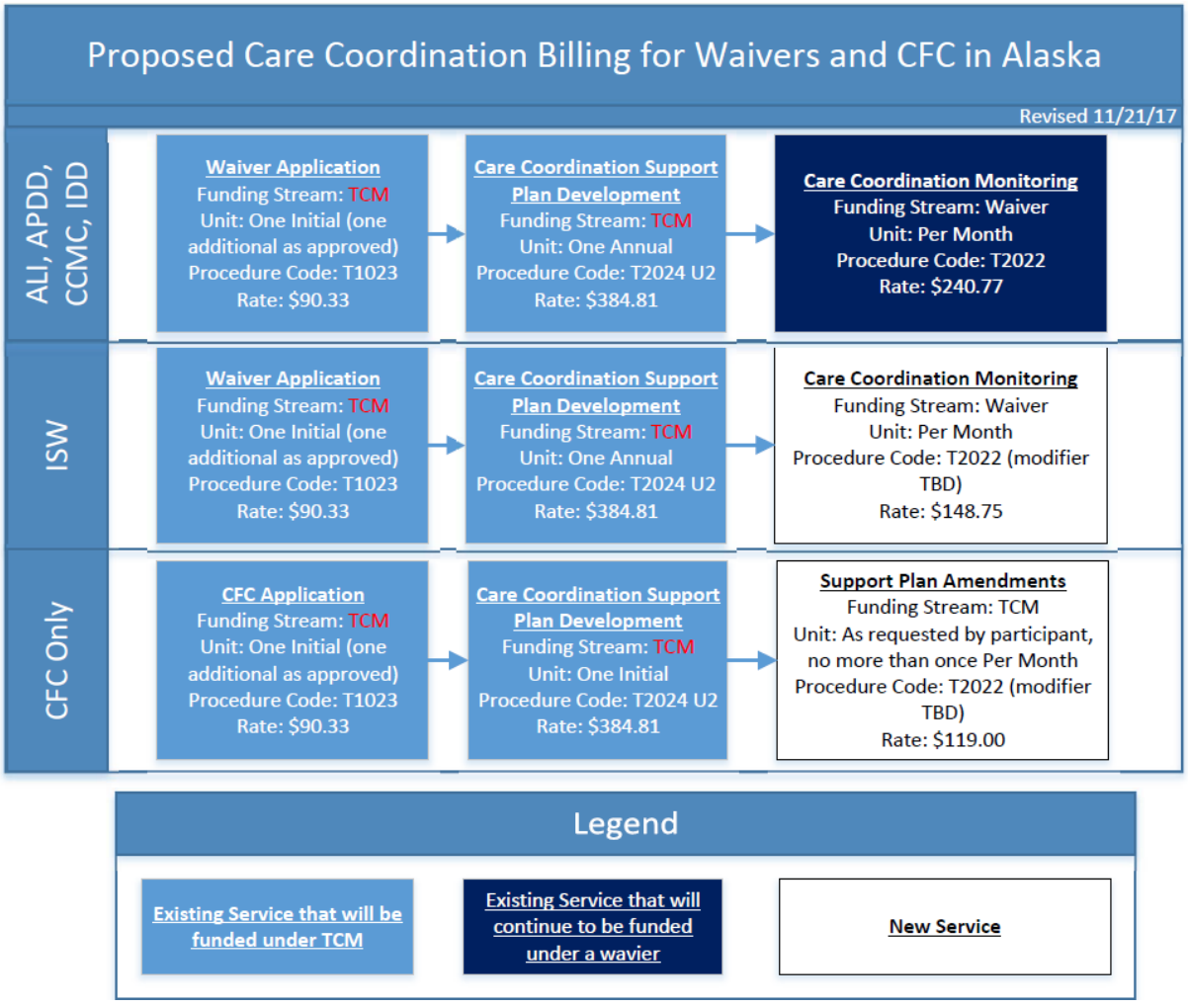
CARE COORDINATION SERVICES AND TARGETED CASE MANAGEMENT SERVICES

1. Do these proposed rates just affect the new limited support Waiver or will these go into effect for all Care Coordination services?

Response: The two Medicaid payment rate charts that are adopted by reference in this regulations package will apply to all (existing and new) waivers. The rates remain the same for existing care coordination services, but some terms have changed to reflect changes in the regulations: "screening" has been changed to "initial application" and "plan of care development" to "support plan development".

