 4 MR/DD Waivers	Number: 4-2	Page: 5
	SUBJECT: ICF/MR Placement		
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2. CC oversight.

a. IPP. The CC

- i. participates in development of the IPP,
- ii. reviews the annual IPP with the recipient/representative by telephone, and
- iii. participates in meetings regarding care of the recipient.

b. Continuing coordination. The CC

- i. facilitates involvement by the representative in care and planning,
- ii. counsels the recipient/representative regarding compliance with Medicaid requirements, and
- iii. monitors ICF/MR compliance with the LTC reauthorization process.

3. Recipient/representative participation. The recipient/representative

- a. participates in development of the IPP and all meetings regarding care and planning, and
- b. notifies the CC regarding critical incidents or concerns about quality of care.

E. **Transfer/Discharge.**

1. Notification.

- a. The ICF/MR provides written notice of the date and reasons for discharge/transfer
 - i. to the recipient/representative, by letter, and
 - ii. to the liaison and CC, by sending copies of the letter.
- b. The liaison notifies DPA by emailing a copy of the discharge/transfer letter.

2. Planning.

- a. The CC contacts the recipient/representative to discuss the options for services after discharge/transfer.
 - i. For a recipient resuming waiver status, the CC
 - (A) confirms eligibility,
 - (B) requests a nursing facility level of care determination, and
 - (C) makes arrangements for development of a POC with appropriate participants.
 - ii. For a recipient requesting home and community-based services, the CC provides information regarding the HCBW services application and selection process.
- b. The ICF/MR
 - i. participates in discharge/transfer planning, and
 - ii. supports the recipient in his/her transition to other services.

3. Exit interview. The liaison

- a. conducts an exit interview with ICF/MR and the recipient/representative,
- b. writes a report for the recipient record, and
- c. provides a copy of the report to the SDS Quality Assurance Unit.