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:

E. Proposed Effective Date: (mm/dd/yy)
07/01/24

Approved Effective Date of Waiver being Amended: 07/01/23

2. Purpose(s) of Amendment

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

The purpose of this amendment is to amend Appendix C-2-e to allow legally responsible individuals (LRIs) to provide In-Home Supports services or Supported Living services under specific circumstances and amend Appendix C-1, to add limitation to the number of hours an LRI may provide of In-Home Supports and Supported Living services.

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 Waiver Administration and Operation	

Component of the Approved Waiver	Subsection(s)
☐ Appendix B Participant Access and Eligibility	
☒ Appendix C Participant Services	C-1, C-2.e
☐ Appendix D Participant Centered Service Planning and Delivery	
☐ Appendix E Participant Direction of Services	
☐ Appendix F Participant Rights	
☐ Appendix G Participant Safeguards	
☐ 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:

Updating Appendix C-2-e allowing Responsible Individuals (LRIs) to provide In-Home Supports and Supported Living in specific circumstances

Application for a §1915(c) Home and Community-Based Services Waiver

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**

Draft ID: **AK.007.01.01**

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/23
Approved Effective Date of Waiver being Amended: 07/01/23

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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:

☒ **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).

The ISW allows Medicaid-eligible individuals with an intellectual or developmental disability (I/DD) and who meet institutional level of care 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.

The waiver is administered by the Alaska Department of Health (Department), 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 waiver contains an individual budget limit, set at $25,608 in Waiver Year 1 (WY1) of this waiver cycle. The waiver also contains an individual cost limit, set at $38,412 in WY1 of this waiver cycle, which reflects a geographic differential that is applied to waiver service payment rates. This allows all ISW participants a fair and equitable opportunity to receive the same amount of services regardless of where they live in Alaska.

Both limits are indexed to service rate inflation in subsequent years, unless the Department Commissioner determines no inflation adjustment will occur in a specific fiscal year.

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.

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 an ICF/IID. Upon approval, the Care Coordinator assists with the person-centered Support Plan development and all subsequent Support Plan amendments, 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:

Text will be updated after public input closes.

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: Newman

First Name: Anthony

Title: Director, Division of Senior and Disabilities Services

Agency: Division of Senior and Disabilities Services, Department of Health

Address: 240 Main St, Suite 600

Address 2: none

City: Juneau

State: **Alaska**

Zip: 99801

Phone: (907) 465-5481 **Ext:** ☐ **TTY**

Fax: (907) 465-1170

E-mail: anthony.newman@alaska.gov

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

Last Name:

Newman

First Name: Anthony

Title: Director, Division of Senior and Disabilities Services

Agency: Division of Senior and Disabilities Services, Department of Health

Address: 240 Main St, Suite 600

Address 2: none

City: Juneau

State: **Alaska**

Zip: 99801

Phone: (907) 465-5481 **Ext:** ☐ **TTY**

Fax: (907) 465-1170

E-mail: anthony.newman@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:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Alaska**

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

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:

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.

Completed.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix C-3 “Provider Specifications for Services” (continued):

All service providers must be certified under 7 AAC 130.220 and operate in compliance with the Provider Conditions of Participation and with the Conditions of Participation for each service the provider offers. The Provider Conditions of Participation, Program Operation: Certification Requirements are listed below and the Conditions of Participation for relevant services are located in "Other Standard" in Appendix C-3, Provider Qualifications.

I. Program operations.
A. Certification requirements.
1. The provider must demonstrate readiness to provide services and comprehension of applicable Medicaid regulations and pertinent service Conditions of Participation through documents describing provider operations.
2. The provider must submit in a format provided by Senior and Disabilities Services (SDS)
a. a complete application for certification with all required information and documentation, or
b. a complete application to renew certification with all required information and documentation submitted not later than 60 days before the expiration date of the current certification period, in accordance with 7 AAC 130.220(d); and
c. if requesting an exception under 7 AAC 130.220(j), a complete application to provide both care coordination and other home and community-based waiver services.
3. The provider must prepare in written form and implement the following policies and procedures and, when requested, submit the written policies and procedures to SDS within the required timeframe:
a. background checks;
b. complaint management;
c. confidentiality of protected health information, including a Notice of Privacy Practices;
d. conflicts of interest;
e. critical incident reporting;
f. emergency response training;
g. evaluation of employees;
h. financial accountability;
i. independence and inclusion;
j. medication management (not required of providers licensed under 7 AAC 75.010 – 75.140 or certified under 7 AAC 127.050, or care coordinators certified under 7 AAC 130.200);
k. person-centered practice;
l. quality improvement;
m. restrictive interventions;
n. termination of provider services; and
o. training.
4. In addition to the required application forms, the provider must submit to SDS within the required timeframe
a. the following documents:
i. State of Alaska business license;
ii. Certificate of Insurance or similar documentation of coverage, as required under section C.1.
iii. licenses for assisted living homes and foster homes;
iv. building or use permits for site-based services, if required by state or local laws;
v. vehicle permit for hire, if required by state or local laws;
vi. vehicle registration;
vii. food service permit; and
viii. verification that agency staff have attended and completed SDS training on critical incident reporting and settings requirements;
b. the following personnel information:
i. organization chart, including the names of individuals filling each position;
ii. list of names of board members;
iii. names of individuals with an ownership interest in the provider agency;
iv. list of names of personnel and position for individuals not listed on the organization chart; and
v. list of volunteers and contractors who work on-site and have unsupervised access to recipients or to protected health information;
c. other information regarding requirements specified in the service Conditions of Participation; and
d. a complete quality improvement report for an application to renew certification.
5. The provider must implement and abide by all policies and procedures that were submitted for the purposes of gaining certification or renewing certification.
6. The provider must grant to SDS, for certification, renewing certification, and oversight purposes, access to all service

locations and to locations where the provider proposes to render services.

Appendix D.1.b "Service Plan Development Safeguards" (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 participant 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.

To obtain an exception, entities submitted an application and SDS used the following criteria for determining whether to grant an exception:

(1) Review of narrative description ensuring administrative separation of HCB services from care coordination:
a. Included a basic description of the duties of the HCB services supervisor(s) and the care coordination supervisor(s).
b. Explained how recipients are given choice of Care Coordinator.
c. Explained how recipients are given choice of HCB services and other natural supports or services offered in the community.
d. Explained 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 an 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 HCB services from care coordination. This plan/policy/procedure ensures that:
a. The agency has administrative separation of supervision of care coordination and HCB services.
b. The attached organization chart shows two separate supervisors, one for care coordination and one for HCB services.
c. Care coordination recipients are offered choice for HCB services between and among available service providers.
d. Care coordination recipients are not limited to HCB 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 HCB 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 HCB services without influence from the internal agency Care Coordinator and HCB service staff.
b. Recipients choose how, when, and where to receive their approved HCB services.
c. Recipients are free to communicate grievance(s) regarding care coordination and/or HCB 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 the Centralized Reporting system (by recipients 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 https://health.alaska.gov/dsds/Pages/conflictFree.aspx

Appendix G.2.a.i "Safeguards Concerning the Use of Restraints" (continued):

The plan must also include: 1.) a protocol for analyzing the use of restrictive intervention each quarter, 2.) a procedure for taking corrective action based on the analysis, and 3.) a process for summarizing the quarterly analyses and any corrective actions taken. The summary must be submitted to SDS with the provider's application for renewal of certification under 7 AAC 130.220, Provider certification, or upon request.

Appendix H.1.a.i: "Systems Improvement" (continued):

The QIW meets monthly or as needed to develop or review recommended plans of action. Each QIP includes a statement of the problems or risk to be corrected, the desired results or changes, the specific action steps needed, identification of person/s responsible for each step, the timeframe for completion of the QIP, and the plan for monitoring 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 and issues to be brought forth to QISC. Membership includes: SDS Director (Chair), Deputy Director (Vice-chair), Chief of Quality (Alternate designee), Chief of Programs, Chief of Developmental Programs, SDS staff from the Adult Protective Services unit, Central Application Processing unit, Assessment unit, Review unit, General Relief unit, Grants unit, Infant Learning/Early Intervention unit, IDD unit, Provider Certification and Compliance unit, Policy and Program Development unit, Quality Assurance unit, Research and Analysis unit and the Central Intake unit.

Appendix I.1 "Financial Integrity" (continued):

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 assistant 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 five and ten 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:

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 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 Department. Documentation is reviewed by PI and a meeting is scheduled with the Medicaid Fraud Control unit and SDS 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 2 CFR part 200 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 for the federal program requirements. These audits include all of the Department’s federal programs and can be accessed through this link https://legaudit.akleg.gov/.

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:

All functions associated with administering this waiver are performed by the Division of Senior and Disabilities Services (SDS) within the Department of Health (Department).

The Department is the single state agency responsible for administering the Medicaid State Plan, under AS 47.07.040. SDS conducts administrative responsibilities associated with providing home and community-based waiver services. SDS ensures that waiver services specified in the approved waivers 1.) are accessible in a timely manner, and 2.) are provided in accordance with state and federal laws and regulations, Department policies and procedures, and the CMS-approved waivers.

The State Medicaid Director, as the Department's Commissioner designee, performs oversight of these activities through participation as the Chair of the Department's Quality Improvement Steering Committee (QISC).

The QISC meets quarterly, and more often, if necessary, to address SDS concerns and to review the quarterly reports submitted by the Quality Improvement Workgroup (QIW). The quarterly QIW report provides the status of performance measures, remediation efforts, system improvement efforts, and action plans. The QISC reviews these QIW 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 Strategy (QIS). The QISC has ultimate responsibility for the proper implementation of SDS policies and procedures affecting the health, safety and welfare of waiver recipients and the provision of quality services to these recipients, through monitoring, recommending, and implementing changes in the QIS. As such, the QISC reviews and approves the development and application of all waiver performance measures, including reviewing data collection processes, to ensure that useful information is gathered that improves the quality of the service delivery system and assures the health, safety and welfare of waiver recipients.

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.

Performance Measure:
A.a.1:# and% of LOC determination reviews completed by contractor within 5 business

days. Numerator: # of LOC determinations reviews completed by contractor within 5 business days. Denominator: # of LOC denials submitted to the contractor for review.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Harmony Database

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 = 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:

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:

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	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 fewer intensive needs than people on Alaska's IDD waiver (AK.0260).

The individual cost limit is based upon historical expenditure and utilization patterns established during the previous waiver cycle. The State's individual cost limit is $38,412 in Waiver Year 1 (WY1), indexed to service rate inflation the following years the waiver is in effect, unless the Department Commissioner determines no inflation adjustment will occur in a specific fiscal year. The individual budget limit (referenced in Appendix C-4) 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, "Additional Limits on the Amount of Waiver Services."

Alaska has another waiver (AK.0260) with a prioritized system (a "waitlist") that allows people with the greatest needs to access that waiver. Waiver 0260 does not contain an individual cost limit. To address those ISW participants who may experience evolving needs, the State has established a reserve capacity mechanisms (see Appendix B-2-c "Participant Safeguards") to ensure that participants who are enrolled on the ISW and develop increased needs for services, but do not meet the terms for the emergency allocation, will be referred to the other waiver.

If an individual is denied entrance to a 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: 38412

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 indexed to service rate inflation each year the waiver is in effect unless the Department Commissioner determines no inflation adjustment will occur in a specific fiscal year.

○ **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 $38,412 in Waiver Year 1 (WY1) that applies to all waiver participants and is indexed to service rate inflation unless the DOH Commissioner determines no inflation adjustment will occur in a specific fiscal year. The individual budget limit (referenced in Appendix C-4) can be no higher than the individual cost limit. The individual cost limit of $38,412 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 individual 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, a tool called the Developmental Disabilities Registration and Review (DDRR) scores 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 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 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 IDD Unit leadership. IDD Unit leadership may determine that the DDRR should be updated based on relevant information. Updating the DDRR may allow the individual to be drawn for the IDD waiver (AK.0260), which has no individual 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, 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 issues and if so, the Care Coordinator then amends 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 to 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 (DDRR-ISW) waitlist, and 3.) meet ICF/IID level of care.

The DDRR-ISW waitlist is maintained when the ISW waiver is at maximum capacity. The DDRR-ISW waitlist uses the Developmental Disabilities Registration and Review form to collect demographic information for the individual who is interested in applying for the ISW. The State places the applicant on the DDRR-ISW waitlist according to the date on which the State receives their initial application form. When waiver capacity becomes available, an SDS Qualified Intellectual Disabilities Professional (QIDP) selects the applicant who has been on the DDRR-ISW the longest.

Applicants selected from the DDRR-ISW waitlist 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 a 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.

Appendix B: Participant Access and Eligibility

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

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

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
§435.115 Extended Medicaid due to increased spousal support
§435.116 Pregnant women
§435.117 Deemed newborns
§435.118 Infants and children under age 19
§435.119 Adult group
§435.120 Individuals receiving SSI
§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 in 1972
§435.135 Individuals who would be eligible for SSI/SSP but for OASDI COLA increases since April 1977
§435.137 Disabled widows and widowers ineligible for SSI due to increase in OASDI
§435.138 Disabled widows and widowers ineligible for SSI due to early receipt of social security
§435.145 Children with Title IV-E adoption assistance, foster care or guardianship care
§435.150 Former foster care children
§435.170 Pregnant women eligible for extended or continuous eligibility
§435.210 Individuals eligible for but not receiving cash
§435.211 Individuals eligible for cash except for institutionalization
§435.222 Reasonable classification of individuals under age 21
§435.227 Children with non-IV-E adoption assistance
§435.229 Optional targeted low-income children
§435.236 Institutionalized individuals eligible under a special income level

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 period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by

law), 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 September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (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.

09/06/2023

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.

AND qualify as a Health Program Manager II or the equivalent as indicated below. One degree to qualify as a QIDP and an HPM II suffices.

- A Registered Nurse licensed by the State of Alaska under AS 08; or
- A professional that holds a Master's degree from an accredited college in health, public health, behavioral health, health care services, health practice, senior health care, developmental disabilities, health sciences, health care administration, or a closely related field; and has at least one year of advanced professional-level experience in health program planning, development, coordination, evaluation, or implementation, technical health care assistance and consultation, health care utilization or quality assurance examination, and/or health care service delivery; or
- A Bachelor's degree from an accredited college in biological, health or behavioral science, health practice, health education, business administration, or a closely related field; and has two years of advanced professional-level experience performing health program planning, development, coordination, evaluation, or implementation, technical health care assistance and consultation, health care utilization or quality assurance examination and/or health care service delivery; OR

Any combination of education and/or experience that provides the applicant with the competencies in:

- Analysis and Assessment: Uses information technology in accessing, collecting, analyzing, maintaining, and disseminating data and information.
- Writing: Recognizes or uses correct English grammar, punctuation, and spelling; communicates information (e.g., facts, ideas, or messages) in a succinct and organized manner; produces written information, which may include technical material and information that is appropriate for the intended audience.
- Community Dimensions of Practice: Distinguishes the roles and responsibilities of governmental and non-governmental organizations in providing programs and services to improve the health of a community.
- Partnering: Develops networks and builds alliances; collaborates across boundaries to build strategic relationships and achieve common goals.
- Public Health: Applies knowledge of the concepts, principles, theories, methods, and tools associated with protecting and improving the health of people and their communities, including promoting healthy lifestyles, researching disease and injury prevention, and detecting, preventing, and responding to infectious diseases.

Equivalent to those typically gained by:

- A Bachelor's degree from an accredited college in biological, health or behavioral science; health practice; education; public, healthcare, or business administration; or a closely related field;

AND/OR

- Progressively responsible professional experience performing health program planning, development, coordination, evaluation, or implementation; providing technical health care assistance and consultation; conducting health care utilization or quality assurance examinations; and/or delivering health care.

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, an applicant must be determined to meet the definition of a person with a developmental disability as defined in AS 47.80.900(6) and have indicated an interest in being selected for the ISW by applying for placement on the Developmental Disabilities Registration and Review ISW (DDRR-ISW) waitlist.

Once an applicant has been drawn from DDRR-ISW waitlist and offered the opportunity to pursue the ISW, the initial ICF/IID level of care process begins. SDS conducts a review of the complete application submitted by a Care Coordinator, which includes diagnostic, medical, developmental, and functional evaluations and other records. SDS reviews relevant diagnostic documentation to ensure that the individual has a qualifying diagnosis in one of the following categories: intellectual disability; other intellectual disability-related condition; cerebral palsy; seizure disorder; autism spectrum disorder. SDS determines that the diagnosis originated before the individual reached 22 years of age, is likely to continue indefinitely, and results in substantial functional limitations to three or more areas of major life activities including self care, learning, language, self-direction, mobility, and for applicants over the age of 16, capacity for independent living and economic self-sufficiency.

For participants under three years of age, the ICF/IID level of care is determined initially and reevaluated annually through a Comprehensive File 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 at least two 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 measures adaptive and maladaptive behaviors in the skill areas of motor, social and communication, personal-living and community-living. The assessment results are scored using the ICAP Compuscore software and result in a Broad Independence score for the participant. The participant must fall below the Broad Independence cut off score for their age in order to meet level of care.

The ICAP is administered annually for participants between the ages of three and seven.

The ICAP is administered for initial applicants who are over the age of seven. For participants over age seven, an ICAP is administered every third year. In the two years between ICAPs, participants over the age of seven receive an interim level of care assessment accompanied by an updated qualifying diagnosis certificate or a Comprehensive File Review annually.

Once an assessor establishes that level of care is unchanging due to participant condition over multiple successive years, the assessor conducts a Comprehensive File Review every third year, instead of an ICAP, and in the intervening years, the assessor conducts an interim level of care assessment. The Comprehensive File Review includes: 1.) prior ICAP reviews, 2.) functional assessments and 3.) a qualifying diagnosis certificate.

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 diagnosis, relevant documents, and ICAP score as outlined in 7 AAC 130.206.

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 File Review of current developmental assessments.

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

The ICAP is administered for initial applicants who are over the age of seven. For participants over age seven, an ICAP is administered every third year. In the two years between ICAPs, participants over the age of seven receive an interim level of care assessment accompanied by an updated qualifying diagnosis certificate.

Once an assessor establishes that level of care is unchanging due to participant condition over multiple successive years, the assessor conducts a Comprehensive File Review every third year, instead of an ICAP, and in the intervening years the assessor conducts an interim level of care assessment.

The Comprehensive File Review includes: 1.) prior ICAP reviews, 2.) functional assessments and 3.) a qualifying diagnosis certificate.

An interim level of care determination includes: 1.) a review of the results of the most recent assessment as well as documents contained in the renewal application, including qualifying diagnosis certificate, and 2.) confirmation of the stability of the participant's condition. 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 State has developed a teleassessment policy for conducting assessments and reassessments. These assessments will occur when applicants and State staff agree that a teleassessment will be more efficient due to potential travel delays or where connectivity issues with the internet exist. In cases where rural health care providers have agreed to permit participants and SDS to use their telehealth technology, there are signed agreements in place.

These agreements outline the procedures and secure technology requirements for all parties. SDS intends to conduct assessments and reassessments by telephone in areas where there is no internet connectivity and where the need to travel may result in delays to assessment and level of care determination. For initial assessments, SDS will make every effort to travel to complete the assessment in-person but will use other methods if travel is not possible or if it would result in a significant delay in assessing the participant.

