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 section 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 waiver's 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)*

05/01/27

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:

Throughout this waiver amendment, the state has updated language to reflect the current regulatory requirements. Additionally, the state has reorganized and re-written this waiver to mirror the language in the state's other approved waivers and to make it easier for stakeholders to read, find, and understand the contents of the waiver. The state's processes have stayed the same, aside from the Purpose of the Amendment changes listed below.

Main
- Added transition plan for moving from the Inventory for Client and Agency Planning (ICAP) assessment tool to the Developmental Disability Assessment Tool for Children (DDAT-C) and the Developmental Disability Assessment Tool (DDAT).

Appendix A
- Updated and reorganized language.

Appendix B
- Updated and reorganized language;
- Updated safeguard language to align with current practice;
- Updated selection of entrants to the waiver language to align with current practice;
- Updated eligibility groups served to align with current practice;
- Revise language to clarify level of care terminology;
- Described the state's process to transition from the Inventory from the Inventory for Client and Agency Planning (ICAP) to the Developmental Disability Assessment Tool for Children (DDAT-C) and the Developmental Disability Assessment Tool (DDAT); and
- Specified the qualifications of individuals who perform reassessments.

Appendix C
- Updated and reorganized service definitions and provider specifications language to reflect current regulatory requirements and to mirror the language in the state's other approved waivers;
- Changed Adult Host Home to match statutory name: Host Home Care Service;
- Added Host Care Home license as a type of Respite service provider;
- Clarified remote/telehealth delivery of waiver services language to align with current practice;
- Clarified which services can be provided by a legally responsible individual or relative; and
- Specified the state's option to provide services in acute care hospitals to align with current practice.

Appendix D
- Updated and reorganized language; and
- Updated safeguard language to align with current practice.

Appendix F
- Updated and reorganized language;
- Updated language to align with the Office of Administrative Hearings' processes; and
- Updated grievance policy to comply with Federal Access Rule.

Appendix G
- Updated and reorganized language;
- Changed the name of "behavioral support plan" to "restrictive intervention plan" to allow for inclusion of modifications to the settings rule; and
- Added information for medication management in licensed foster homes.

Appendix H
- Updated and reorganized language; and
- Added additional task committees listed.

Appendix I
- Updated and reorganized language;
- Updated to include all audits performed by the state; and
- Updated care coordination rate setting methodology align with current practice and to mirror the language in the state's other approved waivers.

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**	A.1.b, B
☑ **Appendix A - Waiver Administration and Operation**	2.a
☑ **Appendix B - Participant Access and Eligibility**	2.c, 3.f, 4.b, 6.c,d,f,h,i,j, 7.a,b, 8, QI.a-ii, QI.b-i
☑ **Appendix C - Participant Services**	C-1/C-3, 1.c,d, 2.a, 2.e,f,g 5.1,2,3, QI.ai-ii, QI.b-i
☑ **Appendix D - Participant Centered Service Planning and Delivery**	1.b,d,d-i, d-ii, e, f,g,i 2.a,b QI-a-ii, QI.b-i
☐ **Appendix E - Participant Direction of Services**	
☑ **Appendix F - Participant Rights**	1, 2.b, 3.b,c
☑ **Appendix G - Participant Safeguards**	1.b,c,d,e 2.a,b,c 3.b,c QI.a-ii, QI.b-i
☑ **Appendix H**	1.a-i, 1.b-i, 1.b-ii
☑ **Appendix I - Financial Accountability**	1, 2.a,b,d, 5.b, QI.a-ii, QI.b-i
☐ **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:

Transition to new assessment tools.

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 section 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.007.01.06**

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: July 31, 2027). The time required to complete this information collection is estimated to average 163 hours per response for a new waiver application and 78 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 in 42 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 section 1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under section 1915(b) of the Act.**
Specify the section 1915(b) waiver program and indicate whether a section 1915(b) waiver application has been submitted or previously approved:

Specify the section 1915(b) authorities under which this program operates *(check each that applies):*

☐ **section 1915(b)(1) (mandated enrollment to managed care)**

☐ **section 1915(b)(2) (central broker)**

☐ **section 1915(b)(3) (employ cost savings to furnish additional services)**

☐ **section 1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under section 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 section 1915(i) of the Act.**

☐ **A program authorized under section 1915(j) of the Act.**

☐ **A program authorized under section 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 section 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 section 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 section 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 section 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 section 1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR Part 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. 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 Part 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:

To be completed after public comment 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: P.O. Box 110680

Address 2: none

City: Juneau

State: **Alaska**

Zip: 99811

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: P.O. Box 110680

Address 2: none

City: Juneau

State: **Alaska**

Zip: 99811

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 section 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: Ricci

First Name: Emily

Title: Deputy Commissioner

Agency: Department of Health

Address: 3601 C Street

Address 2: Suite 902

City: Anchorage

State: **Alaska**

Zip: 99503

Phone: (907) 269-7800 **Ext:** ☐ **TTY**

Fax: (907) 465-1190

E-mail: emily.ricci@alaska.gov

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:

SDS will start the process of transitioning from the Inventory for Client and Agency Planning (ICAP) to the Developmental Disability Assessment Tool for Children and the Developmental Disability Assessment Tool. Both tools are standardized and validated by interRAI and are customized to align with the federal definition of developmental disability under 42 USC § 15002(8)(A) and AS 47.80.900(6). The transition does not apply to any initial applicants or enrolled participants under three years of age.

The Comprehensive File Review, the Developmental Disability Assessment Tool for Children and the Developmental Disability Assessment Tool will be the primary tools used to assess eligibility and to determine Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) level of care. SDS will administer these tools to assess initial waiver applicants' level of care and reassess enrolled waiver participants' level of care.

ASSESSMENT TOOLS
- Individuals up to three years of age: Comprehensive File Review (current practice, no transition applies);
- Individuals three years of age up to four years of age: Comprehensive File Review;
- Individuals four years of age up to 18 years of age: Developmental Disability Assessment Tool for Children (DDAT-C);
- Individuals 18 years of age and older: Developmental Disability Assessment Tool (DDAT).

To ensure there is no disruption for an enrolled waiver participant's eligibility during the transition period, due to the implementation of the new assessment tool, SDS will utilize a dual assessment approach. Any enrolled participant who is three years of age and older and found ineligible will be reassessed using the legacy tool, the ICAP. If the ICAP finds the participant eligible, SDS will sustain the eligibility of the participant for that level of care evaluation year. Alternatively, if the participant is found ineligible with the ICAP, appeal rights apply in accordance with Appendix F and the state's Fair Hearing regulations.

The transition period is estimated to last approximately one year, until every initial applicant and enrolled waiver participant ages four and older has been assessed with either the DDAT-C or the DDAT at least once.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Continued from Appendix C-3 "Provider Specifications for Services"

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 130.220);
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 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. The department's oversight methods of SDS span the full range of operational and administrative responsibilities

The department is the Single State Medicaid 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 are:

1.) accessible in a timely manner, and
2.) 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 commissioner's designee, performs oversight of these activities 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 SDS' 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 the QIW reports, evaluates the results, approves the actions of the QIW, or makes recommendations for augmenting remediation or system improvement efforts, 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 participants and the provision of quality services to participants through monitoring, recommending, and implementing changes in the QIS.

The QISC reviews and approves the development and application of all waiver performance measures, including reviewing data collection processes to ensure that the data gathered is useful and improves the quality of the service delivery system while assuring the health, safety and welfare of waiver participants.

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:
As indicated in sections 3 and 4 of this appendix, no non-Medicaid or non-State agency performs waiver administration. Thus this section does not need to be completed.

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:
As indicated in sections 3 and 4 of this appendix, no non-Medicaid or non-State agency performs waiver administration. Thus this section does not need to be completed.

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.* Note: Medicaid eligibility determinations can only be performed by the State Medicaid Agency (SMA) or a government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care evaluation, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care evaluation tool. States should ensure that any use of an evaluation tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

Function	Medicaid Agency
Participant waiver enrollment	☑
Waiver enrollment managed against approved limits	☑
Waiver expenditures managed against approved levels	☑
Level of care waiver eligibility 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 state's quality improvement strategy, provide information in the following fields to detail the state's 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 scheduled Quality Improvement Steering Committee (QISC) meetings held between the Office of the Commissioner of the Department of Health and the Division of Senior and Disabilities Services (SDS), within the Single State Medicaid Agency. Numerator: # of scheduled QISC meetings held. Denominator: Total # of scheduled QISC meetings.

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

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:

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.

The Department of Health and SDS will reschedule the QISC meetings.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

The quarterly QISC meetings are the State Medicaid Agency's opportunity to exercise oversight over SDS' performance of waiver functions. QISC minutes are distributed to the committee members and include reference to remediation activities, if any.

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**	☐ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
Specify: n/a	
	☐ **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 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 Sub Group	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		☑

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☑	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, based on a review of the assessment or the support plan, the department determines that the expected cost of the services that the enrolled participant requires exceeds this waiver's cost limit, the department will not authorize the participant's continued enrollment on this waiver and will refer the participant 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:

The state has established policies governing the selection of individuals for entrance to the waiver based on objective criteria and is in compliance with the requirement that otherwise eligible individuals have comparable access to all services offered on the waiver.

To be considered for the ISW waiver, applicants must:

- be determined to meet the definition of a person with a developmental disability as defined in AS 47.80.900(6);
- request placement on the Developmental Disabilities Registration and Review ISW (DDRR-ISW) waitlist;
- meet ICF/IID level of care; and
- be in accordance with the certification of a qualifying diagnosis and have submitted documents that support the diagnosis as described in 7 AAC 130.206(d)-(e), Waiver options for the recipient category of individuals with intellectual and developmental disabilities

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, a 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, depending on the applicants age, a Comprehensive File Review, the Developmental Disability Assessment Tool for Children (DDAT-C) or the Developmental Disability Assessment Tool (DDAT) 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)*:

- ○ **Section 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)

- ☑ **Parents and Other Caretaker Relatives (42 CFR § 435.110)**
- ☑ **Pregnant Women (42 CFR § 435.116)**
- ☑ **Infants and Children under Age 19 (42 CFR § 435.118)**
- ☑ **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 section 1902(a)(10)(A)(ii)(XIII)) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in section 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 section 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 section 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
§435.218 Individuals with MAGI-based income above 133 percent FPL
§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, 2027 (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 section 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 section 1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or section 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 period after September 30, 2027 (or other date as required by law).

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law) (select one).

● **Spousal impoverishment rules under section 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 section 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 (Section 1634 State/SSI Criteria 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 section 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 period after September 30, 2027 (or other date as required by law).

b. Regular Post-Eligibility Treatment of Income: Section 1634 State and SSI Criteria State after September 30, 2027 (or other date as required by law).

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 section 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 period after September 30, 2027 (or other date as required by law).

c. Regular Post-Eligibility Treatment of Income: 209(b) State or after September 30, 2027 (or other date as required by law).

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 period after September 30, 2027 (or other date as required by law).

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules after September 30, 2027 (or other date as required by law)

The state uses the post-eligibility rules of section 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 section 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 or 42 CFR § 435.735:

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 period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

e. Regular Post-Eligibility Treatment of Income: Section 1634 State or SSI Criteria State - January 1, 2014 through September 30, 2027 (or other date as required by law).

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 period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

f. Regular Post-Eligibility Treatment of Income: 209(b) State - January 1, 2014 through September 30, 2027 (or other date as required by law).

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 period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - January 1, 2014 through September 30, 2027 (or other date as required by law).

The state uses the post-eligibility rules of section 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.

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 an entity 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 to determine level of care are 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.

The Division of Senior and Disabilities Services (SDS) is in the process of transitioning from the Inventory for Client and Agency Planning (ICAP) to the Developmental Disability Assessment Tool for Children (DDAT-C) and the Developmental Disability Assessment Tool (DDAT). Both tools are standardized and validated tools by interRAI, as noted in Attachment #1 Transition Plan.

The state's level of care criteria is consistent with 42 CFR § 435.1009, persons with ID or related conditions. The level of care evaluation tool is functional and does not limit participation to individuals with certain conditions.

To be eligible for or to remain enrolled on this waiver, applicants and enrolled waiver participants must meet Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) level of care. In determining if an applicant meets level of care for an ICF/IID, the applicant must first meet the definition of a person with a developmental disability as defined in AS 47.80.900(6) and be drawn from the Developmental Disabilities Registration and Review ISW (DDRR-ISW) waitlist, before SDS starts the level of care determination process.

Once an applicant has been drawn from DDRR-ISW waitlist and offered the opportunity to pursue enrollment onto this waiver, the initial ICF/IID level of care process begins. SDS conducts a review of the complete application submitted by a care coordinator, which includes current diagnostic, medical, developmental, and functional evaluations and other records. SDS reviews relevant diagnostic documentation to ensure that the individual has a qualifying diagnosis in accordance with 7 AAC 130.206(d)-(e), Waiver options for the recipient category of individuals with intellectual and developmental disabilities.

An assessor administers the DDAT-C, the DDAT, a Comprehensive File Review (CFR), or an Interim Level of Care Review, to determine if the initial waiver applicant meets or the enrolled waiver participant continues to meet ICF/IID level of care in accordance with 7 AAC 130.213, Assessment and interim level-of-care-review and 7 AAC 130.215, Level-of-care determination.

SDS annually verifies that enrolled waiver participants continue to meet the level of care for an ICF/IID.