When the new regulations are approved, these types of care coordination services may be billed only as Targeted Case Management services rather than as waiver services. The following chart shows the new payment structure by program type, billing code and payment rate:



2. Will the public hearing on the proposed regulations have any effect on ALI Meal, Transportation, Adult Day, or Care Coordination providers?

Response: Only care coordination services are affected by the proposed regulations, in that some services will be paid as Targeted Case Management services (see above response and chart).

3. What is the frequency and method of recipient contact for Target Case Management at 128.010 (a} (2) (D)? Are contacts only client-initiated? Are a certain number of contacts written into plan?

Response: This regulation must be considered in conjunction with "applicable requirements"; this means the provider must review the contact requirements for waiver recipients or CFC recipients.

CFC recipient contacts with a care coordinator must be initiated by the recipient except as specified in 7 AAC 128.010 (a)(2)(A) – (C). Under (D) of this regulation, a recipient who needs a plan amendment is responsible for initiating contact with the care coordinator.

Ongoing monitoring by a care coordinator is not a Community First Choice program requirement. If the recipient needs ongoing care coordination and monitoring, the care coordinator should assist the recipient to apply for a home and community based waiver so that the recipient can receive monthly care coordination services.

4. Does 7 AAC 130.240 (b) (1) (B) mean that one of the in-person contacts in 3 months be accomplished in the setting where Individual Support Waiver services are provided or does this mean that one of the in person contacts in 12 months be accomplished in the setting where Individual Support Waiver services are provided? We believe it should be 12 months to be consistent with current care coordination requirements in the COPs and that this specificity should be added to the proposed regulations.

Response: ISW care coordination regulations require one in-person contact every three months resulting in four in-person contacts over a 12 month period. A minimum of one of the four annual in-person contacts must occur in one of the settings where ISW services are provided.

5. Does Targeted Case Management (TCM) at 145.290 only apply to Community First Choice (7 AAC 127) or are there other areas that TCM apply to? Do demographic differentials apply to TCM? Is there a certification requirement to be a TCM?

Response: Long Term Services and Supports Targeted Case Management provided by a care coordinator includes completion and submission of the application for waiver services, the development and submission of the annual (initial and renewal) support plan, and development and submission of amendments to the support plan for CFC-only participants (who are not also on a waiver).

Payment rates for Targeted Case Management will not include a demographic differential, but will include a geographic differential. Individuals providing targeted case management services must be certified by SDS as care coordinators.

6. We have many clients in our (behavioral health) practice with multiple chronic disease states that could benefit from case management. Our group is set up as a private practice. We do have an RN case manager but so far have been unsuccessful in getting Medicaid to reimburse for her services. Would these regulations change that?

Response: No. The proposed regulations address only long term services and supports provided through SDS to people who need such services and who meet an institutional level of care for a nursing facility, an intermediate care facility for individuals with intellectual disabilities, an institution for mental diseases for individuals 65 and older, or a residential psychiatric treatment facility for individuals under age 21. While a support plan would take a recipient's behavioral health treatment plan into consideration, the RN case manager could not be reimbursed under the proposed regulations.

7. At 130.240(j)(4)(A) and (B), what are examples of what is considered a remote location?

Response: Examples include Old Harbor, Dutch Harbor, Barrow, Holy Cross, Iliamna, Kobuk, Yakutat, Pelican, Gustavus, and Metlakatla.

8. The wording in 130.240(j)(4)(A) seems to state any community that is accessible by road from Anchorage is not remote except if you can only access it by crossing an international boundary. Since Haines is only accessible by crossing an international boundary is Haines considered remote? Since Juneau is not accessible by road from Anchorage this would also be considered remote. Are we interpreting this correctly?

Response: While Haines and Juneau are not accessible by road except by crossing an international boundary, the determination of whether they are considered to be remote can be made only by reading the definition in conjunction with 7 AAC 130.240 (d)(2); the department will waive monthly in-person visits in a remote community if the circumstances specified exist. Because there are care coordinators available in Haines and Juneau, neither is considered to be "remote" under the SDS regulations.