When a participant's reassessment reveals a change in condition, Alaska Statute at AS 47.07.045 (b) requires a finding of "material improvement" before the State may terminate waiver services. Material improvement means that a participant who has previously qualified for this waiver no longer needs the level of care provided by an intermediate care facility for persons with intellectual and developmental disabilities either, because the qualifying diagnosis has changed or the participant is able to demonstrate the ability to function in a home setting without the need for waiver services.

In 2006, a successful court challenge found that the State did not have adequate criteria or a formal process for determining when a waiver participant's condition materially improved. In response, the State developed the "Material Improvement Review Process" (MIRP) to fully assess and confirm that a participant is no longer eligible for waiver services.

The QIDP assessor making the finding of material improvement begins the MIRP by contacting the participant, the participant's legal representative and/or the participant's Care Coordinator requesting any additional documentation the participant believes may contribute to an understanding of their current condition. The assessor allows at least 15 business days for the participant, the participant's legal representative and/or the participant's Care Coordinator to either submit additional documentation to SDS or communicate with SDS that they are in the process of submitting documentation. Next the assessor completes a thorough review of existing documentation, including any new information received on the participant's condition.

The assessor uses the "Material Improvement Reporting form for IDD Participants" adopted by reference in 7 AAC 130.219(e)(4)(A)(ii);(iii), to review and analyze existing and new information about the specific ways in which the

participant's condition has changed since their qualifying assessment. The assessor then includes on the form a written detailed narrative explaining how the participant's condition has improved to the point of material improvement. Next, two additional QIDP assessors, as well as the assessor supervisor, conduct a Quality Control (QC) review of the Material Improvement form and all relevant documentation, including any newly received documentation of the participant's condition. The purpose of the QC review is to ensure scoring validity, consistency, and completeness.

In the final step of the MIRP, SDS submits the written analysis and supporting documents to the State's MIRP contractor for a "third party review" of eligibility. The MIRP contractor is not a service provider or associated with the service provider. The Department of Health's Grants and Contracts unit reviews contracts to ensure that there are no such conflicts of interests before they are finalized. The contractor employs individuals with QIDP qualifications who independently review the qualifying and denial assessments and all accompanying documentation. The contractor either upholds or overturns the SDS decision, which becomes the final level of care determination.

SDS QIDP staff review the contractor's evaluation and contacts the contractor with questions and discusses any discrepancies in findings at this time. The QIDP review ensures the justification summary finding is in alignment with AS 47.07.045. The IDD unit will review the contractor's final summary, by the following business day after receiving it, makes a final decision, and sends the level of care determination to the participant and care coordinator. The participant has the right to appeal the decision through the Fair Hearing process.

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):*

All information related to assessments, waivers, material improvement, and levels of care is maintained in the SDS Harmony Database. Unit managers monitor timelines for assessments coming due reviewing reports generated from information in the Harmony Database. The Harmony Database tracks all timelines. Care Coordinators have access to Harmony which permits them to track when reapplications are due. In addition, SDS policy specifies timelines for the scheduling and completion of the assessment, as well as for the SDS review and level of care determination. MIRPs must be reviewed by the contractor five business days from the time it is received from the Ddepartment, by contract.

Unit managers also track reevaluation timeliness. Although SDS does not report on this measure to CMS, timeliness is evaluated and measured by SDS to ensure adherence to the eligibility processes.

In instances where SDS has not received a level of care reapplication in a timely manner, notices are sent to the Care Coordinator to prompt compliance and notice of possible closure. If reapplications are not received, SDS sends a closure notice and begins the closure process.

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:

SDS maintains all documentation related to level of care evaluations and reevaluation determinations in the participant's official electronic record within the Harmony Database for a minimum of three years.

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:
B.a.l: # and % of assessments conducted for LOC within 30 business days of receiving a complete initial application. Numerator: # of applicants for whom an assessment for LOC was conducted within 30 business days of receiving a complete initial application. Denominator: # of applicants with a complete initial application reviewed during the reporting period.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Harmony Database

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 = 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:

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:
B.c.2:# and % initial LOC determinations completed by qualified state assessor. Numerator: # of participants who received an initial LOC determination by qualified state assessor. Denominator: # of participants who received an initial LOC determination reviewed during the reporting period.

Data Source (Select one):
Other

If 'Other' is selected, specify:
Harmony Database

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 = 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**	☐ **Annually**

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

Performance Measure:
B.c.3:# and % of initial LOC determination criteria applied correctly. Numerator:# of initial LOC determination criterion applied correctly. Denominator: # of participants who received an initial LOC determination reviewed during the reporting period.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Harmony Database

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 = 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.

SDS employs the use of quality improvement task committees, the SDS Quality Improvement Workgroup (QIW), and the Department of Health's Quality Improvement Steering Committee (QISC) to discover and identify problems and/or issues within the waiver program.

Quality Improvement Task Committees:

Quality Improvement task committees are charged with the discovery and remediation responsibilities associated with established performance measures within the SDS's five 1915(c) Medicaid waivers. Data is aggregated separately for each individual waiver. Task committees meet, as needed, to review performance measure data, identify performance deficiencies, implement and report on corrective action on individual cases, and recommend system improvement to QIW. When individual first-level remediation is identified as needed, the task committee may make recommendations to unit managers to initiate remediation activities. When performance measures fall consistently below 86%, the task committee is responsible for: 1.) developing a Quality Improvement Plan (QIP) that identifies systemic root causes and implements measures to bring about improvements; 2.) reviewing and seeking approval of the QIP through the QIW; and 3.) and tracking activities until compliance is achieved or develop new strategies if initiated QIPs do not reach intended goals.

Level of Care Review Task Committee:

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 SDS Level of Care (LOC) performance measures. Membership includes: manager of the Assessment unit (Chair), manager of the IDD unit (Vice-chair), and SDS staff from the Review unit, Policy and Program Development unit, Quality Assurance unit, Research and Analysis unit, Central Application Processing unit, Nursing unit, and the SDS Training Coordinator.

On a weekly basis, unit managers responsible for Level of Care activities review status reports, identify deficiencies in performance, and plan and implement remediation activities. On a monthly, or as needed basis, this Committee reviews aggregated monthly, quarterly and annual data, analyzes trends, and makes recommendations for systems improvements to the QIW.

Quality Improvement Workgroup (QIW):

The Director or the Director's designee is the chair of the QIW; members include SDS unit managers and the SDS Leadership Team. The QIW reviews task committee data, makes recommendations for systemic remediation, and determines what needs to move forward to the QISC.

Quality Improvement Steering Committee (QISC):

The Department's Commissioner or designee, currently the Medicaid and Health Care Policy/State Medicaid Director, chairs the QISC. The Committee reviews data and reports forwarded from the QIW, considers resource requests to meet objectives, and provides guidance and recommendations to SDS Leadership.

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 the State's performance in determining level of care, the IDD unit manager is responsible for initiating remediation activities .

As part of monthly discovery activities, the unit managers review reports generated through the SDS information management system, Harmony Database, 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 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 Department's 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 QIW. 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 an applicant is found eligible for the waiver, the participant, the participant's legal representative, along with the participant's Care Coordinator completes a waiver Support Plan.

Section VIII of the Support Plan, "Recipient Choice of Services," requires the participant or the participant's legal representative to initial a series of statements indicating that they understand the choices available of receiving: 1.) Medicaid-funded care in an institution, 2.) Medicaid home and community-based services, 3.) only non-Medicaid services, or 4.) no services at all.

Section VIII also outlines the assistance SDS and/or the participant's Care Coordinator will provide after a choice is made. Finally, the section requires the participant and/or their legal representative to indicate their choice. The Support Plan is then signed by everyone involved in the planning effort. The "Recipient Choice of Services" section of the Support Plan is updated and reviewed with the participant at least annually.

Care Coordinators are trained to refer the participant, and/or the participant's legal guardian and the participant's team to electronic and hard-copy waiver service information resources.

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 electronic file and stored in the SDS Harmony Database.

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):

Limited English Proficient persons seeking waiver services have equal access to both financial and functional eligibility determinations.

The Department's Division of Public Assistance (DPA) performs financial and non-financial eligibility determinations, per federal regulation, for home and community-based waivers and uses telephone-based professional interpreter services for Limited English Proficient persons.

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 ask either local health clinic staff, with whom they have developed a relationship, or ask the applicant and/or participant's friends or family to provide interpretive services.

To facilitate Support Plan development and monitor waiver services for Limited English Proficiency persons, SDS Care Coordinators are either bilingual or arrange for interpreters to perform these functions in the applicant and/or participant's language of origin.

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	**Employment Services**		
Statutory Service	**Residential Habilitation**		
Statutory Service	**Respite**		
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:	**Sub-Category 1:**
01 Case Management	01010 case management

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

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

Service Definition *(Scope):*

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

Care Coordinators assist individuals to gain access to home and community-based waiver services under 7 AAC 130; Community First Choice services under 7 AAC 127; and other state plan services, as well as medical, social, educational, and other services with funding sources other than Medicaid. Care Coordinators do this through a person-centered process led by the recipient and the planning team of the recipient's choosing.

Care Coordinators also perform targeted case management services, which include helping recipients to complete an application and then submitting the application for home and community-based waiver services, Community First Choice services, or both.

Once an applicant is determined eligible, Care Coordinators assist applicants with identifying goals, planning for services and selecting service providers. Care Coordinators then assist the recipient-directed team to develop an initial Support Plan. Finally, Care Coordinators assist recipients to direct the team in reviewing goals and renewing the Support Plan annually.

On-going care coordination is a home and community-based waiver service that includes monthly monitoring of the effectiveness of the Support Plan. Care Coordinators remain in contact with the recipient throughout the support plan year, in manner and with a frequency appropriate to the needs of the recipient.

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

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 7 AAC 130.220, Provider certification and 7 AAC 130.240, Care coordination services and the relevant Conditions of Participation adopted by reference in 7 AAC 160.900.

Other Standard *(specify):*

All certified providers must meet the requirements contained in the Provider Conditions of Participation listed in Main B: Additional Information Needed (Optional) and the relevant service Conditions of Participation. Below is the Care Coordination Services Condition of Participation, Personnel and Training excerpts:

A. Personnel.
1. Care coordination services/targeted case management program administrator.
a. The provider must designate a care coordination services program administrator who is responsible for the management of the program including the following:
i. orientation, training, and supervision of Care Coordinators;
ii. implementation of policies and procedures;
iii. intake processing and evaluation of new admissions to the services;
iv. participation in the development of support plans in collaboration with 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 support plan;
(B) assessing whether the services assist the recipients to attain the goals outlined in the support plan and recommending changes as appropriate;
(C) evaluating the quality of care rendered;
vi. development and implementation of corrective action plans for identified problems or deficiencies in delivery of care coordination services; and
vii. submission of required reports to Senior and Disabilities Services, including critical incident reports.
b. The provider may use a title other than program administrator for this position, (e.g., program director, program manager, or program supervisor).
c. 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.
d. The program administrator must
i. be at least 21 years of age;
ii. meet the following experiential requirements: 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.
iii. meet the following education requirements:
(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, in addition to the required one year of experience as a supervisor; 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, in addition to the required one year of experience as a supervisor; 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 the required one year of experience as a supervisor.
e. 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.
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 develop a support plan to meet the needs of the population to be served; and
(B) the ability to supervise professional and support services staff.
2. Care Coordinators.

a. Care Coordinators shall be at least 18 years of age, and qualified through experience and education in a human services field or setting.
b. Required education and additional experience or alternatives to formal education:
i. 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
ii. 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
iii. 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
iv. 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.
c. 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.
i. The care coordination knowledge base must include:
(A) an understanding of person-centered planning, including how this applies not only to the development of the support plan but also to the on-going monitoring of services;
(B) the medical, behavioral, habilitative, and rehabilitative conditions and requirements of the population to be served by the Care Coordinator;
(C) the laws and policies related to Senior and Disabilities Services programs;
(D) the terminology commonly used in human services fields or settings;
(E) the elements of the care coordination process; and
(F) the resources available to meet the needs of recipients.
ii. The care coordination skill set must include:
(A) the ability to support a recipient in directing the development of a support plan, based on his/her strengths and abilities, that leads to a meaningful life at home, at work, and in the community;
(B) the ability to effectively assist the recipient in communicating the recipient's choices and decisions and collaborating with supporters such as family members, guardians, or other decision-making assistants;
(C) the ability to organize, evaluate, and present information orally and in writing; and
(D) the ability to work with professional and support staff.
d. 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.
i. 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.
ii. Applicants not licensed under AS 08 are responsible for providing to Senior and Disabilities Services the following with an initial application for certification:
(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.

B. Training.
1. An individual who seeks certification to provide care coordination services or targeted case management 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 one or two year period of certification;
ii. 16 hours annually of continuing education that is relevant to a Care Coordinator's job responsibilities; and
b. when submitting an application for renewal certification, 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 attendance and successful completion by a Care Coordinator 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 the training increases the knowledge, abilities, or skills of the Care Coordinator and 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:

Up to four years per 7 AAC 130.220(c)

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 7 AAC. 130.238, Certification of care coordinators, and 7 AAC 130.240, Care coordination services and the relevant Conditions of Participation adopted by reference in 7 AAC 160.900.

Other Standard *(specify):*

All certified providers must meet the requirements contained in the Provider Conditions of Participation, listed in Main B: Additional Information Needed (Optional) and the relevant service Conditions of Participation. Below is the Care Coordination Services Conditions of Participation, Personnel and Training excerpts:

A. Personnel.
1. Care coordination services/targeted case management program administrator.
a. The provider must designate a care coordination services program administrator who is responsible for the management of the program including the following:
i. orientation, training, and supervision of Care Coordinators;
ii. implementation of policies and procedures;
iii. intake processing and evaluation of new admissions to the services;
iv. participation in the development of support plans in collaboration with 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 support plan;
(B) assessing whether the services assist the recipients to attain the goals outlined in the support plan and recommending changes as appropriate;
(C) evaluating the quality of care rendered;
vi. development and implementation of corrective action plans for identified problems or deficiencies in delivery of care coordination services; and
vii. submission of required reports to Senior and Disabilities Services, including critical incident reports.
b. The provider may use a title other than program administrator for this position, (e.g., program director, program manager, or program supervisor).
c. 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.
d. The program administrator must
i. be at least 21 years of age;
ii. meet the following experiential requirements: 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.
iii. meet the following education requirements:
(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, in addition to the required one year of experience as a supervisor; 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, in addition to the required one year of experience as a supervisor; 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 the required one year of experience as a supervisor.
e. 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.
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 develop a support plan to meet the needs of the population to be served; and
(B) the ability to supervise professional and support services staff.
2. Care Coordinators.

a. Care Coordinators shall be at least 18 years of age, and qualified through experience and education in a human services field or setting.
b. Required education and additional experience or alternatives to formal education:
i. 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
ii. 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
iii. 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
iv. 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.
c. 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.
i. The care coordination knowledge base must include:
(A) an understanding of person-centered planning, including how this applies not only to the development of the support plan but also to the on-going monitoring of services;
(B) the medical, behavioral, habilitative, and rehabilitative conditions and requirements of the population to be served by the Care Coordinator;
(C) the laws and policies related to Senior and Disabilities Services programs;
(D) the terminology commonly used in human services fields or settings;
(E) the elements of the care coordination process; and
(F) the resources available to meet the needs of recipients.
ii. The care coordination skill set must include:
(A) the ability to support a recipient in directing the development of a support plan, based on his/her strengths and abilities, that leads to a meaningful life at home, at work, and in the community;
(B) the ability to effectively assist the recipient in communicating the recipient's choices and decisions and collaborating with supporters such as family members, guardians, or other decision-making assistants;
(C) the ability to organize, evaluate, and present information orally and in writing; and
(D) the ability to work with professional and support staff.
d. 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.
i. 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.
ii. Applicants not licensed under AS 08 are responsible for providing to Senior and Disabilities Services the following with an initial application for certification:
(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.

B. Training.
1. An individual who seeks certification to provide care coordination services or targeted case management 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 one or two year period of certification;
ii. 16 hours annually of continuing education that is relevant to a Care Coordinator's job responsibilities; and
b. when submitting an application for renewal certification, 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 attendance and successful completion by a Care Coordinator 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 the training increases the knowledge, abilities, or skills of the Care Coordinator and 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:

Up to four years per 7 AAC 130.220(c)

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 may be provided to 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, 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 support plan and increasing participation in and access to community settings and resources.

Day habilitation services may be offered in a variety of non-residential settings in the community, separate from the recipient's private residence or other residential setting, unless the provider is granted a waiver under 7 AAC 130.260 (d) regarding the setting.

When day habilitation is provided in a residential setting, the rendering of activities must not duplicate or replace community engagement activities afforded to all recipients of residential habilitation services. The services must also be provided with the intent of facilitating community integration.

Residential settings include a participant's private home, another private residence, and provider owned or operated licensed residential settings where the residential habilitation subtypes of group home or family home services are provided.

When a participant living in a residential habilitation setting receives day habilitation services in their residence, the day habilitation provider, not the residential habilitation provider, will be engaged with the participant. The day habilitation provider and the residential provider are not the same individual and there is no duplicate billing by one provider.

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

Per 7 AAC 130.260, the department will only pay for a maximum of 624 hours each year of all types of day habilitation services from all providers combined. The department may approve a limited amount of additional day habilitation services if the department finds that:
(A) the recipient's current physical or behavioral condition places the recipient at risk of institutionalization or incarceration if additional day habilitation services are not provided;
(B) the recipient's support plan and records indicate that the recipient has a critical need for additional day habilitation services because of one or more of the following:
• the recipient has an acute or degenerative physical condition that necessitates participation in activities to maintain or improve that condition that are available only in the community
• the recipient exhibits behaviors that create a risk of physical harm to the recipient or others that can only be mitigated by the development of skills related to appropriate behavior in the community;
• the recipient's one-to-one support provided under 7 AAC 130.267 was recently terminated, and the recipient needs to learn skills required for living successfully in the community;
or
• the recipient's release from an intermediate care facility for individuals with intellectual disabilities or the criminal justice system within the current or prior support plan year increases the need for additional day habilitation services for teaching or training skills for community integration;
and
(C) the recipient's medical, social, educational, or other records support the recipient's need for, and capacity to engage in and benefit from, additional active teaching or training; those records include the following:
• the current and prior year assessments under 7 AAC 130.213;
• the current and prior year support plans;
• records maintained under 7 AAC 105.230(d);
• direct service case notes.

The day habilitation services provided in all residential settings combined must be no more than 10% of the total units of service approved for a plan year and justified and approved in the recipient’s support plan. Residential settings include a participant’s private home, another private residence, and provider owned or operated licensed residential settings where the residential habilitation subtypes of group home or family home services are provided.

Day habilitation services provided in a residential setting that are provided online are subject to the 10% residential settings limit. The remaining 90% of a participant’s approved day habilitation services are provided in the community.

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 HCBS Agency: Day Habilitation Services

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 HCBS Agency: Day Habilitation Services

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

SDS certified waiver provider under 7 AAC 130.220, Provider certification and 7 AAC 130.260, Day habilitation services and the relevant Conditions of Participation adopted by reference in 7 AAC 160.900.