TOOLS USED TO ASSESS LEVEL OF CARE

DEVELOPMENTAL DISABILITY ASSESSMENT TOOL FOR CHLDREN (DDAT-C)

SDS administers the DDAT-C for initial applicants and enrolled participants between the ages of four and up to 18 years of age. It assesses overall functioning, including health, behavior, cognition, environment, relationships, strengths, risks, and needs across medical, psychological, social, and daily living domains.

DEVELOPMENTAL DISABILITY ASSESSMENT TOOL (DDAT)

SDS administers the DDAT for initial applicants and enrolled participants 18 years of age and older. It assesses overall functioning, including health, behavior, cognition, environment, relationships, strengths, risks, and needs across medical, psychological, social, and daily living domains.

COMPREHENSIVE FILE REVIEW (CFR)

SDS uses the CFR for initial applicants and enrolled waiver participants under four years of age. It 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 the applicant's or participant's skills attainment to that of peers in the following developmental areas or their equivalents: self-care, language, learning, mobility, and self-direction.

SDS also uses the CFR for enrolled waiver participants four years of age and older and for whom the SDS assessor has established that the participant's level of care is unchanging due to the participant's condition remaining stable over multiple successive years. However, during the transition period, SDS will not use the Comprehensive File Review process to reassess level of care for enrolled waiver participants ages four years of age or older.

INTERIM LEVEL OF CARE REVIEW

During the transition period, SDS will not use the Interim Level of Care Review process to reassess level of care for enrolled waiver participants.

SDS uses the Interim Level of Care Review for enrolled waiver participants seven years of age or older. An assessor administers a level of care assessment every third year. In the two years between assessments, participants over the age of seven receive an Interim Level of Care Review assessment accompanied by an updated qualifying diagnosis certificate. The Interim Level of Care Review must include a review of the most recent assessment results as well as documents contained in the renewal application, including an updated qualifying diagnosis certification and confirmation of the stability of the participant's condition.

An assessor may administer a level of care assessment if the participant's Interim Level of Care Review or their Comprehensive File Review indicates a material change in condition has occurred. An assessment may be administered any time, at SDS' discretion.

INVENTORY FOR COMMUNITY AND AGENCY PLANNING (ICAP)

SDS administers the ICAP for applicants and enrolled waiver participants three years of age and older. It 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 the applicant's Broad Independence score. In order to meet ICF/IID level of care, the applicant's Broad Independence score must fall below the Broad Independence cut off score associated with the applicant's or enrolled waiver participant's age.

Following the end of the transition period, the department will no longer use the ICAP to determine level of care.

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 Division of Senior and Disabilities Services (SDS) is in the process of transitioning from the Inventory for Client and Agency Planning (ICAP) to the Developmental Disability Assessment Tool for Children (DDAT-C) and the Developmental Disability Assessment Tool (DDAT). Both tools are standardized and validated tools by interRAI, as noted in Attachment #1 Transition Plan.

SDS conducts the initial level of care assessments and reassessments in accordance with 7 AAC 130.213, Assessment and interim level-of-care-review and 7 AAC 130.215, Level-of-care determination.

INITIAL LEVEL OF CARE ASSESSMENTS FOR WAIVER APPLICANTS

Depending upon the age of the initial applicant, SDS uses the Comprehensive File Review, the DDAT-C, or the DDAT.

ANNUAL LEVEL OF CARE REASSESSMENTS FOR ENROLLED WAIVER PARTICIPANTS

Depending upon the age of the enrolled waiver participant, SDS uses the Comprehensive File Review, Level of Care Review, the DDAT-C, or the DDAT.

SDS may administer the DDAT-C or the DDAT if a participant's Interim Level of Care Review or the Comprehensive File Review indicates a material change in condition has occurred or at the discretion of SDS.

During the transition period, SDS will not use the Interim Level of Care Review. Additionally, SDS will not use the Comprehensive File Review process for enrolled waiver participants four years of age and older.

MATERIAL IMPROVEMENT

When a participant's reassessment reveals a material change in condition, AS 47.07.045(b) requires a finding of "material improvement" before SDS may terminate waiver services. The state uses the Material Improvement Review Process (MIRP) to fully assess and confirm that a participant is no longer eligible for waiver services in accordance with 7 AAC 130.219, Enrollment in home and community-based waiver services; disenrollment.

FAILURE TO MEET LEVEL OF CARE REQUIREMENT

If an applicant or participant is denied eligibility for and enrollment in the waiver they are provided with the opportunity for a Fair Hearing, as further specified in Appendix F.

To ensure there is no disruption in an enrolled waiver participant's eligibility during the transition period, SDS will utilize a dual assessment approach. Any enrolled waiver participant ages three years of age and older found ineligible using the Comprehensive File Review, the DDAT-C, or the DDAT will be reassessed using the legacy tool, the ICAP. If the ICAP finds the participant eligible, SDS will sustain the eligibility of the participant for that level of care evaluation year. Alternatively, if the participant is found ineligible with the ICAP, appeal rights apply in accordance with Appendix F and the state's Fair Hearing regulations.

ASSESSMENT AND REASSESSMENT MODALITY

SDS may conduct level of care initial assessments and reassessments in-person or by teleassessment, as defined in 7 AAC 130.319 (21).

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:

SDS ensures that the qualifications of the individuals who perform reassessments are appropriate for the target group specified in this waiver.

The individual performing reassessments may be a QIDP or may be a SDS staff member who possesses any combination of education and/or experience that provides 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

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):*

SDS requires annual reassessments as described in B.6.f. Unit managers monitor annual reassessment timelines by reviewing Harmony database system reports. MIRPs must be reviewed by the contractor within five business days from the date it is received from SDS.

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 may include a notice of possible closure. If renewal applications are not received, SDS sends a closure notice to the care coordinator and the participant 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 assessments and reassessment in the participant's electronic record in 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 state's quality improvement strategy, provide information in the following fields to detail the state's 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.i: # 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**
☐ **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):*

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** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	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 or issues within the waiver program. The task committee that oversees quality improvement for this appendix is the Level of Care Review Task Committee.

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 performance measures. Membership includes: Assessment unit manager (chair), IDD unit manager (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 Training unit.

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 basis, or as needed, this committee reviews aggregated monthly, quarterly, and annual data, analyzes trends, and makes recommendations for systemic improvements to the QIW and may rise to the QISC, as described in Appendix H.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information

regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

SDS unit managers are responsible for discovering individual problems.

SDS identifies individual problems and systemic deficiencies by reviewing reports submitted to SDS' Centralized Reporting system and any subsequent investigation and Harmony database generated reports.

When discovery activities reveal problems, the unit managers analyze the data to discover if the problem involves individual performance issues or systemic level of care determination processes problems.

If discovery points to issues with an individual assessor's performance, remediation activities may be: meeting with staff, prescribe additional training, or using the department's prescribed progressive discipline process.

If discovery points towards systemic issues, these are addressed and analyzed at the Level of Care Review Task Committee which develops remediation recommendations and those are presented to the QIW. Systemic remediation activities may be: updated forms, Harmony database reports, procedures, or regulatory changes.

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 or participant's legal representative, if applicable, along with the participant's care coordinator completes the support plan.

The care coordinator is responsible for providing the participant or the participant's legal representative, if applicable, with information about the services that are available on the waiver, feasible alternatives, and for ensuring the participant or the participant's legal representative, if applicable, understands they have freedom of choice between institutional or home and community-based waiver services.

Section VII of the support plan, "Recipient Choice of Service," requires the participant or the participant's legal representative, if applicable, to initial a series of statements indicating that they understand the choices available:
- Medicaid home and community-based waiver services;
- Services in an institution or nursing facility;
- Non-Medicaid waiver community services only; or
- No Medicaid or community services.

Section VII of the support plan describes the assistance SDS and the participant's care coordinator will provide to the participant after they make their choice. Finally, the section requires the participant or their legal representative, if applicable, to indicate their choice. The support plan is then signed by everyone involved in the planning effort. The "Recipient Choice of Service" section of the support plan is updated and reviewed with the participant at least annually.

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 "Recipient Choice of Service" section, are maintained in the participant's electronic record and maintained in the Harmony database for a minimum of three years.

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) determines eligibility for Medicaid benefits and provides timely and meaningful access for Limited English Proficient persons who are unable to speak, read, or write in English and for individuals who request interpreter services. DPA makes every effort to arrange for interpreter assistance and inform Limited English Proficient persons that these services are available free of charge

SDS contracts for language interpreter services needed during the functional level of care assessment. Due to the rural nature of some Alaska villages and the variety of languages spoken in Alaska, professional interpreters are not always available. In the event professional interpreters are not available, SDS may collaborate with the applicant or participant, or their legal representative, if applicable, to see if any informal interpretive services may be an option. They may ask if either local health clinic staff, with whom they have developed a relationship, or if any of the applicant's or participant's family or friends are able to provide informal 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's 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 the waiver level of care determination 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	**Host Home Care**		
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: 01 Case Management

Sub-Category 1: 01010 case management

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

Care coordinators assist individuals to gain access to home and community-based waiver services under 7 AAC 130 and 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 participant and the planning team of the participant's choosing.

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

Once a home and community-based waiver services applicant is determined eligible, care coordinators assist applicants with identifying goals, planning for services, and selecting service providers. Care coordinators then assist the participant-directed planning team to develop an initial support plan. Finally, care coordinators assist participants to direct the team in reviewing goals and renewing the support plan annually.

Ongoing 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 participant throughout the support plan year, in the manner and frequency appropriate to the needs of the participant.

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

n/a

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☑ **Remote/via Telehealth**

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 provider under 7 AAC 130.220, Provider certification, 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 A: 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 recertification, 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 provider under 7 AAC 130.220, Provider certification, 7 AAC. 130.238, Certification of care coordinators, 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 A: 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 recertification, 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:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Day habilitation services may be provided to assist participants, 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 participants, 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 participants 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 participant's accomplishing the outcomes and goals specified in the participant'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 participant'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 participants 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 percent of the total units of service approved for a plan year and justified and approved in the participant'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.

Distance delivery may not be more than 10 percent of the total units of day habilitation approved for a support plan year.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☑ **Remote/via Telehealth**

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 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 A: Additional Information Needed (Optional) and the relevant service Conditions of Participation. Below are 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 plans of care 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 plan of care;
(B) assessing whether the services assist the recipients to attain the outcomes and goals outlined in the plan of care; 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 plan of care 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 plan of care; 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:**

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

Service Definition *(Scope):*

Employment services assist participants to become gainfully employed (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 participant's person-centered support plan, and are planned to maximize the participant's independence and provide the minimum amount of support required for the participant to obtain and maintain employment as participant 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, including distance delivery if authorized in the participant's support plan, 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 a residential setting if self-employed (including self-employment for subsistence) or if a participant has an agreement with their employer to work from home.

Pre-employment services provide time-limited learning and work experiences that allow participants to develop general work readiness and non-job specific strengths and skills that are applicable to all work settings.

Pre-employment services may also assist a participant to determine individual strengths, interests, abilities, and support needs, or become gainfully employment per 42 CFR §440.180(c)(2)(i). If an individual identifies self-employment as their desired outcome, pre-employment services may include supporting the participant as they determine the concept of their business and develop a business plan, as well as referring the participant 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 participants working towards 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 participant.

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. Incidental assistance with the participant's activities of daily living at the workplace is considered an ancillary part of employment services.

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:

Distance delivery may not be more than 10 percent of the total units of employment services approved for a support plan year.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☑ **Remote/via Telehealth**

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 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 A: 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 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 field or 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 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) employment services 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 job developers and job coaches.
e. Prior to appointment as the employment services program administrator, the administrator must obtain the National Certification in Employment Services (NCES), the certified employment support professional certification through the Association of People Supporting Employment First (APSE) or obtain and maintain the Association of Community Rehabilitation Educators (ACRE) certification in employment services.
f. The program administrator may also serve as the job developer or job coach.

2. Job Developer.

a. A job developer must be at least 18 years of age and qualified through experience and education.
b. Required experience: one year of full-time or equivalent part-time experience providing services to individuals in a human services field or setting.
c. Required education and additional experience or alternatives to formal 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.
d. In addition to possessing the skill set of a job coach and meeting education and experience requirements, the job developer must possess the following knowledge base and skills:
i. The job developer knowledge base must include
(A) the medical, behavioral, and habilitative conditions and requirements of the population to be served;
(B) employment services 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 job developer skill set must include
(A) job exploration for individuals with disabilities;
(B) benefits counseling, including the impact of wages on state and federal disabilities benefits;
(C) researching employment opportunities;
(D) job development and job matching;
(E) ability to implement employment services outlined in the support plan to meet the needs of the recipient.
e. Within six months of employment as the job developer, a job developer must obtain the National Certification in Employment Services (NCES), the certified employment support professional certification through the Association of People Supporting Employment First (APSE) or obtain and maintain the Association of Community Rehabilitation Educators (ACRE) certification in employment services.
f. The job developer may also serve as the job coach.