9. The wording in (B) seems to indicate that communities such as Juneau and Douglas would not be considered remote as they are connected by a road and the services are available in one of them. Are we interpreting this correctly?

Response: Yes.

10. Should a community be considered remote if they have established services available in the community?

Response: No.

PAYMENTS AND BILLING

11. Why is the payment rate for ongoing care coordination in the Individualized Supports Waiver (ISW) lower than the ongoing care coordination in the Intellectual and Developmental Disabilities (IDD) waiver?

Response: Proposed regulations at 7 AAC 130.240(b)(1)(A) state the department will pay a monthly care coordination rate for ISW recipients if the care coordinator makes one in-person contact at least once every three months. Monthly care coordination for other waivers requires one in-person contact every month at 7 AAC 130.240(b)(2)(A). Rates are contained in the proposed amended *Chart of Personal Care Attendant and Waiver Services Rates*, adopted by reference in 160.900(d)(10).

12. The certification requirements for care coordinators remain the same for SDS programs, but the proposed monthly care coordination rates differ in that the ISW rates factors in the lower, in-person contact requirements for ISW, and the fact that the service plans for ISW recipients will not be as complex because the ISW includes an individual cost limit and fewer service choices. Based on these differences, SDS envisions that a care coordinator's caseload can be higher so as not to affect the care coordinator's total monthly income. How will billing work for monthly ISW services provided, if the in-person requirement is only quarterly?

Response: The rate is a monthly rate, so care coordinators should bill Medicaid on a monthly basis. The proposed rate spreads the cost of one in-person visit across three months and accounts for two phone contacts in months between in-person visits, to come up with an average rate per month.

13. Some providers have retained higher rates through a hold harmless provision in recent years. Will the rates on the proposed amended *Chart of Personal Care Attendant and Waiver Services Rates* that is adopted by reference in 160.900(d)(10) apply to all providers?

Response: These regulations do not propose to change regulatory language related to agencies that have rates higher than those shown on the *Chart of Personal Care and Waiver Services Rates*. The regulatory language related to rates in this category states that these higher rates are still in effect, per public notice on September 12, 2016 and October 24, 2016.

14. What will the modeled rate methodology be for TCM per 145.290(e)? HCBS providers have a specific process for identifying providers who are included

and excluded from this process.

Response: The methodology for TCM includes components for wages, fringe benefits and administrative and general expenses to arrive at a service costs per hour. The estimated number of hours of direct care per client per month is calculated by dividing 2,080 hours a year by 12 months and then dividing the result by the estimated case load size. A proposed rate per month is calculated by multiplying the service cost per hour by the estimated number of hours of direct care per client per month.

15. Regarding the Support Plan Amendment rate on the Chart of Long Term Services and Support Targeted Case Management (TCM) Services Rates , what is the theory, methodology and analysis that established a rate of $119 per month?

Response: The proposed Long Term Services and Supports Targeted Case Management rate of $119 was calculated using a modeled methodology that included components for wages, fringe benefits and administrative and general expenses to arrive at a service cost per hour. A wage of $25 per hour, a fringe benefits component of 23.15%, and an administrative and general component of 11.5% were utilized in the model. This resulted in a service cost per hour of $34.33. The estimated time per client per month of 3.466 hours was calculated by the number of working hours per month of 173.33 (2,080 hours a year / 12 months) divided by the estimated case load size of 50 clients a month. The $34.33 service cost per hour was multiplied by 3.466 hours per client per month to arrive at a proposed rate of $119.

16. Regarding the Care Coordination Monthly rate for ISW on the Chart of Personal Care Attendant and Waiver Service Rates for Care Coordination what is the theory, methodology and analysis that established a rate of $148.75?

Response: The proposed Long Term Services and Supports Targeted Case Management rate of $148.75 was calculated using a modeled methodology that included components for wages, fringe benefits and administrative and general expenses to arrive at a service costs per hour. A wage of $25 per hour, a fringe benefits component of 23.15%, and an administrative and general component of 11.5% were utilized in the model. This resulted in a service cost per hour of $34.33. The estimated time per client per month of 4.333 hours was calculated by the number of working hours per month of 173.33 (2,080 hours a year / 12 months) divided by the estimated case load size of 40 clients a month. The $34.33 service cost per hour was multiplied by 4.333 hours per client per month to arrive at a proposed rate of $148.75.