Other Standard *(specify):*

All certified providers must meet the requirements contained in the Provider Conditions of Participation, listed in Main B: Additional Information Needed (Optional) and the relevant service Conditions of Participation. Below is the Day Habilitation Services Conditions of Participation, Personnel and Training excerpts:

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;
iv. participation in the development of support plans in collaboration with Care Coordinators and other service providers;
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 support plan;
(B) assessing whether the services assist the recipients to attain the outcomes and goals outlined in the support plan; 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 title other than program administrator for this position (e.g., program director, program manager, or program supervisor).
c. The program administrator must:
i. be at least 21 years of age;
ii. meet the following experiential requirements: 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; and
iii. meet the following educational requirements:
(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 support plan 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 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's record or file.
c. Required skill set:
i. the ability to communicate with the direct service worker's 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 support plan; 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 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:

Up to four years per 7 AAC 130.220(c)

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):

Employment Services

HCBS Taxonomy:

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

03 Supported Employment	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:**

Employment services assist recipients to acquire and maintain gainful employment (including self-employment) in a job that meets their career goals. Employment services include pre-employment and supported employment services that are provided over a specified period of time, are based on a defined outcome documented on the recipients person-centered support plan, and are planned to decrease over time as recipient work-related goals and objectives are achieved. Consistent with the person-centered approach to these services, individuals accessing employment services should be encouraged, on an ongoing basis, to explore their interests, strengths, and abilities relating to employment or career advancement.

Employment services may be offered in a variety of settings, but, because independence and community integration are goals for these services, they may not be provided in sheltered workshops or other similar specialized vocational facilities, or any other setting that has the effect of isolating individuals who receive home and community-based waiver services from the broader community of individuals not receiving waiver services. Employment services may be provided in settings chosen by the recipient if self-employed (including subsistence) or at the recipient's residence or other location if the recipient has an agreement with their employer to work remotely.

Employment services include Pre-employment as a sub-type separate from Supported Employment sub-type. Pre-employment services provide time-limited habilitation that allow recipients to develop general work readiness and non-job-specific strengths and skills that are applicable to all work settings. Pre- employment services are distinguished in nature from noncovered vocational services by the intent of the habilitative goals that are presented through the support plan, to foster readiness for community-based employment. Pre-employment services are designed to assist a recipient to determine individual strengths, interests, abilities, and support needs, and to ensure that the person has the underlying skills necessary to locate, secure and sustain gainful employment per 42 CFR §440.180(c)(2)(i).

Pre-employment services may also assist a recipient to determine individual strengths, interests, abilities, and support needs, or locate and secure gainful employment. If an individual identifies self-employment as their desired outcome, pre-employment services may include supporting the recipient as they determine the concept of their business and develop a business plan, as well as referring the recipient to the appropriate community resources for additional guidance in identifying potential sources of financing and additional assistance in developing and launching a business. While the service can assist recipients working toward self-employment, the majority of the work that needs to be done, from research to writing a business plan, will be the responsibility of the recipient.

Supported employment services include the progressive phases of job-specific training, job coaching, ongoing intermittent support to assist with keeping a job or career advancement, and support to maintain self-employment.

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:

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 HCBS Agency: Employment Services

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Employment Services

Provider Category:

Agency

Provider Type:

Certified HCBS Agency: Employment Services

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

SDS certified employment services provider under 7 AAC 130.220, Provider certification and 7 AAC 130.270, Employment services and the relevant Conditions of Participation adopted by reference in 7 AAC 160.900.

Other Standard *(specify):*

All certified providers must meet the requirements contained in the Provider Conditions of Participation, listed in Main B: Additional Information Needed (Optional) and the relevant service Conditions of Participation. Below are the Employment Services Conditions of Participation, Personnel and Training excerpts:

A. Personnel.
1. Employment Services program administrator.
a. The provider agency must designate an employment 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 25 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 possessing the skill set of an employment services specialist, and meeting education and experience requirements, the administrator must possess the knowledge base and skills necessary to carry out the 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; and
(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 develop and evaluate a support plan to meet the needs of each recipient to be served; and
(B) the ability to effectively supervise and support employment services specialists.
e. Prior to appointment as the employment services program administrator, the administrator must receive and maintain National Certification in Employment Services, or an equivalent certification in employment services.
2. Employment services specialist.
a. Employment services specialists must be at least 18 years of age, qualified through education or experience, and possess, or develop before providing services, the skills necessary to perform the tasks included in the employment services plan.
b. Required education:
i. high school or general education development (GED) diploma; and
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’s record or file.
c. Required skill set:
i. Job 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 ongoing training for employment services specialists to ensure they are qualified to perform, and to maintain a safe environment while providing, employment services.
2. In addition to training requirements outlined in the Provider Conditions of Participation, the employment services program administrator must provide and document in employee records, training on the following topics, at a minimum, for employment services specialists:
a. state policy and regulations governing the provision of employment services;
b. understanding the needs of the population to be served;
c. current best practices on the delivery of employment services;
d. universal precautions and basic infection control procedures;
e. personal care skills for those recipients who require assistance while receiving employment services; and
f. workplace safety including proper use of tools and equipment and fall prevention.
3. Within one year of employment, the employment services specialist must receive and maintain documentation in their employee record of the National Certification in Employment Services, or an equivalent certification in employment services.

Verification of Provider Qualifications

Entity Responsible for Verification:

SDS Provider Certification and Compliance Unit

Frequency of Verification:

Up to four years per 7 AAC 130.220(c)

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 may be provided to assist participants 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 supports 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.

SDS reviewers carefully review all services, goals and objectives contained in each submitted waiver support plan for possible duplication between waiver and state plan services and remediate prior to approving or authorizing all state-funded services.

Supported-living habilitation and In-home supports services are provided, for the most part, in the participant's residence, the home of a relative, a semi-independent or supported apartment or living arrangement.

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 to the acquisition of skills necessary for daily living in the recipient's residence, and are approved in the recipient's support plan. For example, other environments where an individual can receive residential habilitation include community settings that relate to goals and objectives of residential habilitation, such as going to the grocery store to purchase food for the residence or going to the bank to make arrangements to pay the rent. These goals should be documented in the participant's annual support plan.

Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. The method by which the costs of room and board are excluded from payment for residential habilitation is specified in Appendix I-5.

Payment is not made, directly or indirectly, to members of the individual's immediate family, except as provided in Appendix C-2.

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

A Legally Responsible Individual (LRI) may not be paid to provide more than forty (40) hours of in-home supports or supported living in a seven (7) day period, regardless of the number waiver participants that they have a legal duty to support.

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 HCBS Agency: Residential Habilitation Provider: In-Home Supports and Supported Living

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:

Certified HCBS Agency: Residential Habilitation Provider: In-Home Supports and Supported Living

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

SDS Certified Residential Habilitation provider under 7 AAC 130.220, Provider certification and 7 AAC 130.265, Residential habilitation services and the relevant Conditions of Participation adopted by reference in 7 AAC 160.900.

Other Standard *(specify):*

All certified providers must meet the requirements contained in the Provider Conditions of Participation, listed in Main B: Additional Information Needed (Optional) and the relevant service Conditions of Participation. Below is the Residential Habilitation Conditions of Participation, Personnel and Training excerpt:

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;
iv. participation in the development of support plans in collaboration with Care Coordinators and other service providers;
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 support plan;
(B) assessing whether the services assist recipients to attain the goals outlined in the support plan and recommending changes as appropriate; 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 in the service provided; and
vii. submission of required reports to Senior and Disabilities Services, including critical incident reports.
b. The provider may use a title other than program administrator for this position (e.g., program director, program manager, or program supervisor).
c. The program administrator must
i. be at least 21 years of age;
ii. meet the following experiential requirements: 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.
iii. meet the following education requirements:
(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 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 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 support plan; 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.

Verification of Provider Qualifications

Entity Responsible for Verification:

SDS Provider Certification and Compliance Unit

Frequency of Verification:

Up to four years per 7 AAC 130.220(c)

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 who are in need of relief or will be unable to provide for participants for limited periods of time, if those caregivers provide the oversight, care, and support needed to prevent the risk of institutionalization of a participant 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, or at community locations that contribute to furthering the goals of the recipient.

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

Because the intent of respite care services is to offer relief to unpaid caregivers, units of respite care services authorized in the participant's Support Plan 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 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	Certified HCBS Agency: Respite: Licensed
Agency	General Acute Care Hospital

Provider Category	Provider Type Title
Agency	Certified HCBS Agency: Respite: Non-Licensed
Agency	Skilled Nursing Facility

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 HCBS Agency: Respite: Licensed

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;
State of Alaska Foster Home License under AS 47.33 and regulations at 7 AAC 50, Community care licensing.

Certificate *(specify):*

SDS Certified Respite Provider under 7 AAC 130.220, Provider certification and 7 AAC 130.280, Respite care services and the relevant Conditions of Participation adopted by reference in 7 AAC 160.900.

Other Standard *(specify):*

All certified providers must meet the requirements contained in the Provider Conditions of Participation, listed in Main B: Additional Information Needed (Optional) and the relevant service Conditions of Participation. Below is the Respite Conditions of Participation: Personnel and Training excerpt:

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 title 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 Division of Senior and Disabilities Services programs.
ii. The program administrator skill set must include:
(A) the ability to evaluate and 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 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's record or file.
c. Required skill set:
i. the ability to communicate with the direct service worker's 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 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 (ALH): AK Dept. of Health, Division of Health Care Services, Licensing and Certification Unit
License (Foster Home): AK Dept. of Family and Community Services, Office of Children's Services
Certification: SDS Provider Certification and Compliance Unit

Frequency of Verification:

License (ALH): Every two years
License (Foster Home): Every two years
Certification: Up to four years per 7 AAC 130.220(c)

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:

AK Dept. of Health, Division of Health Care Services, Licensing and Certification 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:

Certified HCBS Agency: Respite: Non-Licensed

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

SDS Certified Respite Provider under 7 AAC 130.220, Provider certification and 7 AAC 130.280, Respite care services and the relevant Conditions of Participation adopted by reference in 7 AAC 160.900.

Other Standard *(specify):*

All certified providers must meet the requirements contained in the Provider Conditions of Participation, listed in Main B: Additional Information Needed (Optional) and the relevant service Conditions of Participation. Below is the Respite Conditions of Participation: Personnel and Training excerpt:

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 title 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 Division of Senior and Disabilities Services programs.
ii. The program administrator skill set must include:
(C) the ability to evaluate and develop a service plan to meet the needs of the population to be served;
(D) the ability to organize, evaluate, and present information orally and in writing; and
(E) 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 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's record or file.
c. Required skill set:
i. the ability to communicate with the direct service worker's 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 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:

Up to four years per 7 AAC 130.220(c)

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:

AK Dept. of Health, Division of Health Care Services, Licensing and Certification 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:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

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. 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 possessed 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:

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 HCBS Agency: Intensive Active Treatment Service

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 HCBS Agency: Intensive Active Treatment Service

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. SDS Certified Intensive Active Treatment Provider under 7 AAC 130.220, Provider certification and 7 AAC 130.275, Intensive active treatment services and the relevant Conditions of Participation adopted by reference in 7 AAC 160.900.

Other Standard *(specify):*

n/a

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, for all SDS Provider Certification and Compliance Unit.

Frequency of Verification:

Up to four years per 7 AAC 130.220(c)

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

Service Definition *(Scope):*

Transportation services may be provided to recipients when natural supports are not available to provide transportation, and the services are necessary to enable participants, and approved escorts, 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 Ddepartment will not make separate payment for transportation services for providers of family home, group home, and in-home supports 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 Support Plan.

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 HCBS Agency: Transportation Services

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 HCBS Agency: Transportation Services

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

SDS certified transportation provider under 7 AAC 130.220, Provider certification and 7 AAC 130.290, Transportation services and the relevant Conditions of Participation adopted by reference in 7 AAC 160.900.

Other Standard *(specify):*

All certified providers must meet the requirements contained in the Provider Conditions of Participation, listed in Main B: Additional Information Needed (Optional) and the relevant service Conditions of Participation. Below are the Transportation Services Conditions of Participation, Personnel, Policies, and Training excerpts:

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's 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. Policies.

1. The provider must have written policies regarding program operations, including, at a minimum, the type of services offered, the hours of operation, scheduling, waiting periods, and the availability of alternate transportation when the provider's vehicles are not operational.
2. The provider must have written incident and accident protocols, including evacuation procedures for recipients in case of accidents, or of medical or weather emergencies.

C. 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:

Up to four years per 7 AAC 130.220(c)

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 to each waiver applicant or participant 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 the 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 provider, including providers of Home and Community - Based waiver services (HCBS), to undergo a criminal background check. Under Alaska regulations at 7 AAC 10.900, Barrier crimes and conditions, 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 Department of Health (Department) Licensing and Certification Section, Background Check unit conducts the background check, which includes review of records from both Alaska and those states the individual has lived in for the prior ten 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, Barrier crimes and conditions, define barrier crimes as criminal offenses inconsistent with the standards of licensure, certification, approval or eligibility to receive Medicaid payments, and list those crimes that are permanent, ten, 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 renewal certification 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)

Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.

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.*

I. WAIVER SERVICES PROVIDED BY RELATIVES and/or COURT APPOINTED LEGAL GUARDIANS

The Department may allow Relatives and Legal Guardians to provide home and community-based waiver services if they meet the conditions established through regulation and all the required employment and training qualifications for the provided service. The Department does not dictate specific circumstances in which Relatives or Legal Guardians may furnish services. Legal Guardians are distinct from Legally Responsible Individuals.

Relatives: The Department considers Relatives to be individuals who are related to the waiver participant by blood, marriage or adoption and do not have a duty under state law to support the participant. Relatives are considered "family members" but not "immediate family members" as defined in 7 AAC 130.319(10). Relatives providing waiver services must be older than 18 years of age.

Legal Guardians: The Department considers Legal Guardians to be individuals who have been appointed by a court as stated under 7 AAC 120.202, to be the participant's Legal Guardian. The Legal Guardian may be the participant's spouse, adult child, parent, or sibling of the participant, relative, or another individual.

The Legal Guardian may provide waiver services to the participant if the court has authorized the Legal Guardian to provide specific services under AS 13.26.167(2) or AS 13.26.311(c), the Legal Guardian is qualified to provide services and employed by a provider certified under 7 AAC. 130.220. A Legal Guardian may provide services to a participant when the court has deemed it is not a conflict to provide those services or the court has determined that any potential conflict of interest is insubstantial, and that the appointment would clearly be in the best interests of the participant.

Payment may be made to Relatives and Legal Guardians for waiver services, except care coordination, are subject to all regulatory requirements and limits, service requirements, and the required minimum employment and training qualifications for the waiver service provided.

The Department prohibits Relatives, Legal Guardians, any individual with a legal duty to support the recipient under state law, a holder of power of attorney for the participant, and the participant's personal care assistant, from providing care coordination services, per regulation 7 AAC 130.240, Care coordination services.

Controls employed to ensure that payments are made only for services rendered include monthly monitoring by Care Coordinators and certified provider agencies' documentation of the services rendered and who was paid for the services. SDS certified provider agencies are required to document services, maintain the records for seven years, and adhere to audit requirements.

II. WAIVER SERVICES PROVIDED BY LEGALLY RESPONSIBLE INDIVIDUALS (LRIs)

Waiver services may be provided by Legally Responsible Individuals (LRIs) only in the following circumstances:
- The court has authorized the LRIs to provide specific services under AS 13.26.167(2) or AS 13.26.311(c); or
- In-Home Supports services (for minors) in specific circumstances; or
- Supported Living services (for adults) in specific circumstances.

Legally Responsible Individuals (LRIs): The Department considers Legally Responsible Individuals (LRIs) to be individuals who have a legal duty to support the participant under state law. An LRI is typically:
- the parent (biological, adoptive, or stepparent) or court appointed Legal Guardian who must provide care to a minor child who is a waiver participant; or
- the spouse of a waiver participant.

II.A. RESIDENTIAL HABILITATION IN-HOME SUPPORTS SERVICES (FOR MINORS) AND RESIDENTIAL HABILITATION SUPPORTED LIVING SERVICES (FOR ADULTS) PROVIDED BY LRIs

The Department may allow an SDS certified provider to employ a Legally Responsible Individual (LRI) to provide In-Home Supports services or Supported Living services, only in specific circumstances, including:
1. the participant lives in a remote area of the state; or
2. a lack of qualified providers who can furnish services at necessary times and places; or

3. the LRI has unique abilities necessary to meet the needs of the participant; and
4. the service must be one that the LRI doesn't ordinarily provide, exceeding the range of activities that an LRI would ordinarily provide in the household on behalf of a person without a disability of the same age, and which are habilitative, documented in the support plan, and necessary to assure the health and welfare of the participant and avoid institutionalization.

II.B. LIMITATIONS AND CONTROLS FOR THE PROVISION OF RESIDENTIAL HABILITATION IN-HOME SUPPORTS AND SUPPORTED LIVING SERVICES PROVIDED BY LRIs

1. An LRI will not be approved to provide more than forty (40) hours paid services with in a seven (7) day period.
2. If one or more of the above specific circumstances above (under II.A.) is met to allow an LRI to provide services, the following conditions and situations must also be met:

a) the LRI must meet all provider qualifications and requirements to provide the service and comply with the Provider Conditions of Participation and the Residential Habilitation Conditions of Participation;
b) the LRI must be employed by an SDS certified home and community-based waiver provider;
c) the service delivery must be cost effective;
d) the use of the LRI must be age and developmentally appropriate;
e) the use of the LRI as a paid provider must enable the person to learn and adapt to different people and form new relationships;
f) the participant must be learning skills for increased independence;
g) the services must be habilitative in nature;
h) the service must be specified and approved in the participant's support plan;
i) having a LRI provide services:

i. truly reflects the participant's wishes and desires;
ii. increases the participant's level of independence;
iii. increases the participant's choices; and
iv. increases access to the amount of service hours for needed supports.

As is required for all providers, the provider certification process requires that the provider agency must be able to provide information on supervision policies, including how the provider assesses the employee's performance to ensure the employees can work effectively and to identify skills that need further development.

Controls employed to ensure that payments are made only for services rendered include monthly monitoring by Care Coordinators and certified provider agencies' documentation of the services rendered and who was paid for the services. SDS certified provider agencies are required to document services, maintain the records for seven years, and adhere to audit requirements.

A Legally Responsible Individual may not be paid to provide more than forty (40) hours in a seven (7) day period, regardless of the number waiver participants that they have a legal duty to support. Payments for services provided by an LRI for more than forty (40) hours in a seven (7) day period, will be considered an overpayment and subject to recovery.

The Department prohibits LRIs, individuals with a legal duty to support the recipient under state law, from providing care coordination services, per regulation 7 AAC 130.240, Care coordination services.

○ **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:

SDS administers an open and continuous provider certification process. The SDS website contains a Provider Certification and Training link to the complete Home and Community-Based Waiver Services Certification Application Packet. The Application Packet can be downloaded by interested parties. SDS accepts all applications for review and provides extensive technical assistance to those applicants needing assistance with completion. Qualified providers approved by the State for certification are instructed to enroll with the State's Fiscal Agent.