3. Job Coach.

a. Job coaches 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
iii. 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. identifying and teaching required employment-related skills;
ii. job coaching and on the job support;
iii. ability to implement employment services outlined in the support plan to meet the needs of the recipient;
iv. ability to identify natural supports to work towards maximizing independence and integration into the workplace; and
v. ability to provide incidental assistance with activities of daily living while at the workplace.
d. Within six months of employment, the job coach must complete the level of training as specified under (A)(l)(e), the Institute for Community Inclusions Job Coaching training, or equivalent Job Coaching training documented by the provider that demonstrates competencies in the following areas:
i. the history of employment services
ii. values and expectations of work
iii. understanding the profession of employment-services
iv. partners in employment services
v. the role of the job coach
vi. the role of the employee
vii. the role of the employer
viii. the employment services support plan

ix. legal rights at work and self-advocacy
x. preparing for emergencies in the workplace
xi. developing a plan to sustain employment
xii. supporting employees' learning styles
xiii. developing a task analysis
xiv. natural supports, self-maintenance, and fading
xv. distance delivery of services

B. Training.

l. The provider must provide orientation and ongoing training for job developers and job coaches 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 job developers and job coaches:
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. The program administrator must keep on file and submit to the department, when requested, documentation of required minimum education and training as specified under (l)(A).

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:**

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

Service Definition *(Scope):*

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 participant's wishes and needs. Based on the age and residence of the participant, residential habilitation services are rendered as: supported-living habilitation services or in-home support habilitation services.

The activities provided as residential habilitation services must be planned with the objective of maintaining or improving the participant'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, but personal care, protective oversight, and supervision are considered ancillary to the residential habilitation services. The purpose of the residential habilitation service is to teach a participant to acquire, retain, or improve skills to maintain or improve independence in home and personal skills, while personal care is a service that is done for the participant.

Residential habilitation 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 participant's residence, and are approved in the participant's support plan. Other environments where an individual can receive residential habilitation include community settings that relate to goals and objectives of residential habilitation. These goals are to be documented in the participant's annual support plan.

Residential habilitation services may be provided in the participant's living arrangement or in the surrounding community, provided that such services do not duplicate services furnished to a participant as other types of habilitation, and are related to the goals in the approved support plan.

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.

Payment is not to be 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. The state prohibits state plan personal care services to be provided at the same time as residential habilitative services.

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

With the exception of a court appointed legal guardian explicitly authorized to provide waiver services by the court, a Legally Responsible Individual (LRI) may not be paid to provide more than forty (40) hours of In-Home Support 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**
- ☐ **Remote/via Telehealth**

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- 15 minutes: In-Home Support 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- 15 minutes: In-Home Support 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 A: 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 plans of care 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 plan of care;
(B) assessing whether the services assist recipients to attain the goals outlined in plans of care 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 plan of care 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 plan of care; 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:
09 Caregiver Support	09011 respite, out-of-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09012 respite, in-home
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Respite care services may be provided for primary unpaid caregivers, providers of family home habilitation services, and providers of host home care services who are in need of relief or will be unable to provide care 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 participant'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 participant.

Respite care services may be family-directed for participants in specified waiver categories and grant programs. 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, family home habilitation providers, or host home care providers, 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**

☐ **Remote/via Telehealth**

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
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, Foster Home License or Host Care Home License under AS 47.32 and regulations at 7 AAC 75 Assisted living homes, or 7 AAC 67 Foster home licensing standards

Certificate *(specify):*

SDS certified 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 A: 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): Alaska Department of Health, Division of Health Care Services, Residential Licensing unit
License (HCH): Alaska Department of Health, Division of Health Care Services, Residential Licensing unit
License (Foster Home): Alaska Department of Family and Community Services, Office of Children's Services
Certification: SDS Provider Certification and Compliance unit

Frequency of Verification:

License (ALH and HCH): 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:

Alaska Department of Health, Division of Health Care Services, Health Facilities 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 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 A: 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:

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:

Alaska Department of Health, Division of Health Care Services, Health Facilities 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:

Host Home Care

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02023 shared living, other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Host home care services may be provided to participants at least 18 years of age who need assistance with the activities of daily living (ADLs) and whose need for institutional level of care can be met through the support provided in a 24-hour licensed host care home setting. The host home care services must provide a home-like environment where supervision, safety, and security are available for participants, and social and recreational activities are provided in addition to the services necessary to prevent institutionalization. The host home care service provides ongoing, integrated residential supports in a licensed host care home setting. Any personal care provided is considered ancillary to the host home care service.

The service is provided in a licensed host care home under AS 47.32 by a primary caregiver who lives in the home.

The host home care service is intended, but not limited, to provide an additional service option for waiver participants as they transition out of care provided in a licensed foster home. The service provides a non-habilitative home environment for waiver participants who require supportive care. The host home care services provider must ensure that they have the ability to provide the care required by all participants in their home prior to admission. The service includes continuous

responsibility for the participant's health, safety and welfare and is not intermittent in nature.

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

n/a

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

☐ **Remote/via Telehealth**

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: Host Home Care

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Host Home Care

Provider Category:

Agency

Provider Type:

Certified HCBS Agency: Host Home Care

Provider Qualifications

License *(specify):*

Meet the standards under AS 47.32.033, Host care home license

Certificate *(specify):*

Meet the standards under AS 47.07.048, Host home care services, SDS certified provider under 7 AAC 130.220, Provider certification

Other Standard *(specify):*

All host home care service providers are required to meet the host home care license statutory requirements described in Alaska Statute 47.32.033, Host care home license; the host home care service statutory requirements described in Alaska Statute 47.07.048, Host home care services; the requirements contained in the Provider Conditions of Participation, listed in Main A: Additional Information Needed (Optional); and the below personnel requirements.

A. Personnel.
1. Host home care services program administrator.
a. The program administrator shall be qualified as the head of household for the licensed host care home and will serve in dual capacity as the host home care services program administrator. The program administrator is responsible for the day-to-day management of the home.
b. The program administrator must possess the knowledge base and skills necessary to carry out the host home care service.
i. The administrator knowledge base must include:
(A) the medical and behavioral conditions and requirements of the population to be served; and
(B) the laws and policies related to Senior and Disabilities Services programs.
ii. The program administrator skill set must include the ability to organize, evaluate, and present information orally and in

writing; and
c. The responsibilities of the host home care services program administrator must include:
i. orientation, training, and supervision of caregivers;
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 recipient to attain the personal goals outlined in support plan; and
(C) evaluating the quality of care rendered by caregivers;
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.
2. Host home care services caregivers.
a. The provider must ensure that household members providing care and other caregivers meet the requirements in the regulations and the Conditions of Participation.
b. The provider must have a sufficient number of caregivers on site to implement the recipient's support plan and to allow time for a daily routine of unhurried assistance with the activities of daily living that meet the needs and preferences of each recipient.

Verification of Provider Qualifications

Entity Responsible for Verification:

License: Alaska Department of Health, Division of Health Care Services, Residential Licensing unit
Certificate: SDS Provider Certification and Compliance unit

Frequency of Verification:

License: Every two years
Certification: 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:

Intensive Active Treatment

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10040 behavior support
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

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

Service Definition *(Scope):*

Intensive Active Treatment (IAT) assists participants who need immediate intervention to treat a medical or decelerate behavior regression that, if left untreated, would place the participant at risk of institutionalization. This waiver service is only provided to participants 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 day 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.

All IAT services must be prior authorized.

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

Distance delivery may not be more than 10 percent of the total units of intensive active treatment approved for a support plan year.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☑ **Remote/via Telehealth**

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 Services

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 Services

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 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: Alaska Department of Commerce, Community and Economic Development, Division of Corporations, Business and Professional Licensing.
Certificate: If not licensed (above), Alaska Department of Education and Early Development teaching certificate; for all, SDS Provider Certification and Compliance unit.

Frequency of Verification:

License: Every two years
Teaching certification: Every five years
Certification: 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:
15 Non-Medical Transportation	15010 non-medical transportation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Transportation services may be provided to participants 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 participants under 7 AAC 120.405 - 120.490.

The department will not make separate payment for transportation services for providers of family home, group home, and In-Home Support 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 participant's residence, unless approved by the department in the participant's support plan.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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 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 A: 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 section 1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☑ **As a Medicaid state plan service under section 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.*

☐ **As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management).** *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 and the requirements for their training on the HCBS settings regulation and person-centered planning requirements:

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. Ongoing waiver case management is referred to as care coordination. The person performing these case management functions must be certified as a care coordinator.

Care coordinators are required to complete Home and Community-Based Services (HCBS) settings and person-centered planning regulations training at initial certification and care coordination agency program administrators are required to complete settings training at certification renewal.

All care coordinators must comply with the training requirements contained in the Provider Conditions of Participation, listed in Main A: Additional Information Needed (Optional) and the Care Coordination Services Conditions of Participation.

Please see Appendix C-3 for the Care Coordination service and provider specifications.

d. Remote/Telehealth Delivery of Waiver Services. Specify whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely/via telehealth.

Service
Care Coordination
Day Habilitation
Employment Services
Intensive Active Treatment

1. Will any in-person visits be required?

◉ **Yes.**

○ **No.**

2. *By checking each box below, the state assures that it will address the following when delivering the service remotely/via telehealth.*

☑ **The remote service will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc.** ***Explain:***

Distance delivery is defined in 7 AAC 130.319(22) and means a face-to-face interaction between a participant and a provider, using a secure web-based platform that is compliant with P.L. 104-191 (Health Insurance Portability and Accountability Act of 1996 (HIPAA)) and does not include the use of a telephone without a video component.

Devices used to deliver services using distance delivery will not be placed in locations where privacy is assumed, including bedrooms and bathrooms. The state does not set regulations nor have oversight of participants' private residences. The care coordinator is responsible for monitoring and ensuring health and safety for the participant receiving waiver services in the home, including protecting individual rights and privacy.

The care coordinator must document any distance delivery of services in the participant's support plan. The participant can elect to receive all services in-person or they may also choose to receive services by distance delivery. The participant's support plan must include the amount of time the participant will receive distance delivery or in-person delivery methods.

The following services allow for distance delivery: care coordination, day habilitation, employment services and intensive active treatment:

- For day habilitation, employment services and intensive active treatment, distance delivery may not be more than 10 percent of the total amount authorized in the participant's support plan.
- For care coordination, the care coordinator must make at a minimum one contact each month with the participant or the participant's legal representative, if applicable; every six months one of the monthly contacts must be in-person; the remainder may be done by telephone or distance delivery.

☑ **How the telehealth service delivery will facilitate community integration.** ***Explain:***

The distance delivery of services promotes community integration by allowing waiver participants' access to distance delivery services in a similar manner as non-waiver participants. All services delivered via distance delivery promote and ensure safety, functional skills, and independence across settings to support and prepare each participant to access, engage and integrate in the participant's community of choice in accordance with their support plan.

☑ **How the telehealth will ensure the successful delivery of services for individuals who need hands on assistance/physical assistance, including whether the service can be rendered without someone who is physically present or is separated from the individual.** ***Explain:***

The state began allowing distance delivery of services in spring 2020, through Appendix K, and codified distance delivery of services in fall 2022. The participant's person-centered support plan describes participant's needs, including if the participant needs hands on or physical assistance to engage with distance delivered services, and how they will be supported. As part of the planning team's obligation to ensure the health and safety of the participant, the participant and the team must ensure services delivered via distance delivery are rendered in the most appropriate manner.

☑ **How the state will support individuals who need assistance with using the technology required for telehealth delivery of the service.** ***Explain:***

If the participant needs assistance with using the technology required for distance delivery of a service, the participant's support plan includes a description of the participant's support needs and how those needs will be met.

☑ **How the telehealth will ensure the health and safety of an individual.** ***Explain:***

The state requires that services delivered using the distance delivery modality require the same health and safety assurances as services delivered using the in-person modality.

Providers must obtain written consent from participants to use distance delivery platforms. Waiver participants or their legal representative, if applicable, must be informed about the type of connection being used during the distance delivery visit, including whether the connection is secured or unsecured. Waiver participants or their legal representative, if applicable, may choose to revoke their consent at any time. Providers are responsible for ensuring HIPAA compliance for all communication when the participant is sharing protected health information.

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 47.05.310 requires any direct service provider, including providers of home and community-based waiver services 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, receiving certification as an administrator/owner, beginning employment, and volunteering at or residing in an entity.

The entity responsible for conducing background checks is the Department of Health's Background Check Program.

The scope of the background checks includes a review of records, from both Alaska and those states where the individual lived in the previous 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, or ten, five, three and one-year barrier crimes.

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;
- Professional Licensing Registry: Professional registry listing all professions; focused review of individuals licensed to perform health-related activities, including Certified Nurse Aides;
- National Sex Offender Registry (NSOR): The NSOR provides centralized access to registries from all 50 states, Guam, Puerto Rico and the District of Columbia;
- Office of Inspector General (OIG): A database which provides information relating to parties excluded from participation in Medicare, Medicaid and all Federal health care programs;
- Online Resource for the Children of Alaska (ORCA): The Alaska child abuse and neglect and foster care licensing registries;
- ICCIS childcare provider licensing system;
- Alaska Excluded Provider List; and
- State & Federal Fingerprint results (FBI): 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 the Division of Senior and Disabilities Services (SDS) can independently verify the background check information. All home and community-based waiver providers must remain in compliance with the Provider Conditions of Participation for Home and Community-Based Waiver Services and Community First Choice, including 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; (c) the process for ensuring that mandatory screenings have been conducted; and (d) the process for ensuring continuity of care for a waiver participant whose service provider was added to the abuse registry. 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 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 or regulations to care for another person (e.g., the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child). At the option of the state and under extraordinary circumstances specified by the state, payment may be made to a legally responsible individual for the provision of personal care or similar services. *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 types of legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) the method for determining that the amount of personal care or similar services provided by a legally responsible individual is ***"extraordinary care"***, exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization; (c) the state policies to determine that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the state processes to ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made; (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services; and, (g) the procedures that are used to implement required state oversight, such as ensuring 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.*

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 types of relatives/legal guardians to whom payment may be made, the services for which payment may be made, the specific circumstances under which payment is made, and the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or legal guardian, and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that that the provision of services by a relative/legal guardian is in the best interests of the individual. When the relative/legal guardian has decision-making authority over the selection of

providers of waiver services, specify the state's process for ensuring that the relative/legal guardian uses substituted judgement on behalf of the individual. Specify the procedures 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.*

WAIVER SERVICES PROVIDED BY RELATIVES, COURT APPOINTED LEGAL GUARDIANS, OR LEGALLY RESPONSIBLE INDIVIDUALS (LRIs)

The department may allow relatives, court appointed legal guardians, or legally responsible individuals (LRIs) to provide specific home and community-based waiver services if they meet the conditions established through regulation and all the required employment and training qualifications for the service provided.