17. 130.240 (g) indicates the department will recoup payment for Home and Community Based Waiver Services (HCBS) provided by a care coordinator (CC) while that CC provided ongoing care coordination. Who will the department collect the recoupment from?

Response: Overpayments would be recouped from the provider, i.e., the entity who received payment. Under 7 AAC 130.220 (a) a provider may be (1) a waiver services provider or (2) a provider of care coordination services.

Overpayment and recoupment are addressed in 7 AAC 105.260 of the provider responsibilities section of the Medicaid regulations. The purpose of 7 AAC 130.240 (g) is to clarify that SDS will recoup payment for any waiver services provided to a recipient by an individual who, at the same time, is the care coordinator for that person.

COMMUNITY FIRST CHOICE

18. For Community First Choice Personal Care Services case management, why must the contact with the case manager be initiated by the recipient?

Response: The federal regulations for the Community First Choice program require that contact be recipient-driven. Targeted case management services will be provided by the care coordinator when contact is initiated by the recipient. If the recipient has on-going needs or health and safety concerns that require more frequent contact, the recipient or the recipient's representative should work with the care coordinator to request waiver care coordination services instead of Community First Choice case management services.

19. Can CFC PCS be provided outside of a recipient's home?

Response: Yes. CFC PCS in 7 AAC 127 will be provided in the same settings as PCS in 7 AAC 125, which includes services provided while "traveling around and participating in the community" (42 CFR 441.505) in addition to services provided in a person's settings-compliant home. The *Personal Care Services and Community First Choice Personal Care Services Provider Conditions of Participation* will be revised accordingly.

20. In Inclusive Community Choices (ICC) council meetings, the preferred term for individuals was changed from "recipient" to "participant" so why do the proposed regulations refer to "recipient" still?

Response: While the Centers for Medicare and Medicaid (CMS) refers to "participants" in the Community First Choice program, Alaska's Department of Law uses "recipient" in regulations. In non-regulatory materials, SDS will be migrating to the more person-centered term "participant".

21. Can SDS define "treatment plans" in this clause "any treatment plans developed for the recipient?"

Response: 7 AAC 127.039(a)(2)(E)(ii) requires that a recipient's team prepare a support plan that includes an analysis of whether each service in the support plan is consistent with "any treatment plans developed for the recipient." The term "treatment plan" refers to a

plan developed for a recipient that needs to be taken into consideration when developing a support plan for that recipient; a nursing care plan, a behavioral health plan, and physical therapy plan are examples of plans that would need to be considered even though personal care attendants might not be the individuals carrying out the steps of these plans.

22. Who will be responsible for submitting amendments to a recipient's support plan when personal care services need amending?

Response: The personal care agency providing CFC PCS will submit the service plan amendment to SDS using PCA-03 *Amendment to Service Plan* and ensure that the recipient's case manager receives a copy. The case manager will not need to amend the support plan to reflect changes to a personal care service plan until the support plan is renewed.

23. Does 127.050 apply to the Target Case Management Agency (TCMA) or just the Service Provider Agency? If your answer is it does affect the TCMA, then 127.050 (b) (1) refers to *Personal Care Services and Community First Choice Personal Care Services Provider Conditions of Participation* (COP). Why/how would a TCMA comply with these Conditions of Participation? For example, currently care coordinators don't need to have CPR and First Aide training and assistance with self-administration of medication training. This training has been for direct service providers only. Will care coordinators need to have this training? Are there other COP requirements that apply to the care coordinator?

Response: 7 AAC 127.050 does not refer to an agency that provides targeted case management. The Conditions of Participation referenced in 7 AAC 127.050, *Personal Care Services and the Community First Choice Personal Care Services Provider Conditions of Participation* do not set the standards for care coordination agencies that are the providers of targeted case management.

Certification for an agency that provides targeted case management is governed by 7 AAC 128.010(b). The Conditions of Participation that govern care coordination agencies and care coordinators i.e. *Care Coordination Services: Home and Community-based Waiver Services and Targeted Case Management: Community First Choice,* are posted on the OPN site; the file is titled "CC.TCM.COPsRev10.10.17".