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:
C.a.l: # and % of new providers who meet state certification or licensure requirements prior to providing waiver services. Numerator: # of new providers who meet state certification or licensure requirements prior to providing waiver services. Denominator: # new waiver service providers reviewed who require certification or licensure and are enrolled in Medicaid.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS

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 = 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**

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

Performance Measure:
C.a.2: # and % of active providers who continue to meet state certification or licensure requirements while providing waiver services. Numerator: # of active providers who continue to meet state certification or licensure requirements. Denominator: # active providers reviewed who are enrolled in Medicaid.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS

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 = 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:
C. c.3: # and % of care coordinators in compliance with the required SDS training.
Numerator: # of care coordinators in compliance with required SDS training.
Denominator: # of certified care coordinators reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Harmony Database

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 = 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:
C.c.4: # and % of certified provider agencies in compliance with state's critical incident report training requirements. Numerator: # of certified provider agencies in compliance with state's critical incident report training requirements. Denominator: # of certified provider agencies reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Harmony Database

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 = 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:
C.c.5: # and % certified provider agencies in compliance with state's settings training requirements. Numerator: # of certified provider agencies in compliance with state's settings training requirements. Denominator: # of certified provider agencies reviewed that are required to abide by state's settings requirements.

Data Source (Select one):

Other
If 'Other' is selected, specify:
Harmony Database

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 = 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:

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.

SDS employs the use of quality improvement task committees, the SDS Quality Improvement Workgroup (QIW), and the Department of Health's Quality Improvement Steering Committee (QISC) to discover and identify problems and/or issues within the waiver program.

Quality Improvement Task Committees:

Quality Improvement task committees are charged with the discovery and remediation responsibilities associated with established performance measures within the SDS's five 1915(c) Medicaid waivers. Data is aggregated separately for each individual waiver. Task committees meet, as needed, to review performance measure data, identify performance deficiencies, implement and report on corrective action on individual cases, and recommend system improvement to QIW. When individual first-level remediation is identified as needed, the task committee may make recommendations to unit managers to initiate remediation activities. When performance measures fall consistently below 86%, the task committee is responsible for: 1.) developing a Quality Improvement Plan (QIP) that identifies systemic root causes and implements measures to bring about improvements; 2.) reviewing and seeking approval of the QIP through the QIW; and 3.) and tracking activities until compliance is achieved or develop new strategies if initiated QIPs do not reach intended goals.

Qualified Provider Review Task Committee:

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 manager of the Provider Certification and Compliance unit (Chair), SDS staff from the Provider Certification and Compliance unit, General Relief unit, Quality Assurance unit, Policy and Program Development unit, Research and Analysis unit, the Grants unit and the SDS Training Coordinator.

On an as-needed basis, the committee reviews aggregated data to discover the status of provider compliance with certification standards. The committee plans and implements remediation activities and makes recommendations to QIW.

Quality Improvement Workgroup:

The Director or the Director's designee is the chair of the QIW; members include SDS unit managers and the SDS Leadership Team. The QIW reviews task committee data, makes recommendations for systemic remediation, and determines what needs to move forward to the QISC.

Quality Improvement Steering Committee:

The Department's Commissioner or designee, currently the Medicaid and Health Care Policy/State Medicaid, chairs the QISC. The Committee reviews data and reports forwarded from the QIW, considers resource requests to meet objectives, and provides guidance and recommendations to SDS Leadership.

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 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 section of the unit to assist the provider to complete an application or reapplication for certification.

As part of monthly discovery activities, the Provider Certification and Compliance manager reviews the SDS training evidence against a list of certified providers. For those providers who are out of compliance with SDS training requirements, including care coordination and continuing education hours, Critical Incident Reporting training, and settings training, the manager directs staff to issue a notice to correct. The notice 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 notice 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 onsite reviews 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. SDS continues to review progress until the deficiencies are corrected, and reports on the performance of SDS certification and oversight process activities to the QIW.

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 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 in Waiver Year 1 (WY1) (FY24) of $38,412 that applies to all waiver participants and is indexed to service rate inflation the following years the waiver is in effect, unless the Department Commissioner determines no inflation adjustment will occur in a specific fiscal year.

The individual budget limit within the individual cost limit (the individual budget limit can be no higher than the individual cost limit) in WY1 is $25,608 and the State's Medicaid Management Information System (MMIS) applies a geographic differential to waiver services up to the individual cost limit. The geographic differential addresses the regional differences in the cost of doing business across the state. Geographic differential amounts are listed in the Department of Health, Chart of Personal Care Services and Community First Choice Services Rates, found here: https://health.alaska.gov/dsds/Pages/info/costsurvey.aspx.

A participant's Support Plan is developed and approved up to the $25,608 individual budget limit. The individual budget limit comprises 1.) a waiver services component, and 2.) a care coordination service component.

The waiver services component includes: day habilitation, employment services, residential habilitation, respite, intensive active treatment, and transportation. A participant may choose any combination of these waiver services up to the waiver services component budget limit, which in WY1 (FY24) is $21,560.

The cost for the care coordination component is separate from the other waivers services. Participants must receive care coordination services. The care coordination service component budget in WY1 (FY24) is $4,048.

To determine the WY1 (FY24) individual budget limit, the State applied a 3.9% inflation adjustment to the WY5 waiver services component from the previous waiver cycle and added the rebased care coordination rate, effective July 1, 2023.

The amount of the individual budget limit is adjusted during the five-year waiver cycle to account for rate increases that reflect inflation, unless the Department Commissioner determines no inflation adjustment will occur in a specific fiscal year. 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.

The processes that are used to determine how much service a participant will receive starts with the person-centered planning process, during which the participant identifies goals to be achieved via the use of waiver services and natural supports. The participant 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 the State reviews the justification for the requested services and approves the Support Plan.

Participants can adjust their 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.

The MMIS (the claims payment system) applies the geographic differential to the provider's claims based on the region in which the provider operates. The individual cost limit is calculated by multiplying the cost of the individual budget limit of $25,608 for WY1 (FY24) by the geographic differential assigned to the region in which the participant's service provider operates. The highest geographic differential is 150%. The individual cost limit is $38,412, which is achieved by applying the highest geographic differential (150%) to the individual budget limit of $25,608.

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.

If the participant cannot be served safely in the community under the individual budget limit, the recipient may 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 the emergency allocation funding and the reserve capacity can be expedited in case of emergency.

Individuals who are initially assessed for the waiver but whose health and safety needs cannot be met within the individual 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 the participant's representative) will discuss with the participant's 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 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 addressing 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 included in descriptions of the waiver on the State's website and outreach materials; 2.) individuals contacting the State-funded Aging and Disability Resource Centers (ADRC) and Developmental Disabilities Resource Connection (DDRC) 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 process.

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.

Prior to the State's approval of initial certification, providers must develop policies and procedures that inform the State as to how they will operationalize person-centered practices and compliance with settings requirements. The Provider Certification and Compliance (PCC) unit, Division of Senior and Disabilities Services (SDS), Department of Health, is the entity responsible for completing the provider quality reviews. The State assures that all settings criteria are monitored by the PCC unit.

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:

☐ **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, Senior and Disabilities Services (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, SDS 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 (HCB) services on a participant's Support Plan.

Each provider (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 HCB services except when the conflicted entity is the only willing and qualified provider in the area.

For providers (entities) granted an exception to the conflict-free requirements, the SDS has established conflict of interest protections, ensuring that Care Coordinators employed by that entity remain neutral during the development of the Support Plan. SDS 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 SDS' mandatory Care Coordinator training; renewal certification requires completion of the training during each certification period. The training curriculum includes the six assurances of the Medicaid HCB 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 SDS' 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, 2022. For each census area, SDS reviewed in May 2022: 1.) the number of recipients, 2.) the number of Care Coordinators, and 3.) the types of waivers and Community First Choice served by Care Coordinators. The State awarded conflict-free exceptions to four census areas effective July 1, 2022 through June 30, 2025.

Safeguards that address potential and mitigate actual problems arising from the exemptions 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 SDS' Centralized Reporting system, a participant may file a complaint or grievance about SDS 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, Care Coordinators inform each participant about the provider's grievance procedures, the SDS Centralized Reporting process, and gives the applicant and/or participant copies of the "Recipient Rights and Responsibilities" form and the "Notice of Recipient Fair Hearing Rights" information sheet. Each complaint, grievance, and report made to Centralized Reporting is investigated by the appropriate unit.

Criteria used for making determinations for which census areas would be allowed to apply for exceptions to conflict-free care coordination:
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.) Criteria no longer valid, per CMS clarification.
4.) There were no recipients or providers of HCB services or care coordination in a census area.

Continued at Main-B: Additional Information Needed (Optional)

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 the 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 SDS certified Care Coordinators serving 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):

The regulation 7 AAC. 130.217, Support plan development and amendment, and 7.AAC.130.218, Person-centered practice, requires that a person-centered planning team meet prior to developing the Support Plan. With the Care Coordinator's support, the participant chooses and invites team members to attend a participant-led person-centered planning session(s). The team includes the participant, the participant's family and/ or legal representative, providers who are expected to provide services and other team members of the participant's choosing, including natural supports. Meetings are scheduled at a time and location convenient to the participant and those he or she wishes to participate.

With the support of the Care Coordinator, the participant and/or the participant's legal guardian 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 needs. The Support Plan identifies the providers responsible for providing each service to the participant.

As part of the planning process, the Care Coordinator shares information about all the services available through the waiver program and within the participant's community. 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 Care Coordinator helps the participant understand and choose services.

By SDS regulation, the Care Coordinator must submit the initial Support Plan no later than 60 days after the initial determination of level of care. Care Coordinators must submit an annual Support Plan that reflects changes in the participant's health, life plans and goals no more than 60 days and at least 30 days before the expiration of the current Support Plan year.

The Support Plan must reflect the issues identified in the level of care assessment, the preferences of the participant, the participant's legal representative and any medical or health concerns. The Care Coordinator must note any disagreements among planning team members and submit this information with the Support Plan for SDS' review. SDS staff evaluate the Support Plan and communicate with Care Coordinators to resolve any conflicts noted, ensure regulatory compliance, and approve it for service authorization.

The participant must initial and sign the "Recipients Rights and Responsibilities" form. This form outlines participants' rights to make choices about their care, to participate in the care planning process, to receive a copy of their Support Plan, to change providers at any time, and 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 the coordination of all the waiver services on the Support Plan, as well as documenting regular Medicaid services, community resources, and natural supports utilized. The Care Coordinator must deliver a copy of the approved Support Plan to the recipient and each provider within 10 business days of receiving the approved Support Plan from SDS.

Under the Conditions of Participation for 7 AAC 125, Personal Care Assistance, and 7 AAC 127, Community First Choice, a participant receiving both HCB waiver services, and personal care services will coordinate services to avoid any duplications. In addition to waiver services, the Support Plan identifies any anticipated services furnished to the recipient under the State Plan, Personal Care Assistance and/or Community First Choice. SDS reviews services furnished through other State and Federal agencies and ensures that no duplication of services is present.

The Care Coordinator is responsible for monitoring the Support Plan. They discuss concerns with the participant or the participant's legal representative during monthly contact.

With the support of the Care Coordinator, the participant and/or the participant's legal guardians leads the person-centered planning session convened by the Care Coordinator. The Care Coordinator must follow the same process as outlined above.

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 needs. The Care Coordinator submits the SDS 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 participant, members of the planning team, and service providers sign the amendment form.

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 planning process, Care Coordinators identify and address potential risks with the participant and their families. The participant needs and preferred service providers are incorporated into the Support Plan and each service is reviewed to determine the relevance of the service and the risks that may be encountered with delivery of those services. If the participant and/or the participant's legal representative believes that the risks are too great, another service may be chosen. Prior to enrolling onto the ISW, IDD unit staff will review the assessment or the potential participant's Support Plan to ensure the applicant's health and safety can be assured within the service scope of the waiver and the individual cost limit.

Backup arrangements usually deal with alternate staff for primary staff absences/sickness and what to do in the case of an emergency such as an earthquake, fire, or flood. The Support Plan describes how to contact emergency services (fire department, hospital, etc.). The participant or guardian must check “Yes” on the Support Plan to indicate that they have discussed their backup and personal emergency plans with the Care Coordinator.

As part of the requirements for certification, HCB service providers must attest to having developed, implemented, and currently use, when necessary, an Emergency Response Policy and Procedures which must address participant health, safety, and welfare as they relate to: medical emergencies, natural disasters, and emergencies involving the service setting (e.g. fire, gas leak, and structural damage). The attestation is retained in the SDS provider’s file and the provider will make the emergency response policy available for review upon SDS’ request.

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 available to them but utilize waivers as a means to maintain their independent and remote lifestyles. Participants 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 legal 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 “Care Coordination and Long Term Services and Supports Targeted Case Management Conditions of Participation” 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. The participant choses providers that fit their needs, as outlined in the Support Plan, if those providers have the capacity to serve them.

In addition, the Support Plan document includes a “Recipient Choice of Services” 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 they still have the right to choose a provider from another agency instead of 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 SDS policy and that participants’ health and welfare are protected.

Participants must renew their Support Plans annually. Every Support Plan is reviewed and signed by the participant, or the participant’s legal representative before being submitted to SDS for review. SDS staff review all Support Plans for suitability and adequacy based on the participant’s need and level of care assessment, the inclusion of participant goals, discussion of health and safety factors and the participant's signature or the participant’s legal representative’s signature. SDS staff then approve the Support Plan and prior authorize services and confirms the 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 ongoing monitoring of the participant's Support Plan. Using in-person, telephonic contacts and distance delivery methods, when appropriate, the Care Coordinator monitors service delivery to verify the participant's needs are being met and that services are aligned with the Support Plan. The Care Coordinator monitors the effectiveness and quality of services the participant receives from providers and evaluates, with the participant, the need for specific services or changes in services and 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 the participant's health, safety and welfare, and to ensure that the participant has 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 participant's Care Coordinator information regarding how the provider's activities are contributing to the participant's progress toward meeting service goals and whether alternative activities would be more effective if progress is limited.

SDS also takes a role in monitoring the 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 may request the participant contact form 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 and technical assistance. If the Care Coordinator's performance does not improve, SDS will respond with progressive sanctions culminating in loss of provider certification.

Care Coordinators must make one in-person contact with the recipient or the recipient's representative at least once every six months, and one telephone contact or distance delivery contact in each of the subsequent five months.

Development of the annual Support Plan with the planning team may occur in a variety of formats including in person contact, telephone or video conference. Signatures from the planning team members may be secured using email, regular mail, in person or other electronic formats.

Planning team members, providers and the participant receive training on how to file complaints through the critical incident reporting process. State staff may offer technical assistance after researching a problem or complaint, issue notices to correct to providers, require a Corrective Action Plan, open investigations, or sanction a provider depending on the situation.

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 130.240 to monitor Support Plan implementation. Rural exceptions to conflict-free care coordination may allow a Care Coordinator to work for an agency that provides other direct waiver services to the participant, but that Care Coordinator may not provide any other home and community-based waiver services to a participant while he or she 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 from another agency rather than the Care Coordinators agency.

As part of the waiver application process, each applicant receives the SDS “Participant Rights and Responsibilities” 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 Plans, 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, the participant receives a list of all providers certified and enrolled to provide home and community-based waiver services in their location or region.

The State of Alaska has a small population and large geographic area. Every attempt is made to inform participants, their legal 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:
D.a.l: # and % of support plans where services meet the needs identified through the person centered planning (PCP) process. Numerator: # of support plans where services meet the needs identified during the PCP process. Denominator: # of support plans reviewed during the reporting period.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Harmony Database

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 = 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:
D.a.2: # and % of support plans that address personal goals identified through the person centered planning PCP process. Numerator:# of support plans that address personal goals identified through the PCP process. Denominator: # of support plans reviewed during the reporting period.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Harmony Database

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 = 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:
D.a.3: # and % of support plans that address health and safety risks identified through the PCP process. Numerator: # of support plans that address health and safety risks. Denominator: # of support plans reviewed during the reporting period.

Data Source (Select one):
Other

If 'Other' is selected, specify:
Harmony Database

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 = 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**	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify:	
	☐ **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:
D.c.4: # and % of support plans updated/revised when warranted by changes in the participant's needs. Numerator: # of support plans appropriately updated/ revised when warranted by a change in participant's needs. Denominator: # of support plans requiring updates/revisions due to a change in participant's needs that were reviewed during the reporting period.

Data Source (Select one):
Other
If 'Other' is selected, specify:

Harmony Database

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 = 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:
D.c.5: # and % of support plans updated/revised at least annually. Numerator:# of support plans updated/revised at least annually. Denominator: # of support plans reviewed during the reporting period.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Harmony Database

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 = 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:

D.d.6: # and % of participants who report that they received the amount, type, scope, duration and frequency of services requested in their PCP. Numerator: # of participants who report that they received the amount, type, scope, duration and frequency of services requested. Denominator: # of support plans reviewed during the reporting period.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Harmony Database

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 = 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:
D.e.7: # and % of participants afforded choice between/among waiver services. Numerator: # of support plans that include evidence the participant received a choice in waiver services. Denominator: # of support plans reviewed during the reporting period.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Harmony Database

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 = 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**

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

Performance Measure:
D.e.8: # and % of participants afforded a choice between/among providers. Numerator: # of support plans that included evidence the participant received a choice in providers. Denominator: # of support plans reviewed during the reporting period.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Harmony Database

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 = 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.

SDS employs the use of quality improvement task committees, the SDS Quality Improvement Workgroup (QIW), and the Department of Health's Quality Improvement Steering Committee (QISC) to discover and identify problems and/or issues within the waiver program.

Quality Improvement Task Committees:

Quality Improvement task committees are charged with the discovery and remediation responsibilities associated with established performance measures within the SDS's five 1915(c) Medicaid waivers. Data is aggregated separately for each individual waiver. Task committees meet, as needed, to review performance measure data, identify performance deficiencies, implement and report on corrective action on individual cases, and recommend system improvement to QIW. When individual first-level remediation is identified as needed, the task committee may make recommendations to unit managers to initiate remediation activities. When performance measures fall consistently below 86%, the task committee is responsible for: 1.) developing a Quality Improvement Plan (QIP) that identifies systemic root causes and implements measures to bring about improvements; 2.) reviewing and seeking approval of the QIP through the QIW; and 3.) and tracking activities until compliance is achieved or develop new strategies if initiated QIPs do not reach intended goals.

Support Plan Review:

The Support Plan Review Task Committee gathers and reviews data from SDS performance measures to assess whether Support Plans are timely, person-centered, identify personal goals, address needs identified in the annual assessment, and document choices offered to and selected by the participant. Membership includes: manager of the Review unit (Chair), manager of the IDD unit (Vice-chair), and SDS staff from the Quality Assurance unit, Research and Analysis unit, Nursing unit, Policy and Program Development unit, and the Assessment unit.

On a monthly or as needed basis, this Committee reviews support plan performance measures data. Based upon that review, the Committee identifies and initiates the remediation activities needed to cure deficiencies. The Support Plan Review Committee makes systemic improvement recommendations to QIW.

Quality Improvement Workgroup:

The Director or the Director's designee is the chair of the QIW; members include SDS unit managers and the SDS Leadership Team. The QIW reviews task committee data, makes recommendations for systemic remediation, and determines what needs to move forward to the Quality Improvement Steering Committee (QISC)

Quality Improvement Steering Committee:

The Department's Commissioner or designee, currently the Medicaid and Health Care Policy/State Medicaid Director, chairs the QISC. The Committee reviews data and reports forwarded from the QIW, considers resource requests to meet objectives, and provides guidance and recommendations to SDS Leadership.

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 fails to address scope, duration or frequency, SDS may respond in one of three ways, depending upon the severity of the issue.