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. Relatives are allowed to provide some select services, with limitations, and service provision is subject to regulatory requirements, service requirements, and provider employment requirements.

COURT APPOINTED LEGAL GUARDIANS

The department considers court appointed legal guardians to be individuals who have been appointed by the court, as stated under 7 AAC 130.202, to be the participant's court appointed legal guardian. The court appointed legal guardian may be the participant's spouse, adult child, parent of an adult participant, sibling, relative, or another individual. Court appointed legal guardians may furnish limited services in accordance with a court order explicitly authorizing the guardian to provide waiver services. Additionally, court appointed legal guardians may provide In-Home Support and Supported Living Services without an explicit court authorization in their capacity as an LRI.

LEGALLY RESPONSIBLE INDIVIDUALS (LRIs)

The department considers LRIs to be individuals who have a legal duty to support the participant under state law. An LRI is typically:
- the parent (biological or adoptive) or a court appointed legal guardian who must provide care to a minor child enrolled to receive home and community-based services; or
- the spouse of a waiver participant; or
- the court appointed legal guardian who has the legal duty to support an adult enrolled to receive home and community-based services.

Waiver services may be provided by LRIs only in the following two (2) specific circumstances:
1.) the participant's support plan is authorized for In-Home Support services (for minors); or
2.) the participant's support plan is authorized for Supported Living services (for adults).

The department may allow an SDS certified provider to employ a waiver participant's relative, court appointed legal guardian, or LRI to provide waiver services. The provider is responsible for determining that the relative, court appointed legal guardian, or LRI meets the provider qualification requirements on the date of hire.

WAIVER SERVICES THAT RELATIVES AND COURT APPOINTED LEGAL GUARDIANS MAY PROVIDE

RELATIVES (WITH LIMITATIONS)

- Host Home Care

RELATIVES AND COURT APPOINTED LEGAL GUARDIANS (WITH LIMITATIONS)

- Day Habilitation
- Employment Services
- Intensive Active Treatment
- Respite
- Transportation

RELATIVES, COURT APPOINTED LEGAL GUARDIANS, AND LEGALLY RESPONSIBLE INDIVIDUALS (LRI)

- Residential Habilitation-15 minutes:
    - o In-Home Support
    - o Supported Living

LIMITATIONS AND CONTROLS FOR SERVICES PROVIDED BY LRIs

The department may allow an SDS certified provider to employ an LRI. The provider has the responsibility for determining that the LRI meets one of the following specific circumstances at the time of hire:

1.) there is no other direct care worker who can provide the necessary services; or
2.) the LRI has the specific knowledge, skills, or abilities to meet the participant's needs.

With the exception of court appointed legal guardians explicitly authorized to provide waiver services by the court, services provided by an LRI must meet the following conditions:

- the service is one that the LRI would not ordinarily provide in the household to a person of the same age without a disability;
- the service must be specified and approved in the participant's support plan;
- the service is not inclusive of duties that the LRI has for a participant, and that, if not provided, would be considered neglect under AS 47.10.014 or AS 47.24;
- the participant chooses the LRI to be the provider of the service, and the participant's choice is reviewed annually during the person-centered planning meeting;
- the LRI must meet all provider qualifications and requirements to provide the service and comply with "Provider Conditions of Participation for Home and Community-Based Waiver Services and Community First Choice Chore Services" and the "Residential Habilitation Services Conditions of Participation";
- the LRI must be employed by an SDS certified home and community-based waiver provider; and
- the LRI may not provide more than forty (40) hours of paid services within a seven (7) day period regardless of the number waiver participants that they have a legal duty to support.

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. The determination regarding the hiring of an LRI is at the discretion of the hiring agency.

With the exception of a court appointed legal guardian explicitly authorized to provide waiver services by the court, payments for services provided by an LRI for more than forty (40) hours in a seven (7) day period will be considered overpayment and subject to recovery.

PAYMENTS MADE TO RELATIVES, COURT APPOINTED LEGAL GUARDIANS, AND LRIs

Payments made to relatives, court appointed legal guardians, and LRIs for waiver services are subject to all regulatory requirements and limits, service requirements, and the required minimum employment and training qualifications for the waiver service provided.

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.

The department prohibits immediate family members, court appointed legal guardians, LRIs, a holder of power of attorney for the participant, the participant's personal care assistant, or any individual with a legal duty to support the

participant 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 Compliance unit webpage that contains a 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.

g. State Option to Provide HCBS in Acute Care Hospitals in accordance with Section 1902(h)(1) of the Act. Specify whether the state chooses the option to provide waiver HCBS in acute care hospitals. *Select one*:

- **No, the state does not choose the option to provide HCBS in acute care hospitals.**
- **Yes, the state chooses the option to provide HCBS in acute care hospitals under the following conditions.** *By checking the boxes below, the state assures:*
  - ☐ **The HCBS are provided to meet the needs of the individual that are not met through the provision of acute care hospital services;**
  - ☐ **The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;**
  - ☐ **The HCBS must be identified in the individual's person-centered service plan; and**
  - ☐ **The HCBS will be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.**

*And specify:***(a) The 1915(c) HCBS in this waiver that can be provided by the 1915(c) HCBS provider that are not duplicative of services available in the acute care hospital setting;(b) How the 1915(c) HCBS will assist the individual in returning to the community; and(c) Whether there is any difference from the typically billed rate for these HCBS provided during a hospitalization. If yes, please specify the rate methodology in Appendix I-2-a.**

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's 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.1: # and % of new providers who meet state certification or enrollment requirements prior to providing waiver services. Numerator: # of new providers who meet state certification or enrollment requirements prior to providing waiver services. Denominator: # new waiver service providers reviewed who require certification 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**
	☐ **Other** Specify:

Performance Measure:
C.a.2: # and % of active providers who continue to meet state certification or enrollment requirements while providing waiver services. Numerator: # of active providers who continue to meet state certification or enrollment 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**	☐ **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 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*	**Frequency of data collection/generation***(check*	**Sampling Approach** *(check each that*

each that applies):	*each that applies):*	*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:
C.c.4: # and % of certified provider agencies in compliance with the 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**	☐ **Other**

	Ongoing	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 the 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**
☐ **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:

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 issues within the waiver program. The task committee that oversees quality improvement for this appendix is the Qualified Providers Review Task Committee.

Qualified Providers Review Task Committee:

The Qualified Providers Review 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 Provider Certification and Compliance unit manager (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 Training unit.

Quarterly or more frequently 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 and may rise to the QISC as described in Appendix H.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

SDS discovers individual problems and systemic deficiencies by reviewing MMIS error reports, SDS certified providers training evidence, reports submitted to the Centralized Reporting system and any subsequent investigation, and Harmony database generated reports.

When discovery activities reveal problems, the unit managers analyze the data to discover if the problem involves individual performance issues or systemic level of care determination processes problems.

The discovery may point towards billing errors or providers who are out of compliance with SDS training requirements. Remediation activities may include coordinating with the Division of Health Care Services to initiate payment withholding or recovery issuing a notice to correct to a provider or conduct agency onsite reviews.

All noncompliance issues are addressed and analyzed at the Qualified Providers Review Task Committee which develops remediation recommendations and those are presented to 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**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **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 in which 1915(c) HCBS are recieved. *(Specify and describe the types of settings in which waiver services are received.)*

The specific settings where individuals receive services include licensed assisted living homes, licensed host care homes, licensed foster homes, provider-owned, leased, or operated housing, the greater community, facility-based or employment sites.

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 in the future as part of ongoing monitoring. *(Describe the process that the state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring across residential and non-residential settings in which waiver HCBS are received.)*

The state conducts the following processes to assess and determine that all waiver settings meet the Home and Community-Based Services (HCBS) settings requirements. The state

1.) conducts a comprehensive site-specific assessment and validation of all settings serving individuals receiving Medicaid-funded HCBS and proposes remediation strategies to rectify any issues uncovered through the site-specific assessment and validation processes, and

2.) applies ongoing monitoring and quality assurance processes that ensure all settings providing HCBS continue to remain fully compliant with the rule in the future.

All HCBS waiver residential and non-residential settings comply with federal HCBS settings requirements. 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 develop an Independence and Inclusion policy; program administrators must demonstrate successful completion of settings training at each renewal to ensure compliance with settings requirements.

The Provider Certification and Compliance (PCC) unit, within SDS, is the entity responsible for completing the provider quality reviews. The state assures that all settings criteria are monitored frequently by the PCC unit throughout the certification and renewal certification process, every two to four years, at a minimum. In addition, the coordinated approach to monitoring service delivery between the PCC unit, the Division of Health Care Services (DHCS) Residential Licensing unit, and care coordinators ensure that all settings are monitored at multiple points throughout the support plan year.

SDS is required by AS 47.05.010 and 7 AAC 160.140 to regularly monitor providers certified for home and community-based waiver services. The PCC unit reviews settings compliance every two to four years, at a minimum. Reviews verify that providers continue to meet all of the settings criteria under 42 § CFR 441.301(c)(4)(i)-(v).

In addition, the state ensures ongoing monitoring and settings compliance by using a coordinated approach, established through the coordination of the Licensed and Certified Providers Workgroup, which is comprised of four units within SDS: the PCC unit, the General Relief unit, the Quality Assurance unit, and Adult Protective Services unit. Other members of this collaborative workgroup are the Residential Licensing unit and the Office of Long-Term Care Ombudsman.

This workgroup meets monthly, at a minimum, to collaborate and share information about a variety of service monitoring activities including settings monitoring. Findings made by any of the workgroup members are shared with all agencies; findings may be discovered from a regularly scheduled part of the SDS PCC unit's initial certification or renewal certification process or can be a result of a complaint, concern, or investigation where one or more of the workgroup members conduct physical on-site inspections, interviews, calls, file reviews, reviews of Medicaid billing records, critical incident reports, Adult Protective Services reports, residential licensing cycle findings, annual provider quality assessment reports, corrective actions, or investigation results.

The Residential Licensing unit plays a vital role in the settings compliance process when conducting on-site inspections and investigations. Residential Licensing conducts physical on-site inspections and file reviews during the initial licensing application process, the probationary (1 year) licensing cycle and the biennial (2 year) licensing cycle.

Investigations are conducted on an as needed basis, as determined by the critical incidents reported. Residential Licensing utilizes the HCBS Setting: Observational Indicators tool as part of the inspection and investigation process.

The Observational Indicators tool is a form that assists Residential Licensing in determining compliance with settings requirements. When Residential Licensing notes a settings violation, they notify the PCC unit which will begin a Settings Compliance Review.

The Settings Compliance Review includes a file review and on-site compliance review, which includes interviews of the program administrator, staff, and participants.

The PCC settings compliance reviewer utilizes the Settings Qualities Checklist and Exploratory Questions for Home and Community-Based Services Settings tool to assess the setting. When it has been determined that a settings violation has

occurred, SDS will issue a notice of sanctions under 7 AAC 105.440.

The notice will include the grounds for sanction under 7 AAC 105.400, including all relevant facts, the proposed sanction to be imposed by the department under 7 AAC 105.410 - 7 AAC 105.420, whether the matter has been referred for fiscal audit under 7 AAC 160.110, any action required of the provider, and the provider's right to an appeal under 7 AAC 105.460.

The state's grievance process related to settings and person-centered practice will be in compliance with 7 AAC 130.218, 7 AAC 130.220, and § 441.301(c)(7) by its implementation date.

3. *By checking each box below, the state assures that the process will ensure that each setting will meet each requirement:*

- ☑ **The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.**
- ☑ **The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.** ***(see Appendix D-1-d-ii)***
- ☑ **Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.**
- ☑ **Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.**
- ☑ **Facilitates individual choice regarding services and supports, and who provides them.**
- ☑ **Home and community-based settings do not include a nursing facility, an institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting.**

Provider-owned or controlled residential settings. (*Specify whether the waiver includes provider-owned or controlled settings*.)