INDIVIDUALIZED SUPPORTS WAIVER

24. Can a person receiving General Relief Assisted Living Home (GRALH) services apply to be on the Individualized Supports Waiver?

Response: Yes. Because of the annual $17,500 individual cost limit, the ISW does not include 24/7 residential care. A person receiving residential care through the GRALH program who qualifies for ISW services can be on both programs, and will not lose eligibility for GRALH due to receiving ISW benefits. General Relief regulations at 7 AAC

47.330 state that applicants for General Relief must apply for financial assistance from other agencies, organizations, or programs, as required by 7 AAC 47.370. The individual's failure to apply for other supports will result in denial of assistance under 7 AAC 47.300 - 7 AAC 47.525, unless the department determines that the individual is ineligible for a specified program.

25. If an individual is on the Intellectual and Developmental Disabilities (IDD) Waiver wait list and accepts services under the Individual Support Waiver (ISW) services will they remain on the IDD Waiver wait list?

Response: Applicants may request placement on both the Individualized Supports Waiver (ISW) waitlist and the People with Intellectual and Developmental Disabilities Waiver (IDD waiver) waitlist. If an individual who has requested placement on both waitlists is successfully enrolled on the ISW, his/her name will remain on the IDD waiver waitlist.

26. If the CDDG is gone as of Jan 1, and ISW isn't ready til Mar 1, what happens to services between then?

Response: Transitioning recipients who are receiving Community Developmental Disabilities Grant (CDDG) funded services to the Individual Supports Waiver will a gradual process that will continue throughout FY18. The expectation of SDS is that agencies receiving CDDG funds will reduce service delivery to accommodate the decrease in funds, but that services to recipients would continue for the entire fiscal year.

COMMUNICATIONS

27. 7 AAC 130.240 refers to the *Care Coordination Conditions of Participation* and the *Care Coordination and Long Term Services and Supports Targeted Case Management Services Conditions of Participation*, as adopted by reference in 160.900. Are these the same? The Online Public Notice references "CC.TCM.COP" – is there a mistake in the Online Public Notice?

Response: There is not a mistake in the Online Public Notice (OPN). The OPN attachment called "CC.TCM.COP" links to a version of the *Care Coordination Conditions of Participation* (addressing waiver ongoing care coordination) that is amended to include references to Long Term Services and Supports Targeted Case Management (addressing the new role for care coordinators in providing either targeted case management in the Community First Choice program or care coordination in the waiver programs). When the proposed regulations move forward, the title *Care Coordination Conditions of Participation* will be amended to read *Care Coordination and Long Term Services and Supports Targeted Case Management Services Conditions of Participation* and the regulatory citations will be amended accordingly.

28. Was there an E-Alert sent out about this proposed regulations package?

Response: SDS issued an E-Alert titled *Notice of Proposed Changes Medicaid Coverage, Medicaid Payment Rates & the Medicaid Program* on October 24, followed by another E-Alert titled *Notice of Proposed Application for Individualized Support Waiver and Proposed Waiver Amendments* on October 25. The Online Public Notice, containing the proposed regulations and related documents adopted by reference, was published on October 20. Previous to these postings, SDS held a public forum on October 4 and a webinar on October 6 to present proposed changes to long term services and supports envisioned by SDS; both of these were announced by E-Alerts on September 22 and October 3.

29. Could you tell me when the next webinar or call regarding the proposed changes will be taking place? Or if there isn't one planned, someone we could connect with to talk about the changes?

Response: There are no webinars during the public comment period, and the proposed changes cannot be discussed with individuals, per regulations on development of regulations. Instead, this document responds to questions received in writing by 11/17 or through the public hearing held on 11/15, to provide clarification to all interested parties before the public comment period closes on 11/27.

30. Can you provide a copy of the formatted Support Plan identified in 127.039 (a) (3) so that we can review and provide comments before the 11/27/17 date for final comments?

Response: Because the proposed support plan is still in the preliminary stages of development, it is not available at this time.

OTHER

31. Why are the payment rates for Durable Medical Equipment being limited?

Response: This proposed regulations package only addresses services provided through the Division of Senior and Disabilities Services. The questioner is directed to https://aws.state.ak.us/OnlinePublicNotices/Notices/View.aspx?id=187473 for information on the proposed changes to regulations covering Durable Medical Equipment.