If it appears that the Care Coordinator submitted an inadequate plan, SDS staff will return the Support Plan to the Care Coordinator for remediation.

If SDS staff conclude the Support Plan's inadequacies point towards a pattern of Care Coordinator deficiencies, SDS staff will submit a report to Centralized Reporting. Central Intake unit routes the report to the QA unit where it is screened for investigation. If the QA unit staff find the report substantial enough to warrant an investigation, an investigator reviews data, reports, interviews participants and providers to determine if the Care Coordinator is indeed deficient. The investigator may work with the SDS Provider Certification and Compliance unit and the Division of Health Care Services' Residential Licensing unit during the course of the investigation.

If the investigator determines the Care Coordinator is deficient, the investigator prepares a "report of investigation" containing 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 making a determination for a sanction such factors as the seriousness of the offense, extent of violation, history or prior violations, willingness to obey program rules and whether a lesser sanction would be sufficient to remedy the problem are considered. 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 the 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 are not limited to suspending or terminating certification, and suspending or withholding payment for services.

SDS monitors remediation requirements until the deficiencies are corrected and maintains written records on the progress of remediation efforts.

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 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.

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), 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 the applicant the "Recipient Rights and Responsibilities" form and the "Notice of Recipient Fair Hearing Rights" information sheet. The "Recipient Rights and Responsibilities" form addresses applicant and participant rights, including a statement regarding their right to appeal any decision that affects their care. The applicant initials the form attesting that the Care Coordinator has discussed their rights with them. The "Notice of Recipient Fair Hearing Rights" information sheet provides detailed instructions about how a participant may appeal a decision that affects their care.

All notices of adverse action originate with Senior and Disabilities Services (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 participant 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, including 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 electronic file in the Harmony Database where it will remain indefinitely.

A request for a hearing must be made in writing by the applicant, participant, or by their legal 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 SDS staff, 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 (QA) 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 of Health's Division of Health Care Services (DHCS) will provide assistance to the participant in their efforts 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 with regards to all services provided through SDS.

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

Participants, or Care Coordinators on 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 available. Participants may reschedule the mediation to suit their availability and may also decline mediation. 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 (a 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 a SDS staff member who has the authority 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 to the participant, 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 is referred back to OAH 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 ALJ, who is not assigned to preside over the case, will act as a mediator. Both parties must 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.

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, 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.

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 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. SDS uses the Harmony Database to track both incidents and complaints.

While the system provides latitude for filing complaints, it is not a substitute or a prerequisite 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 within the Harmony Database.

During the initial application process, the applicant for waiver services is informed of their rights to notice of adverse action and Fair Hearing when the Care Coordinator assisting the applicant with the application process gives the applicant the “SDS Recipient Rights and Responsibilities” form and the “Notice of Recipient Fair Hearing Rights” information sheet.

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 and Responsibilities” 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 Recipient Fair Hearing Rights” information sheet 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 prerequisite or a substitute for a Fair Hearing. SDS also includes the “Notice of Fair Hearing Rights” with every denial letter that is sent to a participant.

Complaints about a certified provider or involving a participant made orally or in writing through the Central Intake unit are routed to and reviewed by the QA unit. If the complaint involves a vulnerable adult the report is routed to Adult Protective Services 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 also receives the intake. The QA unit 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 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 the required data is entered into the Harmony Database. 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 redacted 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 their provider agency’s complaint system 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 they received, 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 application to renew certification and 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 Quality Assurance unit. The Quality Assurance 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).

The State's Centralized Reporting system (Centralized Reporting) serves as a repository for voluntary reports, required reports, and/or complaints relative to vulnerable adults in Alaska, individuals living in a licensed assisted living facility, and participants receiving services through the Division of Senior and Disabilities Services (SDS). SDS' Central Intake unit, Adult Protective Services unit and Quality Assurance unit, as well as the Department of Health (Department), Division of Health Care Services, Section of Residential Licensing are the entities responsible to act upon received reports. 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, within 24 hours of becoming aware of the incident.

Regulations at 7 AAC 130.224, Recipient safeguards, require all certified providers to report critical incidents within one business day of observing or learning of an incident involving a waiver participant. For medication errors, this timeframe must be met only when the error results in the need for medical intervention. All other medication errors must be documented and tracked by the certified provider agency on a quarterly basis and submitted to SDS upon request.

Critical incidents and events that must be reported under 7 AAC 130.224 include:

- A missing participant;
- Participant behavior that resulted in harm to the participant 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 participant's 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, administration of a medication at a time other than when it was scheduled, administration of a medication other than by the prescribed route, administration of a medication not intended for the participant, administration of a medication intended for the participant but given to another person, and administration of a medication other than the correct dosage;
- An event that involved the participant and a response from a peace officer.

Providers, participants, Care Coordinators, family members, advocates or any citizen may submit a report through the Centralized Reporting system: https://health.alaska.gov/dsds/Pages/CentralizedReporting.aspx. Reporters may also phone or fax a report to SDS.

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.

The Central Intake unit (Central Intake) is responsible for receiving, processing, and routing reports submitted through Centralized Reporting, including required reports and/or complaints relative to vulnerable adults, individuals living in assisted living homes and individuals receiving services managed by SDS. The reports may pertain to physical and sexual abuse, neglect, self-neglect, exploitation (ANE), including financial exploitation, and abandonment of vulnerable Alaskans as well as other critical incidents involving waiver participants.

Central Intake reviews the reports to determine if there are indications of past harm or suspected ANE that requires routing to Adult Protective Services, and/or the Section of Residential Licensing (Residential Licensing) via the SDS Harmony Database, or if a referral to the Department's Office of Children's Services or law enforcement/emergency services is required. The Office of Children's Services houses its own incident management system and Central Intake makes referrals involving children to the Office of Children's Services if the report meets the mandated report criteria.

Central Intake staff are well versed and crossed trained on Adult Protective Services, Quality Assurance, and Residential Licensing policies and procedures.

Within 24 hours or one business day of report receipt, Central Intake reviews and routes all reports to the pertinent unit: Adult Protective Services, Quality Assurance, or Residential Licensing. Adult Protective Services will receive the report if there is an allegation of abuse, neglect or exploitation involving a vulnerable adult as defined under AS.47.24.900. Central Intake may route the same report to multiple units and may indicate the priority depending on the nature of the report.

Quality Assurance will receive the report, if the report is regarding a waiver recipient and is defined as a critical incident report under 7 AAC 130.224 or is a complaint against a certified waiver provider. Residential Licensing will receive the report if the incident occurred at a licensed assisted living home or involved the resident of a licensed assisted living home. Central Intake may route the same report to multiple units and may indicate the priority depending on the nature of the report. Reports meeting the requirements for immediate jeopardy, or Priority 1, are flagged for expedited review by the appropriate unit's screener. Reports meeting the requirements for immediate jeopardy, or Priority 1, are flagged for expedited review by the appropriate unit's screener.

Central Intake reports for adults sixty years of age or older residing in a licensed residential setting are also referred to the Office of Long Term Care Ombudsman as a referral under AS 47.17.013.

The timeline to initiate contact for the reports that are screened in for investigation for the Office of Children's Services, Residential Licensing, and Adult Protective Services are based on the priority level of the report:

- Office of Children's Services: 24 hours, 72 hours, or five days, based on priority level of the report made;
- Section of Residential Licensing: 24 hours, 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).

Adult Protective Services or Residential Licensing take the lead on actions to protect the safety of the adult participant, depending on whether the allegation occurred in a private or licensed setting. Residential Licensing is responsible for reviewing the licensed provider's response to the incidents, and to notify Adult Protective Services if protective placement is needed. Adult Protective Service specialists investigate the screened-in reports and make determinations about whether the adult has capacity to make independent decisions, and if not, whether they are in need of services, guardianship or protective placement.

Adult Protective Services prioritizes their reports/referrals for investigation and provision of services according to whether the situation is emergent or a normal review. For cases that rise to the level of emergent, the adult is seen within 24 hours or the next business day. For normal review cases, the adult is seen within 10 business days. Adult Protective Services investigations are conducted and concluded within 90 calendar days and submitted for closure. If circumstances beyond the control of Adult Protective Services make it impossible to investigate or provide the protective services within these time frames, an investigation shall be initiated or completed as soon as possible.

The Quality Assurance unit is responsible for reviewing the certified (non-licensed) provider agency's response to incidents involving ANE and determines whether circumstances to mitigate any risks to health, safety and welfare and

reduce the risk of reoccurrence have been adequately addressed. If a provider has offered SDS or Residential Licensing an adequate response to the incident, further action may not be required. Alternatively, if a provider has offered an inadequate response or is involved in the incident, then staff will screen the incident for further investigation. The Quality Assurance unit follows the same process for screening in and investigating those reports that fall under 7 AAC 130.224 and those that involve providers response to incidents involving ANE.

The Quality Assurance unit is also responsible for screening other reportable events under 7 AAC 130.224, Critical incident reporting. A majority of reportable events are considered “general events” and are not suspected ANE or sentinel in nature. Once a report is routed via Central Intake to the Quality Assurance unit, screening personnel determine if a report warrants investigation. General events are those reports that per regulation are required to be submitted by the provider and the providers response to the incident was appropriate. Sentinel events are those reports that are screened in for further investigation because the provider’s response may have been inadequate.

During an investigation or site visit Quality Assurance staff may interview provider program administrators and staff and assess provider agency documents including reports related to the event or circumstances addressed in the SDS Critical Incident Report (CIR), agency policies and procedures, and records of staff credentials and training. When the circumstances or events need to be addressed in order to reduce risks to health, safety, and welfare, or provider non-compliance with certification standards, SDS staff requests that the provider agency develop a Corrective Action Plan and may copy the SDS Provider Certification and Compliance unit on the notice that a Corrective Action 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. Quality Assurance staff monitor the progress, adequacy and outcomes of the Corrective Action Plan until any risks to the health, safety and welfare of participants are corrected. Residential Licensing, Quality Assurance or the Provider Certification and Compliance unit actions are entered in the Harmony 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.

For Reports of Harm, Office of Children’s Services screens in for investigation the investigator conducts interviews and completes a safety assessment within 30 days unless there are extenuation circumstances and a supervisor reviews within 15 days. If maltreatment, OCS may work with family to remedy issues in the family or may proceed with guardianship if warranted.

Adult Protective Services and the Quality Assurance unit may collaborate with Residential Licensing on shared investigations. Shared investigations are linked in the Harmony Database and each unit has access to information and actions on linked cases. The Provider Certification and Compliance unit may also be informed of and included in investigations when non-compliance with certification requirements is alleged.

When Residential Licensing receives a report of abuse or neglect in an assisted living home and plans a site visit, they inform Central Intake in the event that a waiver participant might be displaced from the home. In addition, Residential Licensing performs site inspections when immediate risks to the health and safety of the participants exist. Adult Protective Services may be present at these inspections to facilitate protective placement at a new facility if residents wish to accept assistance. The Office of Long Term Care Ombudsman may also be contacted to assist with finding suitable placements for residents to choose a new safe location. Residential Licensing has 14 days to complete an investigation report after the investigation is completed or a license is suspended.

If warranted, the Provider Certification and Compliance unit or the Quality Assurance unit initiates provider remediation activities. The report is kept in the SDS provider record and is considered as part of the renewal of the provider’s certification. Quality Assurance staff review reports from the Harmony Database for SDS’ health and welfare performance measures, trend data, and monitor discovery and remediation of individual providers’ deficiencies and systemic problems.

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 Adult Protective Services and outlines confidentiality requirements as prescribed in AS 47.24.050.

At the conclusion of an Adult Protective Services investigation the investigator sends a second letter to the reporter and participant or the participant's legal representative which states the outcome of the investigation. To maintain confidentiality, the letter does not describe details from the report received or details of the investigation.

For investigations conducted by the Quality Assurance unit, a copy of the Report of Investigation is issued to the provider under investigation and due process for appeal is granted. A copy of the Report of Investigation may be requested by the public via a Public Records Request. The Quality Assurance unit does not release information without a Public Records Request and information may be redacted.

For investigations conducted by the Office of Children's Services, a reporter that requests to be notified may be supplied with information about whether a report is screened in or out but does not receive the outcome of the investigation.

For investigations conducted by the Residential Licensing program a copy of the Report of Investigation is issued to the provider under investigation and due process for appeal is granted. A copy of the Report of Investigation may be requested by the public via a Public Records Request. Residential Licensing does not release information without a Public Records Request and information may be redacted.

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 Quality Assurance unit oversees the CIR process. Incidents are entered and tracked in the Harmony Database. The Harmony Database is also used to monitor technical assistance and dispositions of investigations including requests for additional information regarding incidents for Adult Protective Services, Residential Licensing, and Quality Assurance. These entities enter actions taken into the Database. The Quality Assurance unit has access to all data within the Harmony Database.

The Office of Children's Services utilizes a separate database to independently track cases. When a concern regarding a certified provider is identified, they contact Senior and Disabilities Services.

The Quality Assurance unit reviews monthly CIR reports summarizing incident data and analyzes cumulative incident report data as: 1.) a risk management method to identify prevalence and patterns of adverse events in the participant population, 2.) to evaluate the effectiveness of technical assistance interventions, and 3.) to identify areas for quality improvement in both SDS and provider agency operations.

Adult Protective Services reviews monthly mandated reports using the same methods as the Quality Assurance unit. Both units participate in task committees, share information as applicable, and bring recommendations to SDS' Quality Improvement Workgroup which reviews the information to determine if corrective action is needed and may forward the issue to the Department's Quality Improvement Steering Committee for review and consideration of systemic improvements.

Residential Licensing reviews requisite reporting requirements with licensed providers during initial licensure and renewal inspections and investigates serious incidents. These incidents are received through the Harmony Database where they are screened for priority, assigned to investigators, and the results of the investigation are documented.

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).

The State's regulation under 7 AAC 130.229, Use of restrictive intervention, guides SDS' response to the providers' use of restrictive intervention, including as a subset restraints and seclusion. The State defines restrictive intervention to mean "an action or procedure that limits an individual's movement or access to other individuals, locations, or activities." Examples of restrictive interventions commonly used are: gait belts, bed rails, and doorknob safety covers.

SDS acknowledges restraint use and prohibitions of restraint as aspects of restrictive intervention policy and regulated under 7 AAC 130.229, Use of restrictive intervention, and in the case of licensed assisted living homes under 7 AAC 75.295, Use of intervention and physical restraint. Reporting restrictive interventions is regulated under 7 AAC 130.224, Critical incident reporting, and home and community-based service provider certification requirements under 7 AAC 130.220, Provider certification.

SDS allows for the limited use of some types of restraints and prohibits three methods of restraint: seclusion, prone restraint, and chemical restraint defined as:

1.) Seclusion means 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.
2.) 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.
3.) Chemical restraint means the use of medication that was not prescribed or consented to by a participant and limits or restricts a participant's movement or function.

SDS permits the use of physical restraint under 7 AAC 130. 229, Use of restrictive intervention, when use of less restrictive interventions have been shown to be ineffective and in two circumstances only: 1.) as a response to the risk of imminent danger where the health and safety of the participant or others are at risk, or, 2.) 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.

The Quality Assurance unit investigates reports of unauthorized or inappropriate uses of restraints that led to medical intervention, as reported through Centralized Reporting or as a result of a finding encountered through an on-site review or ancillary investigation. Provider non-compliance may result in a sanction or enforcement action up to and including termination from the Medicaid program. The Quality Assurance unit regularly coordinates their investigations with the Provider Certification and Compliance unit.

To ensure that restrictive interventions will not cause harm to the participant, provider agencies must have written policy and procedures for their use, training provided to all direct service workers, and monitoring that includes: quarterly reviews, corrective action and reporting to SDS if the restrictive intervention 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 in writing their policy and procedure for the use of restrictive interventions, including the use or prohibition of restraints, when applying for new certification and licensure and during renewal of certification and licensing, or when there is a change in the provider's policy and/or procedure. Based on a provider agency's understanding of the standards for use and the adequacy of the training program to be implemented, SDS may permit the use of restrictive interventions, including physical restraint.

SDS promotes, but does not require, the use of time-limited behavioral support plans that use the least restrictive methods needed to manage behaviors and eliminate the circumstances in which restrictive intervention, including restraints, would be necessary. A behavioral 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 participant'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 behavioral supports or a nonviolent crisis program like Crisis Prevention Intervention.

Modifications must be based on a specific, assessed need of a participant, only after the provider attempts positive interventions and other less intrusive methods of meeting the need, and these attempts prove unworkable. The modification must be approved in the Support Plan developed in accordance with 7 AAC 130.217, Plan of care development and amendment, and 7 AAC 130.218, Person-centered practice, and must be supported by a written record that includes:

- identification of the assessed need requiring modification;
- documentation, before any modification of the setting requirements, of positive interventions and other less intrusive methods that were used to address that need and that did not work;
- a description of the modification used; the modification must be directly proportional to the specific assessed need;
- an explanation of the method for collecting and reviewing data to measure the ongoing effectiveness of the modification;
- time limits for periodic reviews to determine if the modification continues to be necessary or should be terminated;
- documentation of the informed consent of the participant for the modification; and
- a documented analysis concluding the modification will not cause harm to the participant.

For a participant with a behavioral support plan, a team, including the participant, the participant's Care Coordinator, the participant's legal representative, and additional members, as needed, including health care and waiver service 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.

The Care Coordinator, in collaboration 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 the participant, or the participant's or legal guardian, 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 behavioral support plan as needed.

For participants without a behavioral support plan, the participant's Care Coordinator is trained to create solutions when a person has a problem accessing services or the community due to behavioral issues, including assessing the need for restrictive interventions and working with the service providers to amend the Support Plan.

All agency direct service workers must meet the following qualifications and have received the prescribed required trainings. Direct service workers must: 1.) 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, 2.) understand the needs of the participant population and the services to be provided as described in the service plan, 3.) pass a criminal background check required by statute at AS 47.05.300 and regulations at 7 AAC 10.900, and 4.) have documentation of current First Aid and CPR training, Critical Incident Reporting

training, Restrictive Intervention training, and, for direct service workers that might assist with self-administration of medications, Assistance with Self-Administration of Medications training. Direct service workers must be supervised by the provider's program 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 restraints, 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 the prohibition of using restraints for which they have been not been trained.

The provider must have on file written verification that each direct service worker has received training appropriate to the type of restrictive intervention the provider has allowed that direct service worker to use. A provider that uses restrictive interventions shall document in the participant's record:

- the date and time;
- the duration of time each type of restrictive intervention was used;
- a description of the behavior that led to the use of restrictive intervention;
- a rationale for, and a description of, each type of restrictive intervention used;
- the participant's response to each type of restrictive intervention used; and
- the name of each staff member involved in the restrictive intervention.

The provider shall maintain a record of restrictive intervention that: 1.) documents the event or circumstances that necessitated the use of restrictive intervention, 2.) the type of restrictive intervention used, 3.) the type of care provided to the participant while a restrictive intervention is applied, and 4.) the outcome for the participant and for the staff involved in the event.

The provider shall develop and implement a plan to manage and report the use of restrictive intervention that includes a plan for documenting and tracking the use of restrictive intervention and meeting reporting requirements on any incidents involving the misuse of restrictive intervention or the use of restrictive intervention that resulted in the need for medical intervention under 7 AAC 130. 224, Critical incident reporting.