- ○ **No, the waiver does not include provider-owned or controlled settings.**
- ◉ **Yes, the waiver includes provider-owned or controlled settings.** (By checking each box below, the state assures that each setting, *in addition to meeting the above requirements, will meet the following additional conditions*):
  - ☑ **The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.**
  - ☑ **Each individual has privacy in their sleeping or living unit:**
    - ☑ **Units have entrance doors lockable by the individual.**
    - ☑ **Only appropriate staff have keys to unit entrance doors.**
    - ☑ **Individuals sharing units have a choice of roommates in that setting.**
    - ☑ **Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.**
  - ☑ **Individuals have the freedom and support to control their own schedules and activities.**
  - ☑ **Individuals have access to food at any time.**
  - ☑ **Individuals are able to have visitors of their choosing at any time.**
  - ☑ **The setting is physically accessible to the individual.**

☑ **Any modification of these additional conditions for provider-owned or controlled settings, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan*(see Appendix D-1-d-ii of this waiver application).***

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

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. Given the importance of the role of the person-centered service plan in HCBS provision, the qualifications should include the training or competency requirements for the HCBS settings criteria and person-centered service plan development. *(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. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for service plan development except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *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. *Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan:***

The Division of Senior and Disabilities Services (SDS) has developed and instituted safeguards to protect against conflicts of interest and to ensure that support plans are developed in the best interests of the participant.

Regulations at 7 AAC 130.217, Support plan development and amendment, require that care coordinators inform the participant about any conflict of interest, provide the participant with a list containing the full range of waiver service providers available, and support the participant in exercising the participant's right to free choice of providers.

When an initial applicant or enrolled waiver participant selects a care coordinator, and each time they change care coordinators if applicable, they complete the "Appointment of Care Coordination / Targeted Case Management Services" form. The form requires the care coordinator to inform each participant about any potential conflicts of interest, the SDS Centralized Reporting process, and requires the care coordinator to give the applicant or participant copies of the "Recipient Rights and Responsibilities" form and the "Notice of Recipient Fair Hearing Rights".

The care coordinator also gives the applicant or participant the "Recipient Rights and Responsibilities" form at initial and renewal support plan development. The form explains their right to choose providers and to change providers at any time.

In addition, the form confirms that the care coordinator has told the applicant or participant to consult with SDS, providers, or their care coordinator if, at any time, they are unhappy with their services or if the services are not the same as those included in the support plan. The applicant or participant initials and signs the form, along with the participant's legal representative, if applicable, indicating they have been informed of their rights and responsibilities.

State regulations at 7 AAC 130.220, Provider certification, ensure compliance with federal conflict-free care coordination requirements, which includes a process for allowing exceptions in census areas where a provider of waiver and care coordination services demonstrates that they are the only willing and qualified provider in the geographic area to develop the person-centered support plan.

Because Alaska is largely rural and sparsely populated in remote regions there may be only one or two service provider agencies offering direct services. These same provider agencies may employ the census area's only care coordinator(s). In such situations, SDS may award that provider agency an exception to the requirement that care coordination be conflict-free.

SDS determines which census areas may qualify for the exception using the following criteria:
1.) The number of direct services providers in the census area;
2.) The number of care coordinators in the census area; and
3.) The number of participants receiving services in the census area.

Prior to SDS granting an exception, the provider agency must:
- explain how the provider will separate the direct service provider functions from the support plan development functions;
- The provider is required to attest, under penalty of perjury;
- the provider agency's current use of a plan/policy/procedure to ensure administrative separation between direct service provider functions and support plan development functions;
- the current use of a plan/policy/procedure to implement dispute resolution/grievance process;
- the outcomes/evidence of all separation and dispute resolution will be made available to SDS, upon request;
- the agency has each individual care coordinator complete a "Conflict of Interest Assurance" form for each participant the care coordinator serves that assures the care coordinator has no conflicts of interest;
- the provider may not submit claims to Medicaid for care coordination services provided by an individual care coordinator that has a conflict of interest with the participants they serve; and
- the failure to mitigate conflict by implementing the requirements in the "Conflict of Interest Exception Application" may result in SDS revocation of the exception.

Through SDS' Centralized Reporting system, any participant, provider, care coordinator, family member, advocate, or member of the public may file a complaint or grievance about SDS awarding a conflict-free care coordination exception to a particular provider agency, file a complaint about the participant experience while attempting to select

a different care coordinator, or file a complaint or concern about any topic. SDS investigates each conflict-free care coordination complaint, grievance, and report made to the Centralized Reporting system.

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in service plan development. *By checking each box, the state attests to having a process in place to ensure:*

☑ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**

☑ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**

☑ **Direct oversight of the process or periodic evaluation by a state agency;**

☑ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**

☑ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

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.

(a) SUPPORTS AND INFORMATION AVAILABLE TO THE PARTICIPANT FOR THE SUPPORT PLAN DEVELOPMENT PROCESS

The participant chooses the care coordinator from an official list of care coordinators, and the care coordinator provides the participant and the participant's legal representative, if applicable, with a list of services available through the waiver. The care coordinator supports the participant in exploring the range of services offered and in making decisions regarding which services meet the participant's needs, preferences, and desires. Care coordinators provide participants and the participants legal representative, if applicable, with the "Recipient Rights and Responsibilities" form. The participant and the participant's legal representative, if applicable, must sign the "Recipient Rights and Responsibilities" form and the participant's support plan.

(b) PARTICIPANT'S AUTHORITY TO DETERMINE WHO TO INCLUDE IN THE SUPPORT PLAN DEVELOPMENT PROCESS

Regulations at 7 AAC 130.218, Person-centered practice, require that a person-centered planning practice is used when developing the support plan development. The participant, based on their capacity and interest in participation, leads the development of the support plan. The participant has the authority to choose the individuals who participate in the support plan development process.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. i. 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; (g) how and when the plan is updated, including when the participant's needs changed; (h) how the participant engages in and/or directs the planning process; and (i) how the state documents consent of the person-centered service plan from the waiver participant or their legal representative. 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):

(a) WHO DEVELOPS THE PLAN, WHO PARTICIPATES IN THE PROCESS, AND THE TIMING OF THE PLAN

In accordance with regulations at 7 AAC. 130.217, Support plan development and amendment, and 7.AAC.130.218, Person-centered practice, and based on the participant's capacity and interest, the participant leads the development of the support plan. The participant has the authority to choose the individuals who participate in the support plan development process and, with assistance from their care coordinator, invites team members to attend participant-led person-centered planning session(s).
Team members include:

- the participant;
- the participant's family or legal representative, if applicable;
- the care coordinator;
- providers who are expected to provide services; and
- other team members of the participant's choosing, including natural supports.

Planning meetings are scheduled at a time and location convenient for the participant and those individuals the participant has selected to participate. Once the plan is developed, the care coordinator must submit the applicant's initial support plan not later than 60 days after the initial determination of level of care determination, and for enrolled participants, care coordinators submit annual support plans not later than 30 days before expiration of the current support plan year.

(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

The support plan must reflect the issues identified in the level of care assessment, as described in Appendix B.6.d. The support plan also includes the preferences of the participant or the participant's legal representative, if applicable, and any medical or health concerns.

(c) HOW THE PARTICIPANT IS INFORMED OF THE SERVICES THAT ARE AVAILABLE UNDER THE WAIVER

As part of the planning process, the care coordinator supports the participant by giving them information to make informed choices regarding services and supports. The care coordinator gives the participant a list of providers that includes the full range of services available through the waiver program and within the participant's community. The information provided must be in plain language and presented in a manner accessible to a participant with disabilities or Limited English Proficiency. The participant is responsible for choosing their provider(s) and has freedom of choice.

(d) HOW THE PLAN DEVELOPMENT PROCESS ENSURES THAT THE SERVICE PLAN ADDRESSES PARTICIPANT GOALS, NEEDS (INCLUDING HEALTH CARE NEEDS), AND PREFERENCES

The support plan process is led by the participant or the participant's legal representative, if applicable, and the participant receives collaborative support from the care coordinator and other members of the planning team. The purpose of the support plan development process is to ensure that the support plan addresses the participant's desired goals and outcomes, needs (including health care needs), and preferences. Services are planned according to the scope, frequency, and duration of the participant's needs.

(e) HOW WAIVER AND OTHER SERVICES ARE COORDINATED

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 the natural supports utilized.

The care coordinator of a participant who receives both home and community-based waiver services and state plan or Community First Choice personal care services coordinates services to avoid any service duplications. In addition to the waiver services provided, the support plan also identifies any anticipated services furnished to the participant 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.

(f) HOW THE PLAN DEVELOPMENT PROCESS PROVIDES FOR THE ASSIGNMENT OF RESPONSIBILITIES TO IMPLEMENT AND MONITOR THE PLAN

The support plan identifies the providers responsible for each service included in the support plan and by signing the support plan, each provider acknowledges the responsibility of each agency to provide the services in accordance with the support plan.

The care coordinator is responsible for monitoring and overseeing the implementation of the support plan and they discuss any concerns with the participant or the participant's legal representative, if applicable, during the monthly contacts.

(g) HOW AND WHEN THE PLAN IS UPDATED, INCLUDING WHEN THE PARTICIPANT'S NEEDS CHANGED

The support plan is updated annually, through the person-centered support plan development process. If a participant's need change during the plan year, the care coordinator submits a support plan amendment.

(h) HOW THE PARTICIPANT ENGAGES IN AND/OR DIRECTS THE PLANNING PROCESS

In accordance with 7 AAC 130.218, Person-centered practice, and based on the participant's capacity and interest, the participant leads the planning process. The participant's legal representative may lead the planning process, if applicable. The participant receives collaborative support from the care coordinator and other members of the planning team. The participant has the authority to choose the individuals who participate in the support plan development process and invites team members to attend participant-led person-centered planning session(s). Planning meetings are scheduled at a time and location convenient for the participant and those individuals the participant has selected to participate. The purpose of the support plan development process is to ensure that the support plan addresses the participant's desired goals and outcomes, needs (including health care needs), and preferences. The support plan must use plain language and be written in a manner that is both accessible to a participant with disabilities or Limited English Proficiency and makes the support plan understandable to the participant and the individuals supporting the participant. Services are planned according to the scope, frequency, and duration of the participant's needs.

(i) HOW THE STATE DOCUMENTS CONSENT OF THE PERSON-CENTERED SERVICE PLAN FROM THE WAIVER PARTICIPANT OR THEIR LEGAL REPRESENTATIVE

When the support plan is complete, the participant signs the support plan. If the participant has a legal representative, the legal representative will sign the support plan. The care coordinator also provides the participant with the "Recipient's Rights and Responsibilities" form, which outlines the participant's 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 know how to give a complaint to their service provider.

ii. HCBS Settings Requirements for the Service Plan. *By checking these boxes, the state assures that the following will be included in the service plan:*

☑ **The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.**

☑ **For provider owned or controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan and the following will be documented in the person-centered service plan:**

- ☑ **A specific and individualized assessed need for the modification.**
- ☑ **Positive interventions and supports used prior to any modifications to the person-centered service plan.**
- ☑ **Less intrusive methods of meeting the need that have been tried but did not work.**
- ☑ **A clear description of the condition that is directly proportionate to the specific assessed need.**
- ☑ **Regular collection and review of data to measure the ongoing effectiveness of the modification.**

☑ **Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.**

☑ **Informed consent of the individual.**

☑ **An assurance that interventions and supports will cause no harm to the individual.**

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.

HOW RISKS ARE ASSESSED

As part of the support plan development process, the participant and members of the planning team assess potential risks with the participant that may be encountered with the delivery of services. They also discuss and document in the support plan an emergency preparedness plan and the participant's concerns for their own safety and level of risk. Strategies for identifying and reducing risks are incorporated into the support plan. If the participant believes that the risks are too great, the participant may choose different service(s).

STRATEGIES TO MITIGATE RISK INCORPORATED IN THE SUPPORT PLAN

All home and community-based services waiver 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 makes the emergency response policy and procedures available to SDS upon request.

The support plan documents an Emergency Response Plan, which is developed by the planning team, directed by the participant. The Emergency Plan detailed in the support plan includes the following elements:

- Describe safety resources closest to the recipient, how the recipient will access these resources, and how these resources will know how best to assist the recipient.
- Document how the recipient was assisted to understand and establish their own emergency response in the event of a natural disaster or other emergency.
- Indicate how this plan will adequately meet the needs of the recipient with specific regard to their living environment and physical ability to self-assist.
- Include the person's concerns for his/her own safety and level of risk.

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 as stated in 7 AAC 130.206(h).

If, based on a review of the assessment or the support plan, the department determines that the expected cost of the services that the enrolled participant requires exceeds this waiver's cost limit, the department will not authorize the participant's continued enrollment on this waiver and will refer the participant to another waiver.

TYPES OF BACKUP ARRANGEMENTS USED, BACKUP PLAN DEVELOPMENT, AND INCORPORATION INTO THE SUPPORT PLAN

All participants have a backup care coordinator listed in their support plan. This ensures that participants always have access to care coordination service.

If participant resides in a licensed host care home, alternate staffing backup arrangements are described in the participant's support plan. The support plan must describe a description of the staffing pattern, including how live-in and shift staff are scheduled.

The participant must check "Yes" on the support plan to indicate that they have discussed their backup and personal emergency plans with the care coordinator.

RISKS ASSOCIATED WITH LIVING IN REMOTE ALASKA COMMUNITIES

People who choose to live in remote Alaskan communities are aware of the risks and limited providers available to them and 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 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, if applicable, and identifies potential issues with service delivery. These strategies are incorporated into

the support plan.

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.

In accordance with the "Care Coordination Services and Long Term Services and Supports Targeted Case Management Conditions of Participation" care coordinators are required to support participants to explore options when selecting a service provider. Initially and on an ongoing basis, as requested, the care coordinator provides the participant with a list of qualified providers and the participant chooses the providers that fit their needs, as outlined in the support plan. In addition, the support plan includes a "Recipient Choice of Services" section in which the participant confirms that their care coordinator has given them a list of certified providers from which they may choose a provider.