Continued at Main-B: Additional Information Needed (Optional)

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:

The State's regulation under 7 AAC 130.229, Use of restrictive intervention, guides SDS' response to the providers' use of restrictive intervention, including as a subset restraints and seclusion. The State defines restrictive intervention under 7 AAC 130. 229 to mean "an action or procedure that limits an individual's movement or access to other individuals, locations, or activities." Examples of restrictive interventions commonly used are: gait belts, bed rails, and doorknob safety covers.

SDS monitors the use of restrictive intervention, including restraints and seclusion, through Care Coordinator activities, Support Plan processing, Critical Incident Reporting management, complaints, and quality assurance reviews. In addition, providers are required to document, analyze, and take corrective action based on the analysis, at least each standard calendar quarter. All providers using restrictive interventions, including restraints, are required to report these evaluations and corrective actions taken when they renew their certification status and upon request of SDS.

The SDS Quality Assurance unit, Provider Certification and Compliance unit and Adult Protective Services unit, in cooperation with the Section of Residential Licensing, monitor the use of restrictive interventions through application reviews, provider agency reports and training records, licensing inspection reports, investigative reports, Care Coordinator activities, Support Plan reviews, Critical Incident Reporting management, complaints, referrals, and quality assurance provider reviews.

The Section of Residential Licensing is responsible for: the licensing of assisted living homes, offering new provider orientation training to providers that includes information related to restrictive intervention (including restraints and seclusion), conducting annual inspections, and investigating complaints and Critical Incident Reports submitted through Centralized Reporting.

Care coordination services, which must include one in-person contact with the recipient or the recipient's representative at least once every six months, and one telephone contact or distance delivery contact in each of the subsequent five months, is another way SDS monitors the use and unauthorized use of restrictive interventions, including 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 the development of the Support Plan, or when necessitated by the participant's challenging or dangerous behavior, the Care Coordinator may facilitate discussion about the need for a behavioral support plan. After the planning team is convened and the behavioral support plan is developed by a licensed professional, the Care Coordinator incorporates the behavioral plan into the Support Plan. During the in-person and monthly contacts, the Care Coordinator reviews with the participant and/or the participant's legal guardian, the behavioral support plan and any authorized use of restraints and documents their responses in the record of service.

For a participant with a behavioral support plan, a team, including the participant, the participant's Care Coordinator, the participant's legal representative, and additional members, as needed, including health care and waiver service 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.

The Care Coordinator, in collaboration 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 the participant, or the participant's or legal guardian, 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 behavioral support plan as needed.

If restraints have been used, the Care Coordinator discusses the event with the provider who used restraints and verifies if use was for circumstances that presented imminent danger or met the requirements outlined in a behavioral support plan. The Care Coordinator also submits a Critical Incident Report when he or she believes that the use of restrictive interventions, including restraints or seclusion, was used in a manner not authorized in the behavioral support plan.

Pursuant to 7 AAC 75.295, Use of intervention and physical restraint, Residential Licensing requires all facilities to have a restraint policy, to provide that policy to residents and their representative upon admission, conduct a restraint assessment upon admission to the facility to determine if the resident requires the use of restraints based on physician recommendations, and requires the facility to submit a Critical Incident Report when physical restraints used unless the restraint was prescribed by a physician in accordance with 7 AAC 75.295 (f). Residential Licensing prohibits the use of chemical restraints unless they are prescribed by a physician (AS 47.33.330(a) (3)).

During the annual Support Plan review process, SDS staff verify with the Care Coordinator the continued need for a behavioral support plan.

When a Quality Assurance unit investigation reveals inappropriate use of restrictive interventions, Quality Assurance unit staff contact the provider to request a Corrective Action Plan that may include training and technical assistance. Quality Assurance unit staff monitor the Corrective Action Plan until it is complete or until unit staff assess a low risk of occurrence.

Through these and other discovery activities, such as Critical Incident Reports, the Quality Assurance 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. This task committee, which includes Adult Protective Services unit staff and members of each appropriate SDS unit, evaluates the information for possible individual remediation, patterns or trends in the use of restrictive intervention, and makes a monthly quality report to the Quality Improvement Workgroup. This quality report may include recommendations for remediation, including technical assistance and training or policy implementation strategies.

In turn, the Quality Improvement Workgroup evaluates the information offered in the monthly quality monitoring report and offers feedback to the Task Committee. Recommendations for larger systemic improvements are made to the Department's Quality Improvement Steering Committee chaired by the Department's Deputy Commissioner. This Quality Improvement Steering Committee has broad departmental membership and meets quarterly to review the quality monitoring report.

Through the initial and ongoing monitoring of certified providers, SDS ensures compliance with standards for the use of restrictive interventions, including restraints and seclusion, by several mechanisms. One mechanism is requiring providers to submit written policies and procedures on the use of restrictive interventions. Following are the criteria SDS looks to be addressed in providers' written policy and procedure: the circumstances under which the use of restrictive intervention is allowed and is it appropriate for the population served; clear prohibitions for the use of chemical, prone, and seclusion restraints; the evaluation of restrictive interventions used during the provision of service; the type and frequency of restrictive intervention trainings; documentation, tracking, evaluation, and reporting methods. The provider must indicate the level of restrictive interventions used, including allowed restraints, and provide training to all applicable direct service workers on those specific levels of intervention.

In addition, providers are required to document and evaluate, at least each standard calendar quarter, all uses of restrictive interventions including restraints, and are required to report these evaluations and corrective actions taken at the time when 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.

The State's regulation under 7 AAC 130.229, Use of restrictive intervention, guides SDS' response to the providers' use of restrictive intervention, including as a subset restraints and seclusion. The State defines restrictive intervention to mean "an action or procedure that limits an individual's movement or access to other individuals, locations, or activities." Examples of restrictive interventions commonly used are: gait belts, bed rails, and doorknob safety covers.

SDS acknowledges restraint use and prohibitions of restraint as aspects of restrictive intervention policy and regulated under 7 AAC 130.229, Use of restrictive intervention, and in the case of licensed assisted living homes under 7 AAC 75.295, Use of intervention and physical restraint. Reporting restrictive interventions is regulated under 7 AAC 130.224, Critical incident reporting, and home and community-based service provider certification requirements under 7 AAC 130.220, Provider certification.

SDS allows for the limited use of some types of restraints and prohibits three methods of restraint: seclusion, prone restraint, and chemical restraint defined as:

1. Seclusion means 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.
2. 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.
3. Chemical restraint means the use of medication that was not prescribed or consented to by a participant and limits or restricts a participant's movement or function.

SDS permits the use of physical restraint under 7 AAC 130. 229, Use of restrictive intervention, when use of less restrictive interventions have been shown to be ineffective and in two circumstances only: 1.) as a response to the risk of imminent danger where the health and safety of the participant or others are at risk, or, 2.) 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.

The Quality Assurance unit investigates reports of unauthorized or inappropriate uses of restraints that led to medical intervention, as reported through Centralized Reporting or as a result of a finding encountered through an on-site review or ancillary investigation. Provider non-compliance may result in a sanction or enforcement action up to and including termination from the Medicaid program. The Quality Assurance unit regularly coordinates their investigations with the Provider Certification and Compliance unit.

To ensure that restrictive interventions will not cause harm to the participant, provider agencies must have written policy and procedures for their use, training provided to all direct service workers, and monitoring that includes: quarterly reviews, corrective action and reporting to SDS if the restrictive intervention 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 in writing their policy and procedure for the use of restrictive interventions, including the use or prohibition of restraints, when applying for new certification and licensure and during renewal of certification and licensing, or when there is a change in the provider's policy and/or procedure. Based on a provider agency's understanding of the standards for use and the adequacy of the training program to be implemented, SDS may permit the use of restrictive interventions, including physical restraint.

SDS promotes, but does not require, the use of time-limited behavioral support plans that use the least restrictive methods needed to manage behaviors and eliminate the circumstances in which restrictive intervention, including restraints, would be necessary. A behavioral 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 participant'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 behavioral supports or a nonviolent crisis program like Crisis Prevention Intervention.

Modifications must be based on a specific, assessed need of a participant, only after the provider attempts positive interventions and other less intrusive methods of meeting the need, and these attempts prove unworkable. The modification must be approved in the Support Plan developed in accordance with 7 AAC 130.217, Plan of care development and amendment, and 7 AAC 130.218, Person-centered practice, and must be supported by a written record that includes:

- identification of the assessed need requiring modification;
- documentation, before any modification of the setting requirements, of positive interventions and other less intrusive methods that were used to address that need and that did not work;
- a description of the modification used; the modification must be directly proportional to the specific assessed need;
- an explanation of the method for collecting and reviewing data to measure the ongoing effectiveness of the modification;
- time limits for periodic reviews to determine if the modification continues to be necessary or should be terminated;
- documentation of the informed consent of the participant for the modification; and
- a documented analysis concluding the modification will not cause harm to the participant.

For a participant with a behavioral support plan, a team, including the participant, the participant's Care Coordinator, the participant's legal representative, and additional members, as needed, including health care and waiver service 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.

The Care Coordinator, in collaboration 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 the participant, or the participant's or legal guardian, 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 behavioral support plan as needed.

For participants without a behavioral support plan, the participant's Care Coordinator is trained to create solutions when a person has a problem accessing services or the community due to behavioral issues, including assessing the need for restrictive interventions and working with the service providers to amend the Support Plan.

All agency direct service workers must meet the following qualifications and have received the prescribed required trainings. Direct service workers must: 1.) 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, 2.) understand the needs of the participant population and the services to be provided as described in the service plan, 3.) pass a criminal background check required by statute at AS 47.05.300 and regulations at 7 AAC 10.900, and 4.) have documentation of current First Aid and CPR training, Critical Incident Reporting

training, Restrictive Intervention training, and, for direct service workers that might assist with self-administration of medications, Assistance with Self-Administration of Medications training. Direct service workers must be supervised by the provider’s program 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 restraints, 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 the prohibition of using restraints for which they have been not been trained.

The provider must have on file written verification that each direct service worker has received training appropriate to the type of restrictive intervention the provider has allowed that direct service worker to use. A provider that uses restrictive interventions shall document in the participant's record:

- the date and time;
- the duration of time each type of restrictive intervention was used;
- a description of the behavior that led to the use of restrictive intervention;
- a rationale for, and a description of, each type of restrictive intervention used;
- the participant's response to each type of restrictive intervention used; and
- the name of each staff member involved in the restrictive intervention.

The provider shall maintain a record of restrictive intervention that: 1.) documents the event or circumstances that necessitated the use of restrictive intervention, 2.) the type of restrictive intervention used, 3.) the type of care provided to the participant while a restrictive intervention is applied, and 4.) the outcome for the participant and for the staff involved in the event.

The provider shall develop and implement a plan to manage and report the use of restrictive intervention that includes a plan for documenting and tracking the use of restrictive intervention and meeting reporting requirements on any incidents involving the misuse of restrictive intervention or the use of restrictive intervention that resulted in the need for medical intervention under 7 AAC 130. 224, Critical incident reporting.

The plan must also include: 1.) a protocol for analyzing the use of restrictive intervention each quarter, 2.) a procedure for taking corrective action based on the analysis, and 3.) a process for summarizing the quarterly analyses and any corrective actions taken. The summary must be submitted to SDS with the provider's application for renewal of certification under 7 AAC 130.220, Provider certification, or upon request.

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:

The State's regulation under 7 AAC 130.229, Use of restrictive intervention, guides SDS' response to the providers' use of restrictive intervention, including as a subset restraints and seclusion. The State defines restrictive intervention to mean "an action or procedure that limits an individual's movement or access to other individuals, locations, or activities." Examples of restrictive interventions commonly used are: gait belts, bed rails, and doorknob safety covers.

SDS monitors the use of restrictive intervention, including restraints and seclusion, through Care Coordinator activities, Support Plan processing, Critical Incident Reporting management, complaints, and quality assurance reviews.

The SDS Quality Assurance unit, Provider Certification and Compliance unit and Adult Protective Services unit, in cooperation with the Section of Residential Licensing, monitor the use of restrictive interventions through application reviews, provider agency reports and training records, licensing inspection reports, investigative reports, Care Coordinator activities, Support Plan reviews, Critical Incident Reporting management, complaints, referrals, and quality assurance provider reviews.

The Section of Residential Licensing is responsible for: the licensing of assisted living homes, offering new provider orientation training to providers that includes information related to restrictive intervention (including restraints and seclusion), conducting annual inspections, and investigating complaints and Critical Incident Reports submitted through Centralized Reporting.

Care coordination services, which must include one in-person contact with the recipient or the recipient's representative at least once every six months, and one telephone contact or distance delivery contact in each of the subsequent five months, is another way SDS monitors the use and unauthorized use of restrictive interventions, including 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 the development of the Support Plan, or when necessitated by the participant's challenging or dangerous behavior, the Care Coordinator may facilitate discussion about the need for a behavioral support plan. After the planning team is convened and the behavioral support plan is developed by a licensed professional, the Care Coordinator incorporates the behavioral plan into the Support Plan. During the in-person and monthly contacts, the Care Coordinator reviews with the participant and/or the participant's legal guardian, the behavioral support plan and any authorized use of restraints and documents their responses in the record of service.

For a participant with a behavioral support plan, a team, including the participant, the participant's Care Coordinator, the participant's legal representative, and additional members, as needed, including health care and waiver service 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.

The Care Coordinator, in collaboration 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 the participant, or the participant's or legal guardian, 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 behavioral support plan as needed.

If restraints have been used, the Care Coordinator discusses the event with the provider who used restraints and verifies if use was for circumstances that presented imminent danger or met the requirements outlined in a behavioral support plan. The Care Coordinator also submits a Critical Incident Report when he or she believes that the use of restrictive interventions, including restraints or seclusion, was used in a manner not authorized in the behavioral support plan.

Pursuant to 7 AAC 75.295, Use of intervention and physical restraint, Residential Licensing requires all facilities to have a restraint policy, to provide that policy to residents and their representative upon admission, conduct a restraint assessment upon admission to the facility to determine if the resident requires the use of restraints based on physician recommendations, and requires the facility to submit a Critical Incident Report when physical restraints used unless the restraint was prescribed by a physician in accordance with 7 AAC 75.295 (f). Residential Licensing prohibits the use of chemical restraints unless they are prescribed by a physician (AS 47.33.330(a) (3)).

During the annual Support Plan review process, SDS staff verify with the Care Coordinator the continued need for a behavioral support plan.

When a Quality Assurance unit investigation reveals inappropriate use of restrictive interventions, Quality Assurance unit staff contact the provider to request a Corrective Action Plan that may include training and technical assistance. Quality Assurance unit staff monitor the Corrective Action Plan until it is complete or until unit staff assess a low risk of occurrence.

Through these and other discovery activities, such as Critical Incident Reports, the Quality Assurance 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. This task committee, which includes Adult Protective Services unit staff and members of each appropriate SDS unit, evaluates the information for possible individual remediation, patterns or trends in the use of restrictive intervention, and makes a monthly quality report to the Quality Improvement Workgroup. This quality report may include recommendations for remediation, including technical assistance and training or policy implementation strategies.

In turn, the Quality Improvement Workgroup evaluates the information offered in the monthly quality monitoring report and offers feedback to the Task Committee. Recommendations for larger systemic improvements are made to the Department’s Quality Improvement Steering Committee chaired by the Department’s Deputy Commissioner. This Quality Improvement Steering Committee has broad departmental membership and meets quarterly to review the quality monitoring report.

Through the initial and ongoing monitoring of certified providers, SDS ensures compliance with standards for the use of restrictive interventions, including restraints and seclusion, by several mechanisms. One mechanism is requiring providers to submit written policies and procedures on the use of restrictive interventions. Following are the criteria SDS looks to be addressed in providers’ written policy and procedure: the circumstances under which the use of restrictive intervention is allowed and is it appropriate for the population served; clear prohibitions for the use of chemical, prone, and seclusion restraints; the evaluation of restrictive interventions used during the provision of service; the type and frequency of restrictive intervention trainings; documentation, tracking, evaluation, and reporting methods. The provider must indicate the level of restrictive interventions used, including allowed restraints, and provide training to all applicable direct service workers on those specific levels of intervention.

In addition, providers are required to document and evaluate, at least each standard calendar quarter, all uses of restrictive interventions including restraints, and are required to report these evaluations and corrective actions taken at the time when they renew their certification status and upon request of SDS.

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:

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 on-site reviews, Support 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 Residential Licensing. Use of seclusion may result in a provider sanction or enforcement action up to and including termination from the Medicaid program.

Residential Licensing 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, Support Plan reviews, Critical Incident reporting management, complaints, referrals, and quality assurance provider reviews. Investigation reports conducted by Residential Licensing are entered into the SDS Harmony Database and 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 participants receiving residential habilitation services. These services may only be provided in licensed assisted living homes. SDS specifies that home and community-based waiver regulations regarding medications, 7 AAC 130.227, Administration of medication and assistance with self-administration of medication, are superseded by assisted living home regulations.

Health-related services, including medication management, are allowed in assisted living homes, AS 47.33.020. Under 12 AAC 44.965, Delegation of the administration of medication, 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 assisted living plan must be evaluated at three-month intervals if an assisted living home provides or arranged for such services. In addition to the 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 patterns, 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 service workers, 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.

Residential Licensing monitors assisted living homes on a biannual basis to determine compliance with regulations. It is responsible for oversight of medication management practices within assisted living homes, including monitoring medication regimens. The biannual 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.

Residential Licensing 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 participants, Residential Licensing requires immediate corrective action. For other deficiencies, Residential Licensing requires the assisted living homes to develop and submit a Corrective Action Plan 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 Residential Licensing which may conduct a follow-up investigation or inspection to determine compliance. If the provider does not comply with the Plan, Residential Licensing has authority to convert a standard assisted living home 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.

Residential Licensing regularly consults with the Alaska Board of Nursing regarding medication questions and clarification of nurse delegation responsibilities. Residential Licensing reports any substantiated findings or concerns regarding the performance of a nurse or the certified nurse 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 of Nursing adopts regulations to carry out the laws governing the practice of nursing and certified nurse aides in Alaska. It makes final licensing decisions and takes disciplinary action against those who violate licensing laws.

If a completed assisted living home's report of inspection or investigation may affect its certification, Residential Licensing sends the completed report to SDS' Provider Certification and Compliance unit. These reports are reviewed and considered during the provider's renewal of certification process.

SDS also monitors other types of certified home and community-based waiver service providers who offer assistance with self-administration of medication. Monitoring takes place through the provider's application or renewal of certification process, provider agency reports, training records, investigative reports, Critical Incident Reporting management, complaints, referrals, and quality assurance investigation, including corrective action plans and sanctions.

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 regarding the administration of medications to waiver participants or assisting with self-administration of medications to the waiver participant 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, Administration of medication and assistance with self-administration of medication, 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 home and community-based waiver providers.

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 participant; monitoring and evaluation of medication administration; medication error reporting requirements; and medication administration training requirements.

A home and community-based waiver service provider seeking certification must create and implement a medication management policy and submit it to SDS at the initial certification stage. SDS reviews the medication management policy at renewal of certification if the service provider's policy or guiding state and/or federal regulations have changed.

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 legal 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 legal representative, a registered nurse, or another health care professional in accordance with statutes or regulations applicable to that professional.

As under AS 47.33.020, the provider may assist a participant to self-administer medication provided the assisting employee is supervised as necessary. Assisted living home staff, certified 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's 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 their own medications.

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 home and community-based waiver participants, waiver provider agencies must determine that the participant requires medication administration as part of the service. If the participant requires this service, 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 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 to renew certification.

(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:

If the error resulted in medical intervention, the providers must report the error as a critical incident, 7 AAC 130.224, Critical incident reporting.

○ **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 compliance with reporting medication errors that result in the need for medical intervention.

The State requires reports from all individuals that have knowledge of an event and links reports together so screeners can compare reports and determine if a report of an involved party is missing or inaccurate. Onsite inspections through Residential Licensing and investigations of reports of harm by Adult Protective Services or critical incidents by Quality Assurance may also identify when a reporter failed to report. When necessary, SDS works with the provider to develop and implement a Corrective Action Plan. The Quality Assurance unit monitors the Corrective Action Plan and collaborates with the Provider Certification and Compliance unit as part of the renewal of certification review, or whenever necessary to address risks to participant health and safety.
SDS certification staff review providers' training and medication error reporting compliance at time of renewal certification.

The State acquires data to identify trends and patterns from Critical Incident reports submitted. The Health and Welfare Task Committee reviews quarterly Critical Incident data summarizing incidents.

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:
G.a.l: # and % of participants who received information on identifying and reporting ANE. Numerator:# of participants who received information on identifying and reporting ANE. Denominator: # of participants who were included in the case review sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Harmony Database

Responsible Party for	Frequency of data	Sampling Approach

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*(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 = 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:
G.a.2: # and % of cases with founded ANEs where appropriate action occurred. Numerator: # of cases with founded ANEs reviewed during the reporting period where appropriate action occurred. Denominator: # of cases with founded ANEs reviewed during the reporting period.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Harmony Database

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:

	☐ **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:
G.a.3: # and % of providers that submitted central intake reports involving critical incidents within the required timeframe. Numerator:# of providers that submitted central intake reports involving critical incidents within the required timeframe. Denominator: # of providers reviewed that submitted central intake reports involving critical incidents during the reporting period.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Harmony Database

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 = 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**

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

Performance Measure:
G.a.4: # and % of substantiated unexplained deaths where appropriate action occurred. Numerator: # of substantiated and unexplained deaths where appropriate action occurred. Denominator: # of substantiated and unexplained deaths reviewed during the reporting period.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Harmony Database

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 = 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:
G.b.5: # and % of central intake reports involving possible ANE of adults reviewed within 1 business day of receipt Numerator: # of central intake reports involving possible ANE of adults reviewed within 1 business day of receipt. Denominator: # of central intake reports reviewed involving possible ANE of adults submitted to SDS. w/in reporting period.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Harmony Database Central Intake Records

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 = 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:
G.b.6: # and % of central intake trends where systemic intervention was implemented. Numerator: of central intake trends identified where systemic intervention was implemented. Denominator: # of central intake trends identified during the reporting period.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Harmony Database Central Intake Records

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:
	☐ **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:
G.c.7: #and% of inappropriate restrictive interventions that were appropriately resolved. Numerator: # of inappropriate restrictive interventions that were appropriately resolved. Denominator: # of inappropriate restrictive interventions reported.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Harmony Database Central Intake Records

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:
	☐ **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:
G.d.8: # and % of provider medication errors that resulted in the need for medical intervention where appropriate followup by provider occurred. Numerator: # of provider medication errors that resulted in need for medical intervention where appropriate followup by provider occurred. Denominator: # of provider medication errors that resulted in need for medical intervention reported.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Harmony Database Central Intake Records

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:
	☐ **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**

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

Performance Measure:
G.d.9: #and% of waiver recipients who are children who received an EPSDT screening at least annually. Numerator:# of waiver recipients who are children who received an EPSDT screening at least annually. Denominator:# of waiver recipients who are children reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS

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 = 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:
G.d.10: #and % of waiver recipients who are adults who received an annual dental wellness visit. Numerator:# of waiver recipients who are adults who received an annual dental wellness visit. Denominator:# of waiver recipients who are adults reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS

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 = 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):*

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.

SDS employs the use of quality improvement task committees, SDS' Quality Improvement Workgroup (QIW), and Department's Quality Improvement Steering Committee (QISC), to discover and identify problems and/or issues within the waiver program.

Quality Improvement Task Committees:

Quality Improvement task committees are charged with the discovery and remediation responsibilities associated with established performance measures within the SDS's five 1915(c) Medicaid waivers. Data is aggregated separately for each individual waiver. Task committees meet, as needed, to review performance measure data, identify performance deficiencies, implement and report on corrective action on individual cases, and recommend system improvement to QIW. When individual first-level remediation is identified as needed, the task committee may make recommendations to unit managers to initiate remediation activities. When performance measures fall consistently below 86%, the task committee is responsible for: 1.) developing a Quality Improvement Plan (QIP) that identifies systemic root causes and implements measures to bring about improvements; 2.) reviewing and seeking approval of the QIP through the QIW; and 3.) and tracking activities until compliance is achieved or develop new strategies if initiated QIPs do not reach intended goals.

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: manager of the Quality Assurance unit (Chair), manager of the Adult Protective Services unit (Vice-chair), and SDS staff from the Adult Protective Services unit, Central Application Processing unit, Assessment unit, Review unit, Nursing unit, Grants unit, Central Intake unit, Intellectual and Developmental Disabilities unit, and the Policy and Program Development unit.

On a monthly or as-needed basis, this Committee reviews Reports of Harm, Critical Incident Reports, complaint reports, discovers deficiencies, and plans and conducts individual and systemic remediation. This Committee is responsible for reporting on individual outcomes for performance measures under certain Health and Welfare assurances, in addition to QIP activities and strategies. The Health and Welfare Task Committee brings issues discovered to QIW.

Mortality Review:

The Mortality Review Team identifies and reviews all deaths reported throughout the Centralized Reporting system. Membership includes: manager of the Quality Assurance unit (Chair) and SDS staff including a Qualified Intellectual Disability Professional (QIDP), a Registered Nurse (RN), the SDS Mortality Review Coordinator, staff from the Adult Protective Services (APS) unit and representatives from the Division of Health Care Services' Section of Residential Licensing and the Office of Long Term Care Ombudsman. Consultants from the Department's Division of Public Health are available as needed.

On a monthly or as needed basis, this Committee reviews information on participant deaths obtained through the SDS critical incident reporting process, including medical records from the Bureau of Vital Statistics, the state Medical Examiner's office, and law enforcement reports to determine if the death is the result of an action or omission (or inaction) on the part of a waiver 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 reviewed carefully by the Committee and may trigger an investigation. Findings are reported to QIW.

Quality Improvement Workgroup:

The Director or the Director's designee is the chair of the QIW; members include SDS unit managers and the SDS Leadership Team. The QIW reviews task committee data, makes recommendations for systemic remediation, and determines what needs to move forward to the QISC.

Quality Improvement Steering Committee:

The Department's Commissioner or designee, currently the Medicaid and Health Care Policy/State Medicaid Director, chairs the QISC. The Committee reviews data and reports forwarded from the QIW, considers resource requests to meet objectives, and provides guidance and recommendations to SDS Leadership.

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 issues by provide agencies, and preventing instances of abuse, neglect, and exploitation through protective placements, training and technical assistance.

Certified and enrolled waiver service providers have front-line responsibility for the health and welfare of the participants they serve. When discovery activities reveal provider deficiencies, the Quality Assurance unit is responsible for overseeing remediation activities. The Quality Assurance unit may issue a "Notice to Correct" to certified or enrolled providers in an effort to improve compliance with standards or work through other jurisdiction partners to make referrals when issues fall outside of the Quality Assurance unit's scope.

For those providers who are out of compliance with health and safety requirements or for whom there is an identified trend of unsafe outcomes for participants, the Quality Assurance unit staff investigate and issue an investigative report. 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' Adult Protective Services staff will conduct an investigation to determine the level of risk and if necessary, facilitate a change in service providers or develop a protective placement that ensures the health and safety of the participant. In addition, SDS may act without offering an opportunity for remediation by the provider with actions that may 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 a review and analysis of provider reports, information provided by participants, and reviews of complaints.

When discovery activities reveal problems with the State's performance on health and welfare measures, SDS' managers of the Central Intake unit, the Quality Assurance unit, the Adult Protective Services unit, Intellectual and Developmental Disabilities unit and Consumer Assessment Tool Review unit are responsible for initiating remediation activities and reviewing data in the Health and Welfare Task Committee. If the problem involves performance issues with individual staff, the unit 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. Personnel details are not produced in task committees. If the unit manager believes the problem relates to systemic issues within SDS, those issues are brought to the pertinent task committee and recommendations are made to the QIW.

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**

Responsible Party*(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☐ **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 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.

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 system developed by the Division of Senior and Disabilities Services (SDS) to measure and improve performance is the Quality Improvement Strategy (QIS). The QIS incorporates discovery and remediation activities for all five Medicaid waivers administered by SDS: IDD-0260, ALI- 0261, APDD-0262, CCMC-0263, and ISW-1566.

The QIS is implemented through the Continuous Quality Improvement (CQI) framework. The CQI framework is responsible for the following:

1.) providing for systematic evaluation of waiver activities to ensure the health, safety and welfare of participants,
2.) facilitating discovery activities through collection of data necessary for remediating individual problems and implementing system improvements, and
3.) providing a reporting mechanism for each waiver's performance to the Department's Leadership.

System Improvements, performance measure progress, and quality improvement strategies are communicated regularly to stakeholder groups including: the Governor's Council on Disabilities and Special Education, the Alaska Commission on Aging, participant advocacy groups such as the Key Campaign, and provider associations such as: the Alaska Association of Developmental Disabilities, as well as through webinars supported by the State's training unit. Additionally, the State also regularly communicates about program changes and issues with quality indicators via its E-Alert system that reaches over 1700 stakeholders.

Quality Improvement Task Committee(s):
Chaired by SDS unit managers, task committees review reports on performance measures and gather information related to the specific quality measures overseen by each committee. Task committee members review data, analyze trends, and make recommendations for individual and system remediation. Task committees bring information forward to the Quality Improvement Workgroup (QIW)

Quality Improvement Workgroup:
The Director or the Director's designee is the chair of the QIW; members include SDS unit managers and the SDS Leadership Team. The QIW reviews task committee data, makes recommendations for systemic remediation, and determines what needs to move forward to the Quality Improvement Steering Committee (QISC)

Quality Improvement Steering Committee:
The Department's Commissioner or designee, currently the Deputy Commissioner for Medicaid and Health Care Policy/State Medicaid Director, chairs the QISC. The Committee reviews data and reports forwarded from the QIW, considers resource requests to meet objectives, and provides guidance and recommendations to SDS Leadership.

Quality Improvement task committees are charged with the discovery and remediation responsibilities associated with established performance measures within SDS's five 1915(c) Medicaid waivers. Data is aggregated separately for each individual waiver. Task committees meet, as needed, to review performance measure data, identify performance deficiencies, implement and report on corrective action on individual cases, and recommend system improvement to QIW. When individual, first level, remediation is identified as needed, the task committee may make recommendations to unit managers to initiate remediation activities. When performance measures fall consistently below 86%, the task committee is responsible for developing a Quality Improvement Plan (QIP) that identifies systemic root causes and implements measures to bring about improvements, review and seek approval of the QIP through the QIW, and track activities until compliance is achieved or develop new strategies if initiated QIPs do not reach intended goals.

Financial Accountability Review: The Financial Accountability Review Task Committee ensures that Medicaid waiver claims for reimbursement are coded and paid in accordance with the waiver reimbursement methodology. Membership includes: manager of the Quality Assurance unit (Chair) and SDS staff from the Consumer Assessment Tool (CAT) Assessment unit (Assessment unit), Consumer Assessment Tool (CAT) Review unit (Review unit), Grants unit, Intellectual and Developmental Disabilities (IDD) unit, Policy and Program Development unit, and representatives from the Department's Program Integrity Office and the Division of Health Care Services.

On a quarterly or as-needed basis, the Financial Accountability Review Committee monitors regulations, policy,

and procedure regarding claims and service utilization. This Committee is also responsible for reviewing Department audit reports and other surveillance reports generated by the Department's Division of Health Care Services (DHCS) to discover deficiencies in provider billing compliance. Under Alaska Statute, waiver service providers are subject to the independent audit statutes. The Committee addresses deficiencies that can be remediated at the SDS level, supports Department-level efforts to recoup overpayments and to sanction providers, as needed, to maintain the financial integrity of the waiver programs and makes recommendations to QIW.

Health and Welfare Review: The Health and Welfare Review Task Committee monitors performance measures related to reports of harm and other critical incidents. Membership includes: manager of the Quality Assurance unit (Chair), manager of the Adult Protective Services unit (Vice-chair), and SDS staff from the Adult Protective Services unit, Central Application Processing unit, Assessment unit, Review unit, Nursing unit, Grants unit, Central Intake unit, IDD unit, and the Policy and Program Development unit.

On a monthly or as-needed basis, this Committee reviews reports of harm, critical incident and complaint reports, discovers deficiencies, and plans and conducts individual and systemic remediation. This Committee is responsible for reporting on individual outcomes for performance measures under certain Health and Welfare assurances, in addition to QIP activities and strategies. The Health and Welfare Task Committee brings issues discovered to QIW.

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 SDS Level of Care (LOC) performance measures. Membership includes: manager of the Assessment unit (Chair), manager of the IDD unit (Vice-chair), and SDS staff from the Review unit, Policy and Program Development unit, Quality Assurance unit, Research and Analysis unit, Central Application Processing unit, Nursing unit, and the SDS Training Coordinator.

On a weekly basis, unit managers responsible for Level of Care activities review status reports, identify deficiencies in performance, and plan and implement remediation activities. On a monthly, or as needed basis, this Committee reviews aggregated monthly, quarterly and annual data, analyzes trends, and makes recommendations for systems improvements to the QIW.

Mortality Review: The Mortality Review Team identifies and reviews all deaths reported throughout the Centralized Reporting system. Membership includes: manager of the Quality Assurance unit (Chair) and SDS staff including a Qualified Intellectual Disability Professional (QIDP), a Registered Nurse (RN), the SDS Mortality Review Coordinator, staff from the Adult Protective Services (APS) unit and representatives from DHCS' Residential Licensing and Certification unit and the Office of Long Term Care Ombudsman. Consultants from the Department's Division of Public Health are available as needed.

On a monthly or as needed basis, this Committee reviews information on participant deaths obtained through the SDS critical incident reporting process, including medical records from the Bureau of Vital Statistics, the State Medical Examiner's office, and law enforcement reports to determine if the death is the result of an action or omission (or inaction) on the part of a waiver 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 reviewed carefully by the Committee and may trigger an investigation. Findings are reported to QIW.

Qualified Provider 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 manager of the Provider Certification and Compliance unit (Chair), SDS staff from the Provider Certification and Compliance unit, General Relief unit, Quality Assurance unit, Policy and Program Development unit, Research and Analysis unit, the Grants unit and the SDS Training Coordinator. On a quarterly or as-needed basis, the committee reviews aggregated data to discover the status of provider compliance with certification standards. The committee plans and implements remediation activities and makes recommendations to QIW.

Support Plan Review: The Support Plan Review Task Committee gathers and reviews data from SDS performance measures to assess whether Support Plans are timely, person-centered, identify personal goals,

address needs identified in the annual assessment, and document choices offered to and selected by the participant. Membership includes: manager of the Review unit (Chair), manager of the IDD unit (Vice-chair), and SDS staff from the Quality Assurance unit, Research and Analysis unit, Nursing unit, Policy and Program Development unit, and the Assessment unit.

On a monthly or as needed basis, this Committee reviews support plan performance measures data. Based upon that review, the Committee identifies and initiates the remediation activities needed to cure deficiencies. The Support Plan Review Committee makes systemic improvement recommendations to QIW.

In addition to the task committees directly responsible for oversight of performance measure analysis and remediation, the SDS QIS includes other types of committees that support quality infrastructure, including: committees for Policy and Procedure, Information Technology, Long Term Care (LTC) and Pre Admission Screening and Resident Review (PASRR), and Long Term Services and Supports Access. These committees meet quarterly, monthly or as needed and report to the QIW.

The Long Term Services and Supports Access Review: This Committee is the entity that regularly reviews and considers access to and availability of long term services and supports for Alaskans in need. These other non-waiver services include state funded grants, state plan services, LTC and Pre-Admission screening, PASRR reviews, and natural supports. The Committee communicates with organizations and agencies that foster information and referrals such as the Aging and Disability Resource Centers, Developmental Disability Resource Connections, and Care Coordinators.

The QIW reviews and analyzes aggregated data collected through activities and reports from all task committees to determine if system changes are necessary to meet performance targets. The QIW drafts the CQI framework and performance measures, reviews findings and first level remediation activities, and determines the need for systemic remediation.

Continued at Main-B: Additional Information Needed (Optional)

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.

The (QISC) provides oversight of the SDS QIS, including continuous quality improvement activities, and reports results to Department Leadership.

While the Commissioner holds ultimate responsibility for quality improvement activities, the Deputy Commissioner for Medicaid and Health Care Policy/State Medicaid Director has been designated by the Commissioner as the individual responsible for overseeing the QISC functions. As the Chair of the QISC, the Deputy Commissioner has the authority to make administrative and programmatic decisions in response to information received by the QISC. The Deputy Commissioner reports findings, outcomes and/or corrective actions to the Commissioner, and, with the QISC, monitors the work of the QIW. The QISC may invite additional Department representatives as necessary to accomplish the QISC's work. 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
- Chief of Developmental Programs, SDS
- Program Integrity Manager, Office of the Commissioner
- Additional SDS or Department staff at the invitation of the Committee.

The QISC meets quarterly and more often if necessary to address concerns of SDS and to review the quarterly reports submitted by the QIW. The quarterly QIW report provides the status of performance measures, remediation efforts, system improvement efforts, and action plans. The QISC reviews these QIW 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.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The QISC is responsible for approving, implementing and monitoring the QIS. The QISC has ultimate responsibility for the proper implementation of SDS policies and procedures affecting the health, safety and welfare of waiver recipients and the provision of quality services to these recipients, through monitoring, recommending, and implementing changes in the QIS. As such, the QISC reviews and approves the development and application of all waiver performance measures, including reviewing data collection processes, to ensure that useful information is gathered that improves the quality of the service delivery system and assures the health, safety and welfare of waiver recipients. The QISC identifies provider needs for training and technical assistance, based upon analysis of QIW data or other available information sources. The QISC ensures that information obtained from analysis of performance measure data is disseminated, as appropriate, to stakeholders and staff. The QISC interfaces with the Department's Audit Committee to participate in implementation of financial accountability monitoring.

Overview of QISC responsibilities:

- Oversee the development and implementation of the QIS including the CQI framework and the work of the Quality Improvement Workgroup (QIW);
- Approve the CQI framework;
- 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 framework;
- Assist with Department-level activities to reduce duplication of effort and to streamline processes;
- Advise the Commissioner on the status of quality improvement measures;
- Evaluate the composition of the QISC; and
- Coordinate efforts and exchange information with external stakeholders.

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 of Health (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. During the Public Health Emergency, on-site audits were changed to desk audits.