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 oversight of 100% of participant support plans at least annually. Support plans may also be updated more frequently and as needed to ensure that plans protect participants' health and welfare and are developed in accordance with regulations at 7 AAC. 130.217, Support plan development and amendment, and 7.AAC.130.218, Person-centered practice.

Participants and the participant's legal representative, if applicable, sign the support plan before it is submitted to SDS. SDS staff review each support plan for suitability and adequacy based on the participant's needs, level of care assessment, participant goals, and health and safety factors and confirm that the support plan is within the individual cost limit.

The following is the state's process of how a sample size is conducted, the frequency of reviews, and the review methodology.

- Sample size of review: 100% review.

- Frequency: at least annually, with more frequent reviews on an as needed basis as support plans are amended to meet participant needs.

- Methodology: SDS Review unit staff are trained to review every support plan for each requirement listed in 7 AAC 130.218(c)(1-12).

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, when the individual's circumstances or needs change significantly, or at the request of the individual, 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, participant health and welfare, and adherence to the HCBS settings requirements under 42 CFR §§ 441.301(c)(4)-(5); (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

(a) ENTITIES RESPONSIBLE FOR MONITORING THE IMPLEMENTATION OF THE SERVICES PLAN, PARTICIPANT HEALTH AND WELFARE, AND ADHERENCE TO SETTINGS REQUIREMENTS

Care coordinators are responsible for monitoring the implementation of the participant's support plan, participant health and welfare, and adherence to the home and community-based services settings requirements under 42 CFR § 441.301(c)(4)-(5).

Care coordinator monitoring responsibilities are to:

- ensure the services are furnished in accordance with the support plan and confirm that the participant's needs are being met;
- coordinate participant access to waiver services in the support plan;
- monitor participant access to non-waiver services included in the support plan, such as primary health care;
- monitor the effectiveness, and modify, as needed, the participant's service back-up plan;
- ensure the participant's continued health, safety, and welfare;
- guarantee that the participant has free choice of providers;
- respond to participant requests for changes in providers by showing the participant alternative provider options;
- provide the participant with a list of other certified and enrolled providers;
- facilitate the participant's transfer to a new provider, as needed; and
- ensuring provider adherence to the home and community-based services settings requirement.

Home and community-based services providers are responsible for implementing 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.

(b) MONITORING METHODS AND FOLLOW-UP METHODS

The methods the care coordinator uses to monitor and follow-up are in-person, telephonic contacts, and distance delivery. The care coordinator monitors the effectiveness and quality of services the participant receives from providers and evaluates, in collaboration with the participant, the need for specific services or changes in services and amends the support plan, as needed.

The care coordinator must document the content of the participant contacts in annotated case notes that the care coordinator signs and dates. The SDS Quality Assurance unit or Medicaid Program Integrity may request the participant's case notes from the care coordinator in response to a complaint, when the state's discovery efforts reveal problems with a participant's care, or for safety investigations, audits, or and Medicaid Program Integrity reviews.

The participant, planning team members, and providers are instructed on how to file complaints through the Centralized Reporting system. SDS staff may offer technical assistance to providers (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.

(c) MONITORING FREQUENCY

Care coordinators must make, at a minimum, one contact each month with the participant or the participant's representative, if applicable; every six months one of the monthly contacts must be in-person; the remainder may be done by telephone or distance delivery. Care coordinators also monitor service delivery through the "Questionnaire for Initial and Renewal Support Plans" that the participant completes annually. The questionnaire captures participant feedback on whether their services were delivered in accordance with the support plan.

b. Monitoring Safeguard. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for monitoring the implementation of the service plan except, at the option of the state, when providers are given this responsibility because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.**
- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health**

and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation. *(Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can monitor service plan implementation).*

SDS has developed and instituted safeguards to monitor the implementation of the support plan.

Regulations at 7 AAC 130.217, Support plan development and amendment, require that care coordinators inform the participant about any conflict of interest, provide the participant with a list containing the full range of waiver service providers available, and support the participant in exercising the participant's right to free choice of providers.

Regulations at 7 AAC 130.240, Care coordination services, require that care coordinators are responsible for monitoring service delivery in accordance with the support plan by regular and ongoing participant contacts and documenting visits using case notes.

At initial and annual renewal support plan development, the care coordinator gives the participant the "Recipient Rights and Responsibilities" form that explains their right to choose providers and to change providers at any time. In addition, the form confirms that the care coordination has told the applicant or participant to consult with SDS, their providers, or their care coordinator if, at any time, they are unhappy with their services or if the services are not the same as those included in the support plan. The applicant or participant initials and signs the form, along with the participant's legal representative, if applicable, indicating they have been informed of their rights and responsibilities.

At the end of the plan year, participants submit the "Questionnaire for Initial and Renewal Support Plans" to their care coordinator. The questionnaire captures participant feedback on whether their services were delivered in accordance with the support plan.

State regulations at 7 AAC 130.220, Provider certification, ensure compliance with federal conflict-free care coordination requirements, including a process for allowing exceptions in census areas where a provider of waiver and care coordination services demonstrates that they are the only willing and qualified provider in the geographic area to develop the person-centered support plan.

Because Alaska is largely rural and sparsely populated in remote regions there may be only one or two service provider agencies offering direct services. These same provider agencies may employ the area's only care coordinator(s). In such situations, SDS may award that provider agency an exception to the requirement that care coordination be conflict-free.

SDS uses the same conflict-free exception process, described in Appendix D.1.b, Service Plan Development Safeguards, to determine if a provider is the only willing and qualified provider in a geographic area who can monitor service plan implementation.

Through SDS' Centralized Reporting system, any participant, provider, care coordinator, family member, advocate, or member of the public may file a complaint or grievance about SDS awarding a conflict-free care coordination exception to a particular provider agency, file a complaint about the participant's experience while attempting to select a different care coordinator, or file a complaint or concern about any topic. SDS investigates each conflict-free care coordination complaint, grievance, and report made to the Centralized Reporting system.

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements. *By checking each box, the state attests to having a process in place to ensure:*

☑ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**

☑ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**

☑ **Direct oversight of the process or periodic evaluation by a state agency;**

☑ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**

☑ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's 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.1: # 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:

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

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** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: Service plans are updated/revised at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual.***

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.b.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% with 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.b.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% with 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:

c. ***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.c.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:

d. ***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.d.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 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.d.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**	☐ **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**

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:

e. ***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.

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 issues within the waiver program. The task committee that oversees quality improvement for this appendix is the Support Plan Review Task Committee.

Support Plan Review Task Committee:

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: Review unit manager (chair), IDD unit manager (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 basis, or as needed, this committee reviews support plan performance measure data and makes systemic improvement recommendations to the QIW and may rise to the QISC as described in Appendix H.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. 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 provider non-compliance, SDS responds in one of the following ways, depending upon the severity of the issue. Responses may include:

- technical assistance by SDS staff;
- submitting a report to the Centralized Reporting system, to be routed to Quality Assurance for investigation; or

- provider sanctions and corrective action plans.

If the deficiencies reveal an immediate risk to a participant's health, safety, or welfare, SDS may act without offering an opportunity for remediation by the provider; 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. Corrective actions and follow-up findings are documented in the Harmony database. If discovery points towards systemic issues, these are address and analyzed at the Support Plan Review Task Committee which develops remediation recommendations and those are presented 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 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.

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.

HOW APPLICANTS AND PARTICIPANTS ARE INFORMED OF THE FAIR HEARING PROCESS

At the time of the appointment of care coordination, care coordinators provide applicants and participants, or their legal representative, if applicable, with two documents that address the right to a Fair Hearing:

- the Notice of Recipient Fair Hearing Rights; and
- the Recipient Rights and Responsibilities form.

Care coordinators are responsible for discussing the documents with the applicant or participant and ensuring that they understand the information being provided.

The Notice of Recipient Fair Hearing Rights provides detailed instructions about how an applicant or participant, or their legal representative, may appeal a decision that affects their care. The participant or their legal representative, if applicable, also receives the Notice of Recipient Fair Hearing Rights as part of any adverse action taken by the Division of Senior and Disabilities Services (SDS).

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, participant, or their legal representative, if applicable, initials the form attesting that the care coordinator has discussed their rights with them. They also receive the Recipient Rights and Responsibilities form at the time of initial application and annually upon renewal application.

INSTANCES WHEN A NOTICE OF RECIPIENT FAIR HEARING RIGHTS MUST BE MADE

In accordance with 7 AAC 49, Hearings, applicants and participants receive a notice of adverse action and accompanying Notice of Recipient Fair Hearing Rights when the:

- 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; or
- their services are denied, suspended, reduced, or terminated.

HOW A NOTICE OF ADVERSE ACTION AND FAIR HEARING RIGHTS IS MADE

All notices of adverse action originate with 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.

HOW A FAIR HEARING IS REQUESTED

The appellant (i.e. applicant, participant, or their legal representative, if applicable) may request a Fair Hearing by mail, fax, email, or telephone, or text within 30 days of the date on the Notice of Recipient Fair Hearing Rights. The notice provides instruction on how the appellant may contact HMS Gainwell, the entity that provides administrative support for Fair Hearing requests. If an appeal request is received by SDS staff instead of HMS Gainwell, SDS promptly refers it to HMS Gainwell for appropriate processing.

The appellant may request an expedited hearing if the time otherwise permitted for a hearing would jeopardize the appellant's life, health, or ability to attain, maintain, or regain maximum function.

WHAT ASSISTANCE IS PROVIDED TO APPELLANTS PURSUING A FAIR HEARING

Appellants who want to request a Fair Hearing and who have limited English proficiency or who need help reading or responding to the notice are assisted by either their care coordinator or their provider agency representative, who makes a request in writing on the appellant's behalf and ensures that it is delivered to HMS Gainwell.

If requested, the Department of Health, Division of Health Care Services, provides assistance to the appellant, in obtaining representation, preparing the case, and gathering witnesses and/or documents to be used in presenting the claim.

Included in the Notice of Recipient Fair Hearing Rights is the contact information for free legal assistance by Alaska-based nonprofit legal entities, who may provide legal assistance if requested by the appellant.

WHO CONDUCTS THE HEARING

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). The SDS Quality Assurance unit's Fair Hearing representatives are responsible for preparing the case for Fair Hearing and representing SDS at hearings.

WHO CAN PARTICIPATE IN THE HEARING

The appellant may choose to represent themselves at the Fair Hearing or may be represented by a legal representative, if applicable, attorney, friend, or family member. Due to conflict of interest concerns, the appellant's care coordinator or other service providers may not represent the appellant at the Fair Hearing, but may accompany the appellant to the hearing, act as an advocate, offer help throughout the process, and refer the appellant to additional sources of assistance, as appropriate.

CONTINUATION OF SERVICES DURING THE APPEAL PROCESS

The Notice of Recipient Fair Hearing Rights informs the appellant that if they continue to satisfy all eligibility criteria, including those at issue in the Fair Hearing request, their services may be automatically continued until the date that the final decision is issued, unless the appellant informs the state that the appellant wants their benefits stopped during the Fair Hearing process.

WHERE THE NOTICE OF ADVERSE ACTIONS AND FAIR HEARING NOTICES ARE KEPT

Copies of the notices are placed in the appellant's electronic file in the Harmony database, where they remain indefinitely.

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**

• **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.

OPERATION OF THE ADDITIONAL DISPUTE RESOLUTION PROCESS

The state offers a process for mediation in advance of a Fair Hearing to address disputes with regards to all services provided through SDS. Mediation services are provided by an Office of Administrative Hearings (OAH) ALJ or a third-party contractor who is a lawyer and who operates under OAH within the Department of Administration. If the parties do not reach an agreement in mediation, the case is referred back to OAH and a Fair Hearing is scheduled.

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, Hearings. The appellant may bypass mediation and continue to schedule a Fair Hearing at any time during this process.

TYPES OF DISPUTES ADDRESSED AND TIMELINES

The types of disputes addressed through this mediation process include but are not limited to:
- initial waiver denial;
- material improvement and waiver termination decisions;
- eligibility for services;
- determination of developmental disability decisions;
- denials of enhanced payments for acuity add-on; and
- any disagreements stated by the appellant which are addressed in the state's notice authorizing or denying services.

Appellants, or care coordinators on behalf of the appellants, 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. OAH schedules the mediation at the earliest time available. Appellants may reschedule the mediation to suit their availability and may also decline mediation. The mediation is voluntary, is not a pre-requisite or substitute for a Fair Hearing, and the appellant retains the right to a Fair Hearing if the disputes are not resolved during the mediation, as set forth in 7 AAC 49, Hearings.

MEDIATION PARTICIPATION

Each mediation is scheduled for one hour with:
- the appellant;
- individuals invited by the appellant to assist and advise on their behalf;
- the mediator, a lawyer contracted by OAH who acts as a neutral party;
- an SDS Fair Hearing representative; and
- an SDS staff member who has the authority to make changes to the existing authorization of services.

Appellants may have others assist and advise on their behalf, without representing the appellant. Care coordinators may assist appellants in retrieving and forwarding new records or information for the mediation. They may also assist in explaining complex ideas to the appellant, as a result of the mediation.

THE MEDIATION PROCESS

During the mediation session, the mediator sets forth basic mediation rules and directs 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 provider.

In addition to the informal mediation, both the appellant and the state may request 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 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.

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**

• **Operational Responsibility.** Specify the state agency that is responsible for the operation of the grievance/complaint system:

OPERATION OF THE GRIEVANCE SYSTEM

The Centralized Reporting system, operated by the SDS Central Intake unit, is the repository for all grievances submitted to SDS. The Centralized Reporting system also receives Reports of Harm, critical incident reports, and reports regarding Residential Licensing. All reports received by the Centralized Reporting system, regardless of the type of report, are tracked within the Harmony database. Grievances are routed by the Central Intake unit to the Provider Certification and Compliance unit, who regularly collaborates with Adult Protective Services, Quality Assurance, and Residential Licensing on grievances that may also result in investigations or corrective actions.

• **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).

THE TYPES OF GRIEVANCES ADDRESSED USING THE GRIEVANCE PROCESS

The state understands grievance to mean an expression of dissatisfaction or complaint related to the state's or a provider's performance of the activities described in paragraphs 42 CFR 441.301(c)(1)-(6), regardless of whether remedial action is requested.

Grievances may include, but are not limited to, complaints about:
- the person centered planning process;
- the person-centered support plan;
- review of the person-centered support plan; or
- home and community-based settings.

THE PROCESS AND TIMELINES FOR ADDRESSING GRIEVANCES/COMPLAINTS

Grievances are usually resolved within 90 days, and expedited reviews are completed within 14 days. Extensions require appellant consent or justification. Extension will only be requested in the event of:
- the appellant requests an extension; or
- The state documents that additional information is needed and that a delay is in the best interest of the appellant.

THE MECHANISMS USED TO RESOLVE GRIEVANCES/COMPLAINTS

The Central Intake unit routes complaints to Adult Protective Services, Quality Assurance unit, or Residential Licensing, depending on the nature of the complaint. Grievances are routed to the Provider Certification and Compliance unit. Adult Protective Services, Quality Assurance, Residential Licensing, and Provider Certification and Compliance unit regularly collaborate on reports that may result in investigation by multiple units or corrective actions.

While investigating a grievance, the Provider Certification and Compliance unit reviews provider records, SDS records pertaining to the substance of the complaint, and, as necessary, conducts on-site interviews. If the grievance is determined to be without merit, the case is closed, and the required data is entered into the Harmony database. Alternatively, if the grievance is founded, SDS plans and implements the appropriate remediation.

Some reports received may not meet the state's definition of a grievance. If the complaint is about the behavior of an SDS employee or an SDS administrative process, the report is routed to the appropriate unit manager to resolve. If the complaint is about perceived deficiencies in SDS operations, SDS addresses them with changes in process, clarification of regulations, individual, unit, or division-wide training. Depending upon the nature of the complaint against state employees, SDS routes the complaint to the state's human resources office or the Alaska State Ombudsman.

HOW THE APPLICANT OR PARTICIPANT IS INFORMED THAT FILING A GRIEVANCE IS NOT A SUBSTITUTE FOR A FAIR HEARING

While the system provides latitude for filing grievances, it is not a substitute or a prerequisite for a Fair Hearing, and filing a grievance with SDS does not preclude the applicant or participant's right to request a Fair Hearing. Applicants or participants who file a grievance with SDS about problems that fall under the scope of the Fair Hearing process are provided with information on how to request a Fair Hearing in the Notice of Recipient Fair Hearing Rights.

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).

DEFINITIONS OF CRITICAL INCIDENTS THAT MUST BE REPORTED

The Division of Senior and Disabilities Services (SDS) Central Intake unit oversees the critical incident reporting process. Critical incidents are submitted through SDS' electronic Centralized Reporting system. Incidents and events that must be reported under 7 AAC 130.224, Critical incident reporting, 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 extent evaluation by or consultation with medical personnel was needed;
- an event that involved the participant and a response from a peace officer;
- reports of abuse, neglect, or exploitation; and
- 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; or
- administration of a medication other than the correct dosage.

Depending upon the nature of the report, Central Intake may route the critical incident report to one or several of the following entities that conduct follow-up actions:

- SDS' Adult Protective Services unit
- SDS' Quality Assurance unit
- Division of Health Care Services, Residential Licensing unit
- Office of Children's Services' Intake unit
- Law Enforcement

INDIVIDUALS REQUIRED TO REPORT CRITICAL INCIDENTS AND TIMEFRAMES

All waiver service providers are considered "persons required to report" incidents including alleged abuse, neglect, or exploitation and must report these types of incidents within 24 hours of becoming aware of the incident, in accordance with AS 47.17.020, for children, and AS 47.24.010, for adults.

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 renewal certification or at SDS' request.

METHOD OF REPORTING

The Centralized Reporting system serves as a repository for voluntary reports, required reports, and concerns or complaints about vulnerable adults, individuals living in licensed assisted living facilities, and participants receiving home and community-based services administered through SDS.

Providers, participants, care coordinators, family members, advocates, SDS staff, or any member of the public may submit a report through the Centralized Reporting system, by phone, email, fax, or in-person.

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.

REPORTING ABUSE, NEGLECT, AND EXPLOITATION: EDUCATION AND TRAINING OF PARTICIPANTS AND UNPAID CAREGIVERS

As part of the initial application and annual renewal application process for home and community-based waiver services, care coordinators are responsible for informing initial applicants and enrolled waiver participants, or their legal representatives, if applicable, on how to identify and report abuse, neglect and exploitation.

The care coordinator explains the applicant's or participant's rights in detail and provides the "Recipient Rights and Responsibilities" form that identifies the state agencies responsible for investigating reports, including contact information and instructions for how to make a report. The the applicant, the participant or their legal representative, if applicable, signs the form along with the care coordinator.

After the form is signed, a copy is given to the applicant or participant or their legal representative, if applicable, for future reference.

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.

RESPONSIBILITY FOR RECEIVING AND ROUTING CRITICAL INCIDENT REPORTS

SDS' Central Intake unit is responsible for receiving, processing, and routing reports submitted through the Centralized Reporting system.

Within 24 hours or one business day of report receipt, Central Intake reviews and routes all reports to the pertinent appropriate entity. Central Intake may route the same report to multiple entities depending on the nature of the report.

Central Intake may route reports to:
- Adult Protective Services, if there is an allegation of undue influence, abuse, neglect, exploitation, self-neglect, or abandonment involving a vulnerable adult as defined under AS.47.24.900;
- Quality Assurance, if the report is regarding a waiver participant and is defined as a critical incident report under 7 AAC 130.224 or is a complaint against a certified waiver provider;
- Residential Licensing, if an incident occurred at a licensed assisted living home or involved a resident of a licensed assisted living home;
- Office of Children's Services, if the report involves a child and meets the mandated reporting criteria;
- Office of Long Term Care Ombudsman, for reports including adults sixty years of age or older residing in a licensed residential setting as a referral under AS 47.24.013;
- Law enforcement or emergency services, if applicable.

RESPONSIBILITY FOR REPORTS AND METHODS OF INVESTIGATION BY RESPONDING AGENCY

Adult Protective Services:

Adult Protective Services evaluates and investigates reports in accordance with AS 47.24, Protection of Vulnerable Adults. Adult Protective Services uses a priority-based response system and assigns a priority level to each report, based on the urgency and nature of the report and the capacity of the vulnerable adult to make independent decisions.

Adult Protective Services responds to reports addressing health, safety, abandonment, abuse, exploitation, neglect, self-neglect or other harm of the vulnerable adult. Adult Protective Services may also evaluate guardianship needs, protective placement, or supportive service needs.

Timeframes:
Priority 1: Face-to-face contact within 24 hours of receipt of report.
Priority 2: Face-to-face contact within five business days of receipt of report. Priority 3: Face-to-face contact within 10 business days of receipt of report.

Adult Protective Services investigations may include: interviewing and observing the vulnerable adult, and other appropriate individuals, to assess health and safety, and other risk factors.

Adult Protective Services' investigation follow-up activities may include: facilitation of protective placements or supportive services, appointment of a surrogate decision maker, and initiation of the guardianship process.

Unless there are circumstances beyond Adult Protective Services' control all investigations are concluded within 90 calendar days. If circumstances beyond the control of Adult Protective Services make it impossible to investigate or provide protective services within these time frames, an investigation shall be completed as soon as possible.

Reporters may request confirmation of receipt of report, but no additional information is provided. In accordance with federal regulations, Adult Protective Services only releases information with the consent of the vulnerable adult or their legal representative, if applicable, or when required by law enforcement or a court order. Adult Protective Services does not release the identity of the reporter, as stated in AS 47.24.050.

Quality Assurance unit:

The Quality Assurance unit evaluates and investigates reports involving waiver participants and certified waiver service

providers in accordance with 7 AAC130.224, Critical incident reporting.

Quality Assurance reviews the appropriateness of the provider's response in mitigating any risks to the participant's health and safety and evaluates if the provider adequately addressed the risk of reoccurrence. Quality Assurance uses a priority-based response system, and investigations are initiated in accordance with the priority assigned, based on the nature of the report.

Quality Assurance investigations may include: interviewing provider staff, interviewing the participant, or the participant's legal representative, if applicable, reviewing previous provider critical incident reports, provider policies and procedures, staff credentials and training records, and reviewing provider records in the Harmony database to track the discovery and remediation history of individual provider's deficiencies.

Quality Assurance investigation follow-up activities may include: initiating a corrective action plan and monitoring the providers' progress and remediation activities until Quality Assurance determines that any risks to participant health and safety are corrected and the risk of incident reoccurrence is reduced.

Quality Assurance investigations are typically expected to be completed within 90 days of assignment but may take longer depending upon the individual circumstances of the investigation.

At the conclusion of an investigation with substantiated findings where a provider sanction is imposed, an investigation report is issued to the provider under investigation and due process for appeal is granted. To maintain confidentiality, parts of the report may be redacted. Quality Assurance will only release a copy of the report to members of the public if a request is submitted as a public records request and the report may be redacted.

Residential Licensing:

Residential Licensing, operating within the Department of Health's Division of Health Care Services, evaluates and investigates reports in accordance with AS 47.32, Centralized Licensing and Related Administrative Procedures, AS 47.33, Assisted Living Homes, and 7 AAC 75, Assisted Living Homes. Residential Licensing reviews reports that involve licensed residential setting providers' responses to incidents that involve risks to the health and safety of participants living in licensed residential settings or if an incident occurred in a licensed residential setting.

Residential Licensing responds to reports related to allegations of abuse, neglect, exploitation, abandonment, unqualified caregivers, situations that present risks or imminent harm to a participant, and when a licensed provider may have violated statutes or regulations.

Residential Licensing uses a priority-based response system and assigns a priority level to each report, based on the response required to ensure participant health and safety or a provider's compliance with regulatory requirements.

Timeframes:
Priority 1: Investigator responds within 48 hours. Priority 2: Investigator responds within five days.
Priority 3: Screened out and not investigated but investigator may gather collateral information or log in a report within 10 days.

Residential Licensing investigations may include: unannounced on-site inspections, interviews with participants and personnel, review of medical and law enforcement records, review required documentation, personnel orientation, training, and background checks.

Residential Licensing investigation follow-up activities may include: issuing the provider a notice of violation or requiring the provider to create a plan of correction. Residential Licensing monitors the provider's progress and remediation activities until Residential Licensing is satisfied with the provider's compliance. Residential Licensing employs a progressive disciplinary process that may culminate in the suspension or revocation of the provider's license.

After a provider's investigation is completed, Residential Licensing finalizes the investigation report within 14 days.

At the conclusion of an investigation, an investigation report is issued to the provider under investigation and due process for appeal is granted. To maintain confidentiality, parts of the report may be redacted. Residential Licensing will only release a copy of the report to members of the public if a request is submitted as a public records request and the report may be redacted.

Office of Children's Services:

The Office of Children's Services conducts an initial assessment, evaluates, and investigates reports in accordance with AS 47.17, Child Protection, and 7 AAC 54, Privacy of Client Records: Child Protection Services.

Central Intake will route reports to the Office of Children's Services under two circumstances:
1. The report alleges abuse, neglect, or exploitation of a minor, regardless of whether that minor is a participant of waiver services;
2. The report involves a participant of waiver services of whom the Office of Children's Services is the guardian.
The Office of Children's Services uses a priority-based response system depending upon the nature of the report.
Timeframes:
Priority 1: Face-to-face contact within 24 hours. Priority 2: Face-to-face contact within 72 hours. Priority 3: Face-to-face contact within seven days.

The Office of Children's Services' investigations may include conducting interviews with the appropriate individuals and completing an initial assessment.

Upon completion of an investigation, the Office of Children's Services sends a letter to the parent or guardian; if there has been a substantiated finding, the Office of Children's Services sends a letter to the alleged maltreater. The Office of Children's Services will notify a mandatory reporter, if requested, whether the report was screened in for an investigation and when the investigation is complete. The Office of Children's Services does not divulge the outcome of any investigation.

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.

RESPONSIBILITY FOR OVERSEEING THE OPERATION OF THE INCIDENT MANAGEMENT SYSTEM

SDS' Central Intake unit, within the Department of Health, the Single State Medicaid agency, oversees the critical incident reporting management system. Adult Protective Services, Quality Assurance, and Residential Licensing use the Harmony database for overseeing and responding to critical incidents and events.

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 the SDS Central Intake unit to make a report that is entered into the Harmony database.

METHODS OF OPERATION, DATA COLLECTION, COMPILATION, PREVENTION, AND OVERSIGHT FREQUENCY

All reports received by Central Intake are entered into the Harmony database. The Harmony database includes: provider operations and compliance, participant information, technical assistance offered to providers, corrective actions and remediation activities, investigation process and results, participant and provider communications, and requests for additional information related to complaints or reports. Additionally, SDS utilizes a critical incident data infrastructure with data mining software to allow identification of health and safety trends among participants.