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 on-site 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 Unified Program Integrity Contractor (UPIC) audit process. Qlarant is the Western Region UPIC contractor and has already performed audits of home and community-based waiver providers in Alaska. 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 on-site or desk audit, a preliminary detailed audit report is drafted by the contract audit firm. This preliminary report is sent to the Department 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 2 CFR part 200 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 for the federal program requirements. These audits include all of the Department's federal programs. These audits are posted online and via this link: https://legaudit.akleg.gov/

Within 90 days after receiving each audit report conducted under AS 47.05.200, 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.

Alaska Statute 47.05.235, established through Senate Bill 74 now requires all Medicaid providers to conduct a self-audit of a random sample of claims once every two years. This statute was implemented through regulations at 7 AAC 160.115, which was effective in June 2018. The second round of self-audits are due no later than December 31, 2022. All overpayments identified through the self-audit process must be identified and returned to the State in accordance with regulation.

In addition, home and community-based service providers are expected to perform an internal evaluation including client satisfaction surveys, which are reviewed by Senior and Disabilities Services (SDS) Quality Assurance (QA) unit staff and considered when the agency seeks renewal certification.

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. As noted above, during the Public Health Emergency, on-site audits have been suspended and the desk audit process has been used exclusively.

On-site reviews are conducted on those providers where it is believed the on-site 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 means 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.*

Continued at Main-B: Additional Information Needed (Optional)

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:
I.a.l: # and % of claims that are supported by documentation that services were delivered. Numerator:# of claims supported by documentation that services were rendered. Denominator: # of claims reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MMIS and Provider Records

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 =* *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:
I.a.2: # and % of claims that are coded and paid for in accordance with the reimbursement methodology in the approved waiver. Numerator: # of claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. Denominator:# of paid claims reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MMIS

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 =* *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:
I.b.3: # and % of rates that are consistent with the approved rate methodology in the five year waiver cycle. Numerator: # of rates consistent with the approved rate methodology. Denominator: # of rates reviewed during the reporting period.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MMIS

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 =* *95%, +/- 5% and 50% distribution*
☐ ***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***
	☐ ***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):*

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.*

SDS employs the use of quality improvement task committees, the SDS Quality Improvement Workgroup (QIW), and the Department of Health's Quality Improvement Steering Committee (QISC) to discover and identify problems and/or issues within the waiver program.

Quality Improvement Task Committees:

Quality Improvement task committees are charged with the discovery and remediation responsibilities associated with established performance measures within the SDS's five 1915(c) Medicaid waivers. Data is aggregated separately for each individual waiver. Task committees meet, as needed, to review performance measure data, identify performance deficiencies, implement and report on corrective action on individual cases, and recommend system improvement to QIW. When individual first-level remediation is identified as needed, the task committee may make recommendations to unit managers to initiate remediation activities. When performance measures fall consistently below 86%, the task committee is responsible for: 1.) developing a Quality Improvement Plan (QIP) that identifies systemic root causes and implements measures to bring about improvements; 2.) reviewing and seeking approval of the QIP through the QIW; and 3.) and tracking activities until compliance is achieved or develop new strategies if initiated QIPs do not reach intended goals.

Financial Accountability Review Task Committee:

The Financial Accountability Review Task Committee ensures that Medicaid waiver claims for reimbursement are coded and paid in accordance with the waiver reimbursement methodology. Membership includes: manager of the Quality Assurance unit (Chair) and SDS staff from the Consumer Assessment Tool (CAT) Assessment unit (Assessment unit), Consumer Assessment Tool (CAT) Review unit (Review unit), Grants unit, Intellectual and Developmental Disabilities (IDD) unit, Policy and Program Development unit, and representatives from the Department's Program Integrity Office and the Division of Health Care Services.

On a quarterly or as-needed basis, the Financial Accountability Review Task Committee monitors regulations, policy, and procedure regarding claims and service utilization. This Committee is also responsible for reviewing Department audit reports and other surveillance reports generated by the Department's Division of Health Care Services (DHCS) to discover deficiencies in provider billing compliance. Under Alaska Statute, waiver service providers are subject to the independent audit statutes. The Committee addresses deficiencies that can be remediated at the SDS level, supports Department-level efforts to recoup overpayments and to sanction providers, as needed, to maintain the financial integrity of the waiver programs and makes recommendations to QIW.

Quality Improvement Workgroup:

The Director or the Director's designee is the chair of the QIW; members include SDS unit managers and the SDS Leadership Team. The QIW reviews task committee data, makes recommendations for systemic remediation, and determines what needs to move forward to the Quality Improvement Steering Committee (QISC)

Quality Improvement Steering Committee:

The Department's Commissioner or designee, currently the Medicaid and Health Care Policy/State Medicaid Director, chairs the QISC. The Committee reviews data and reports forwarded from the QIW, considers resource requests to meet objectives, and provides guidance and recommendations to SDS Leadership.

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 Review Task Committee is responsible for bringing the issue to the Committee, initiating remediation activities with program and quality assurance managers, and monitoring the issue through resolution.

If discovery activities originate with DHCS, which oversees the Surveillance and Utilization Review System, 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 Review Task Committee Chair for ongoing monitoring.

If the data reveals a possible overpayment, it is referred to the Chair of the Financial Accountability Review Task Committee for review. For provider billing issues such as automatic rebilling, the issue is referred to the 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 Department's 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's Office of Rate Review 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 works very closely with the public to design the rate methods.
Prior to formal initiation of the regulatory process and, as part of the rebasing effort, public meetings may be held to solicit public, participant, and provider input. These meetings are noticed through the Alaska Online Public Notice System. The Department may issue notice through the Department's E-Alert system, post pertinent rate charts and regulation information on the Department's website, organize work sessions, present webinars, and convene public hearings.

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. The Commissioner of the Department determines through regulation when an inflation adjustment cannot be made in a specific fiscal year.

Reimbursement rates for Day Habilitation, Employment Services, Respite, Intensive Active Treatment, and Meals, are set using provider cost reports, audited financial statements, and post audit working trial balances. 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].

The methodology to set care coordination rates establish 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 Coordinators presumes a case load of 40 participants.

The methodology to set transportation rates establish wages, fringe benefits, administrative and general costs and mileage rates using public sources such as Alaska Bureau of Labor Statistics, Internal Revenue Services, and other States' approved 1915(c) waivers.

Appendix J reflects rate rebasing. The Department uses 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 are 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 assistant 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 assistant 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. Additionally, the methodology, instructions, and Excel version of the Cost Report along with additional information such as current and historical rates, hold harmless providers and rates, FAQs, contact information for additional info, regulations, templates, training video, and the annual target lists can be found at: https://health.alaska.gov/dsds/Pages/info/costsurvey.aspx

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.***

☒ ***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.***
- ○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver 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.

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:*

Room and board costs are isolated from waiver costs by calculating and accounting for them separately. The State pays only for the waiver service component of the participant's care.

In per diem respite, where room and board is an allowable expense, the licensed facility receives room and board as part of the daily unit cost.

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	11568.54	12905.62	24474.16	373147.17	9885.01	383032.18	358558.02
2	12018.63	13408.94	25427.57	393670.26	10270.52	403940.78	378513.21
3	12487.36	13931.88	26419.24	415322.13	10671.07	425993.20	399573.96
4	12972.88	14475.23	27448.11	438164.85	11087.24	449252.09	421803.98
5	13478.11	15039.76	28517.87	462263.91	11519.64	473783.55	445265.68

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
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.*

During the most recent year of actual data, FY21, this waiver was still in the initial phase-in schedule and the Average Length of Stay was 69 days.

For this waiver cycle, the State estimates that the Average Length of Stay will be 342 days for Waiver Year 1 (WY1) through WY5. This Average Length of Stay estimate is based on FY21 actual data from the other waiver (AK.0260) serving the same target 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 Factor D, average cost of waiver services, the State used the rebased rates, effective July 1, 2023, in WY1 (FY24) . The State then applied a 3.9% inflation rate increase to those waiver service rates for each subsequent waiver year, WY2 - WY5 (FY25 - FY28).

In general, Factor D assumes that payment rates for waiver services will receive annual inflation adjustments; the Commissioner of the Department of Health determines through regulation when an inflation adjustment cannot be made in a specific fiscal year.

Inflation Rate Source:

The State calculated the 3.9% inflation rate using three years of data in the CMS Home Health Agency Market Basket contained in the most recent IHS Global Insights' Healthcare Cost Review (Q3:2022). The inflation rates for each year are: 5.5%, 3.5%, and 2.8% for the midpoint-to-midpoint inflation value for SFY23, SFY24, and SFY25.

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:*

For Factor D', average cost of Medicaid non-waiver services for waiver recipients, the State calculated WY1 (FY24) by starting with WY3 (FY21) actual Medicaid claims data for this population, and applied a 2.4% inflation rate to account for projected inflation increases in WY4 (FY22) and again in WY5 (FY23). The State then applied a 3.9% inflation rate increase to the total cost of Medicaid non-waiver services for this population for each waiver year in the five-year waiver cycle, WY1 – WY5 (FY24-FY28).

In general, Factor D' assumes that payment rates for Medicaid non-waiver services will receive annual inflation adjustments; the Commissioner of the Department of Health determines through regulation when an inflation adjustment cannot be made in a specific fiscal year.

Prescribed Drugs: The State's query for the Factor D' calculation was designed to exclude the costs of prescribed drugs, resulting in only Medicaid non-waiver claims being utilized in Factor D' calculation estimates.

Inflation Rate Source:

The Factor D' waiver inflation rate of 2.4% was used in the initial ISW waiver cycle for FY2019 – FY2023. The State calculated the 2.4% inflation rate using three years of data in the CMS Home Health Agency Market Basket contained in the Global Insights' Healthcare Cost Review (Q2:2017) for the quarters 2016:1 through 2019:4 on pages 56-57/95.

The State calculated the 3.9% inflation rate using three years of data in the CMS Home Health Agency Market Basket contained in the most recent IHS Global Insights' Healthcare Cost Review (Q3: 2022). The inflation rates for each year are: 5.5%, 3.5%, and 2.8% for the midpoint-to-midpoint inflation value for SFY23, SFY24, and SFY25.

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:*

In FY19, the State of Alaska Office of Rate Review developed a rate model that incorporated estimated capital and operating costs that would be included in an Alaska-based ICF/IID, if such a facility existed. The estimated daily rate was $871.07. SDS used this model along with estimated service needs to create the Factor G estimates for average institutional costs for this comparable population in the previous waiver cycle.

In this waiver cycle, for Factor G, average ICF/IID facility costs estimates, the State applied a 5.5% inflation rate to previous waiver cycle's WY5 (FY23) estimate to achieve WY1 (FY24) total cost estimate. The State then applied the 5.5% inflation rate increase to each subsequent waiver year, WY2-WY5 (FY25-FY28).

In general, Factor G assumes that payment rates for Medicaid ICF/IID facilities will receive annual inflation adjustments; the Commissioner of the Department of Health determines through regulation when an inflation adjustment cannot be made in a specific fiscal year.

Inflation Rate Source:

The State calculated the 5.5% inflation rate for the next five-year waiver cycle (WY1—WY5) using out of state ICF/IID facility average inflation rates for the three-year period SFY21-SFY23

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:*

For Factor G', average other Medicaid costs for the comparable population who received institutional care, the State calculated WY1 (FY24) by starting with WY3 (FY21) actual Medicaid claims data for this population, and applied a 2.4% inflation rate to account for projected inflation increases in WY4 (FY22) and again in WY5 (FY23). The State then applied a 3.9% inflation rate increase to the total cost for each waiver year in the five-year waiver cycle, WY1– WY5 (FY24- FY28).

In general, Factor G' assumes that payment rates for Medicaid non-waiver services for the comparable population who receive institutional care will receive annual inflation adjustments; the Commissioner of the Department of Health determines through regulation when an inflation adjustment cannot be made in a specific fiscal year.

Inflation Rate Source:

The Factor G' waiver inflation rate of 2.4% was used in the initial ISW waiver cycle for FY2019 – FY2023. The State calculated the 2.4% inflation rate using three years of data in the CMS Home Health Agency Market Basket contained in the Global Insights' Healthcare Cost Review (Q2:2017) for the quarters 2016:1 through 2019:4 on pages 56-57/95.

The State calculated the 3.9% inflation rate using three years of data in the CMS Home Health Agency Market Basket contained in the most recent IHS Global Insights' Healthcare Cost Review (Q3: 2022). The inflation rates for each year are: 5.5%, 3.5%, and 2.8% for the midpoint-to-midpoint inflation value for SFY23, SFY24, and SFY25.

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	
Employment Services	
Residential Habilitation	
Respite	
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:						**2671920.00**
Care Coordination	1 month	600	12.00	371.10	**2671920.00**	
Day Habilitation Total:						**2478075.00**
Group Day Habilitation	15 minutes	60	555.00	9.75	**324675.00**	
Individual Day Habilitation	15 minutes	300	485.00	14.80	**2153400.00**	
Employment Services Total:						**141932.40**
Group Supported Employment	15 minutes	6	850.00	11.02	**56202.00**	
Individual Supported Employment	15 minutes	12	420.00	17.01	**85730.40**	
Residential Habilitation Total:						**597456.00**
Residential Habilitation	15 minutes	120	360.00	13.83	**597456.00**	
Respite Total:						**1239258.60**
Daily Respite	Daily	30	10.00	420.33	**126099.00**	
Respite	15 minutes	168	815.00	8.13	**1113159.60**	
Intensive Active Treatment Total:						**2135.00**
Intensive Active Treatment	15 minutes	1	70.00	30.50	**2135.00**	
Transportation Total:						**41718.36**
Transportation-more than 20 miles	Per trip	6	54.00	42.39	**13734.36**	
Transportation-less than 20 miles	Per trip	12	110.00	21.20	**27984.00**	

GRAND TOTAL:	**7172495.36**
Total Estimated Unduplicated Participants:	**620**
Factor D (Divide total by number of participants):	**11568.54**
Average Length of Stay on the Waiver:	342

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:						**2776104.00**
Care Coordination	1 month	600	12.00	385.57	**2776104.00**	
Day Habilitation Total:						**2573664.00**
Group Day Habilitation	15 minutes	60	555.00	10.13	**337329.00**	
Individual Day Habilitation	15 minutes	300	485.00	15.37	**2236335.00**	
Employment Services Total:						**147451.80**
Group Supported Employment	15 minutes	6	850.00	11.45	**58395.00**	
Individual Supported Employment	15 minutes	12	420.00	17.67	**89056.80**	
Residential Habilitation Total:						**620784.00**
Residential Habilitation	15 minutes	120	360.00	14.37	**620784.00**	
Respite Total:						**1287990.00**
Daily Respite	Daily	30	10.00	436.72	**131016.00**	
Respite	15 minutes	168	815.00	8.45	**1156974.00**	
Intensive Active Treatment Total:						**2218.30**
Intensive Active Treatment	15 minutes	1	70.00	31.69	**2218.30**	
Transportation Total:						**43338.60**
Transportation-more than 20 miles	Per trip	6	54.00	44.05	**14272.20**	
Transportation-less than 20 miles	Per trip	12	110.00	22.02	**29066.40**	

GRAND TOTAL:	**7451550.70**
Total Estimated Unduplicated Participants:	**620**
Factor D (Divide total by number of participants):	**12018.63**
Average Length of Stay on the Waiver:	342

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:						**2884392.00**
Care Coordination	1 month	600	12.00	400.61	**2884392.00**	
Day Habilitation Total:						**2673951.00**
Group Day Habilitation	15 minutes	60	555.00	10.52	**350316.00**	
Individual Day Habilitation	15 minutes	300	485.00	15.97	**2323635.00**	
Employment Services Total:						**153224.40**
Group Supported Employment	15 minutes	6	850.00	11.90	**60690.00**	
Individual Supported Employment	15 minutes	12	420.00	18.36	**92534.40**	
Residential Habilitation Total:						**644976.00**
Residential Habilitation	15 minutes	120	360.00	14.93	**644976.00**	
Respite Total:						**1338285.60**
Daily Respite	Daily	30	10.00	453.76	**136128.00**	
Respite	15 minutes	168	815.00	8.78	**1202157.60**	
Intensive Active Treatment Total:						**2305.10**
Intensive Active Treatment	15 minutes	1	70.00	32.93	**2305.10**	
Transportation Total:						**45031.08**
Transportation-more than 20 miles	Per trip	6	54.00	45.77	**14829.48**	
Transportation-less than 20 miles	Per trip	12	110.00	22.88	**30201.60**	

GRAND TOTAL:	**7742165.18**
Total Estimated Unduplicated Participants:	**620**
Factor D (Divide total by number of participants):	**12487.36**
Average Length of Stay on the Waiver:	342

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:						**2996856.00**
Care Coordination	1 month	600	12.00	416.23	**2996856.00**	
Day Habilitation Total:						**2777814.00**
Group Day Habilitation	15 minutes	60	555.00	10.93	**363969.00**	
Individual Day Habilitation	15 minutes	300	485.00	16.59	**2413845.00**	
Employment Services Total:						**159148.80**
Group Supported Employment	15 minutes	6	850.00	12.36	**63036.00**	
Individual Supported Employment	15 minutes	12	420.00	19.07	**96112.80**	
Residential Habilitation Total:						**670032.00**
Residential Habilitation	15 minutes	120	360.00	15.51	**670032.00**	
Respite Total:						**1390145.40**
Daily Respite	Daily	30	10.00	471.45	**141435.00**	
Respite	15 minutes	168	815.00	9.12	**1248710.40**	
Intensive Active Treatment Total:						**2394.70**
Intensive Active Treatment	15 minutes	1	70.00	34.21	**2394.70**	
Transportation Total:						**46795.80**
Transportation-more than 20 miles	Per trip	6	54.00	47.55	**15406.20**	
Transportation-less than 20 miles	Per trip	12	110.00	23.78	**31389.60**	

GRAND TOTAL:	**8043186.70**
Total Estimated Unduplicated Participants:	**620**
Factor D (Divide total by number of participants):	**12972.88**
Average Length of Stay on the Waiver:	342

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:						**3113712.00**
Care Coordination	1 month	600	12.00	432.46	**3113712.00**	
Day Habilitation Total:						**2886708.00**
Group Day Habilitation	15 minutes	60	555.00	11.36	**378288.00**	
Individual Day Habilitation	15 minutes	300	485.00	17.24	**2508420.00**	
Employment Services Total:						**165376.80**
Group Supported Employment	15 minutes	6	850.00	12.84	**65484.00**	
Individual Supported Employment	15 minutes	12	420.00	19.82	**99892.80**	
Residential Habilitation Total:						**695952.00**
Residential Habilitation	15 minutes	120	360.00	16.11	**695952.00**	
Respite Total:						**1443584.40**
Daily Respite	Daily	30	10.00	489.84	**146952.00**	
Respite	15 minutes	168	815.00	9.47	**1296632.40**	
Intensive Active Treatment Total:						**2488.50**
Intensive Active Treatment	15 minutes	1	70.00	35.55	**2488.50**	
Transportation Total:						**48609.60**
Transportation-more than 20 miles	Per trip	6	54.00	49.40	**16005.60**	
Transportation-less than 20 miles	Per trip	12	110.00	24.70	**32604.00**	

GRAND TOTAL:	**8356431.30**
Total Estimated Unduplicated Participants:	**620**
Factor D (Divide total by number of participants):	**13478.11**
Average Length of Stay on the Waiver:	342