Adult Protective Services and Quality Assurance review and analyze critical incident reports on a monthly basis at the Health and Welfare Review Task Committee. Issues discussed include:

- risk management methods to identify prevalence and patterns of adverse events in the participant population;
- processes to evaluate the effectiveness of technical assistance interventions; and
- methods used to identify quality improvement areas for SDS and provider agency operations.

The task committee takes follow-up actions and recommendations, as needed, to SDS' monthly Quality Improvement Workgroup (QIW) which reviews the information to confirm the appropriate follow-up activities.

Residential Licensing reviews and analyzes requisite reporting requirements with licensed providers during the initial licensing application process, the probationary (1 year) licensing cycle, and the biennial (2 year) licensing cycle.

Ongoing oversight is also conducted using a coordinated approach, established through the Coordination of Licensed and Certified Providers workgroup, which includes representatives from Quality Assurance, Adult Protective Services, Provider Certification and Compliance, Residential Licensing and the Office of Long-Term Care Ombudsman.

This workgroup meets monthly, at a minimum, to collaborate and share information about service and provider monitoring, identify trends, and violations.

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).

AUTHORIZED RESTRICTIVE INTERVENTIONS AND CIRCUMSTANCES OF USE

The state's regulation at 7 AAC 130.229, Use of restrictive intervention, defines restrictive interventions as "an action or procedure that limits an individual's movement or access to other individuals, locations or activities." The state considers restraints as a subset of restrictive interventions.

SDS permits the use of restrictive interventions, including restraints, when the use of less restrictive interventions has been shown to be ineffective, and in two (2) circumstances only:
- when a participant's behavior is unanticipated and presents an imminent danger to the participant's safety or to the safety of others; or
- in accordance with an approved support plan that includes a restrictive intervention plan, that contains the required elements regarding the use of restrictive interventions or restraints.

PROHIBITED USE OF RESTRICTIVE INTERVENTIONS

SDS prohibits three (3) methods of restrictive intervention:
- seclusion as a restrictive intervention;
- prone restraint; and
- chemical restraint.

Physical restraints may not be used for disciplinary purposes, staff convenience, or as a substitute for adequate staffing levels.

PROTOCOLS FOR THE AUTHORIZED USE OF RESTRICTIVE INTERVENTIONS, INCLUDING RESTRAINTS

All providers must have written policies and procedures that address the providers' use of restrictive interventions, including instances when restrictive interventions are authorized as a response to imminent danger.

Aside from instances of imminent danger, restrictive interventions, including the use of restraints, may only be authorized if a participant has an approved support plan that includes a restrictive intervention plan. Restrictive intervention plans are designed to use the least restrictive methods necessary to manage behaviors and reduce or eliminate the circumstances in which restrictive interventions or restraints would be necessary.

An SDS approved restrictive intervention plan must be initiated when:
- a participant's behavior requires the reoccurring use of restrictive interventions or restraints; or
- there is a modification to any of the following settings requirements in a licensed residential setting, 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 proved unworkable:
- privacy in the participant's living or sleeping unit;
- the freedom and support needed for a participant to control the participant's schedule and activities;
- access to food at all times; and
- visitors of the participant's choosing at any time.

The restrictive intervention plan is developed by the provider in concert with the participant's planning team and is included in the support plan. The department may require the planning team to consult with a professional licensed under AS 08 when a restrictive intervention plan is ineffective at reducing or eliminating the behavior.

In the development of the restrictive intervention plan, the planning team should consider the participant's overall quality of 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.

The restrictive intervention plan must include:
- identification of the assessed need requiring intervention or modification;

- strategies for preventing the behavior, including supporting positive behavior;
- documentation of positive interventions and other less intrusive methods that were used to address that need and that did not work;
- a description of the intervention or modification, which must be directly proportional to the specific assessed need;
- methods for measuring and documenting the plan's effectiveness, time limits for periodic reviews to determine if the intervention or modification continues to be necessary or should be terminated;
- a documented analysis concluding the interventions included in the plan will not cause harm to the participant; and
- if modifying the settings requirements under 7 AAC 130.220(o)(2), the restrictive intervention plan must also include documentation of the informed consent of the participant, or the participant's legal representative, if applicable, for the modification.

If the plan has succeeded in eliminating the behavior, the restrictive intervention plan will be removed from the support plan.

METHODS FOR DETECTING UNAUTHORIZED USE OF RESTRICTIVE INTERVENTIONS, INCLUDING RESTRAINTS

SDS, in cooperation with Residential Licensing, monitors the use of restrictive interventions, including restraints, through on-site reviews, application reviews, provider agency reports and training records, licensing inspection reports, investigative reports, care coordination activities, support plan and restrictive intervention plan reviews, critical incident reports, complaints, and referrals.

At least each calendar quarter, for all uses of restrictive interventions including restraints, providers are required to document each use, evaluate, analyze, take corrective actions based on the analysis, and record any program improvement. Providers must submit the evaluation and corrective action reports to SDS upon renewal certification or at SDS' request.

During the monthly contacts with the participant, the care coordinator reviews any use of restrictive intervention, including the use of restraints. If a restrictive intervention or restraints were used, the care coordinator discusses the event with the provider and verifies its use was for circumstances that presented imminent danger or met the requirements outlined in a restrictive intervention plan. The care coordinator must submit a critical incident report if they believe that the use of restrictive intervention or restraints was incorrectly administered or unauthorized.

When a Quality Assurance unit investigation reveals inappropriate use of restrictive interventions or restraints, unit staff contact the provider to request a corrective action plan that may include training and technical assistance and may progress up to revocation of certification. Unit staff monitor the corrective action plan until it is complete or until unit staff assess a low risk of reoccurrence.

PRACTICES TO ENSURE HEALTH AND SAFETY

State regulations guide the use of restrictive interventions, including the use of restraints. These regulations, found at 7 AAC 130.229 and 7 AAC 75, include safeguards to ensure participant health and safety. Safeguards include the limited circumstances when restrictive interventions can be authorized, prohibited use of several types of restraints, and reporting requirements to ensure that all instances of unauthorized restrictive intervention are reported to SDS for investigation.

Protocols for the authorized use of restrictive interventions require that providers have written policies and procedures that address the providers' use of restrictive interventions, training, documentation, supervision, monitoring, and evaluation of each use of restrictive intervention.

REQUIRED DOCUMENTATION

In accordance with 7 AAC 130.229, Use of restricted intervention, and as a requirement of certification, the providers must develop and implement a plan to manage and report the use of restrictive intervention,

including a plan for documenting and tracking the use of restrictive intervention, meeting reporting requirements regarding 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 certification under 7 AAC 130.220, Provider certification, or upon request.

The provider that uses restrictive interventions, including restraints, must maintain a record of documentation and 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;
- the type of care provided to the participant while a restrictive intervention is applied;
- the name of each staff member involved in the restrictive intervention; and
- the outcome for the participant and for the staff involved in the event.

EDUCATION AND TRAINING REQUIREMENTS FOR PERSONNEL

All providers must comply with education and training requirements in accordance with 7 AAC 130.222, Recipient safeguards, and with education and training requirements in the Provider Conditions of Participation for Home and Community-Based Waiver Services and the Conditions of Participation for each service the provider offers.

The provider must provide, and have on file, for each direct service worker, documentation of attendance and completion of training on the use of restrictive intervention and restraints that includes:
- describing actions that are considered to be restrictive interventions or restraints;
- specifying restrictive interventions and restraints that are prohibited by regulation;
- identifying restrictive interventions and restraints appropriate for use with the population served by the provider;
- outlining the requirements for documenting every use of restrictive intervention or restraints; and
- reporting as a critical incident any misuse of restrictive intervention or restraints and any use that results in medical intervention.

The provider must have written verification on file that each direct service worker has received training appropriate to the type of restrictive intervention or restraints the provider has allowed that direct service worker to use.

Residential Licensing is responsible for the licensure of assisted living homes and offers a new provider orientation training that includes information related to restrictive interventions, including restraints.

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:

METHODS FOR DETECTING UNAUTHORIZED USE OF RESTRICTIVE INTERVENTIONS, INCLUDING RESTRAINTS

SDS, in cooperation with Residential Licensing, monitors the use of restrictive interventions, including restraints, through on-site reviews, application reviews, provider agency reports and training records, licensing inspection reports, investigative reports, care coordination activities, support plan and restrictive intervention plan reviews, critical incident reports, complaints, and referrals.

At least each calendar quarter, for all uses of restrictive interventions including restraints, providers are required to document each use, evaluate, analyze, take corrective actions based on the analysis, and record any program improvement. Providers must submit the evaluation and corrective action reports to SDS upon renewal certification or at SDS' request.

During the monthly contacts with the participant, the care coordinator reviews any use of restrictive intervention, including the use of restraints. If a restrictive intervention or restraints were used, the care coordinator discusses the event with the provider and verifies its use was for circumstances that presented imminent danger or met the requirements outlined in a restrictive intervention plan. The care coordinator must submit a critical incident report if they believe that the use of restrictive intervention or restraints was incorrectly administered or unauthorized.

When a Quality Assurance unit investigation reveals inappropriate use of restrictive interventions or restraints, unit staff contact the provider to request a corrective action plan that may include training and technical assistance and may progress up to revocation of certification. Unit staff monitor the corrective action plan until it is complete or until unit staff assess a low risk of reoccurrence.

METHODS FOR OVERSEEING THE OPERATION OF THE INCIDENT MANAGEMENT SYSTEM, HOW DATA IS ANALYZED TO IDENTIFY TRENDS AND SUPPORT IMPROVEMENT STRATEGIES, AND FREQUENCY OF OVERSIGHT ACTIVITIES

Using the discovery methods mentioned above, the Quality Assurance unit collects and aggregates data regarding the use of restrictive interventions, including restraints, analyzes trends, and prepares a monthly discovery and remediation report for the Health and Welfare Review Task Committee.

The Health and Welfare Review Task Committee is led by Adult Protective Services and Quality Assurance unit staff and includes other SDS staff. The committee evaluates the information for possible individual remediation, patterns or trends in the use of restrictive intervention, including the use of restraints, and makes a monthly quality report to the QIW. This quality report may include recommendations for remediation, including technical assistance and training or policy implementation strategies.

In turn, the QIW 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 (QISC) chaired by the department's deputy commissioner. This QISC has broad departmental membership and meets quarterly to review the quality monitoring report.

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.

AUTHORIZED RESTRICTIVE INTERVENTIONS AND CIRCUMSTANCES OF USE

The state's regulation at 7 AAC 130.229, Use of restrictive intervention, defines restrictive interventions as "an action or procedure that limits an individual's movement or access to other individuals, locations or activities." The state considers restraints as a subset of restrictive interventions.

SDS permits the use of restrictive interventions, including restraints, when the use of less restrictive interventions has been shown to be ineffective, and in two (2) circumstances only:
• when a participant's behavior is unanticipated and presents an imminent danger to the participant's safety or to the safety of others; or
• in accordance with an approved support plan that includes a restrictive intervention plan, that contains the required elements regarding the use of restrictive interventions or restraints.

PROHIBITED USE OF RESTRICTIVE INTERVENTIONS

SDS prohibits three (3) methods of restrictive intervention:
• seclusion as a restrictive intervention;
• prone restraint; and
• chemical restraint.

Physical restraints may not be used for disciplinary purposes, staff convenience, or as a substitute for adequate staffing levels.

PROTOCOLS FOR THE AUTHORIZED USE OF RESTRICTIVE INTERVENTIONS, INCLUDING RESTRAINTS

All providers must have written policies and procedures that address the providers' use of restrictive interventions, including instances when restrictive interventions are authorized as a response to imminent danger.

Aside from instances of imminent danger, restrictive interventions, including the use of restraints, may only be authorized if a participant has an approved support plan that includes a restrictive intervention plan. Restrictive intervention plans are designed to use the least restrictive methods necessary to manage behaviors and reduce or eliminate the circumstances in which restrictive interventions or restraints would be necessary.

An SDS approved restrictive intervention plan must be initiated when:
• a participant's behavior requires the reoccurring use of restrictive interventions or restraints; or
• there is a modification to any of the following settings requirements in a licensed residential setting, 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 proved unworkable:
- privacy in the participant's living or sleeping unit;
- the freedom and support needed for a participant to control the participant's schedule and activities;
- access to food at all times; and
- visitors of the participant's choosing at any time.

The restrictive intervention plan is developed by the provider in concert with the participant's planning team and is included in the support plan. The department may require the planning team to consult with a professional licensed under AS 08 when a restrictive intervention plan is ineffective at reducing or eliminating the behavior.

In the development of the restrictive intervention plan, the planning team should consider the participant's overall quality of 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.

The restrictive intervention plan must include:
• identification of the assessed need requiring intervention or modification;

- strategies for preventing the behavior, including supporting positive behavior;
- documentation of positive interventions and other less intrusive methods that were used to address that need and that did not work;
- a description of the intervention or modification, which must be directly proportional to the specific assessed need;
- methods for measuring and documenting the plan's effectiveness, time limits for periodic reviews to determine if the intervention or modification continues to be necessary or should be terminated;
- a documented analysis concluding the interventions included in the plan will not cause harm to the participant; and
- if modifying the settings requirements under 7 AAC 130.220(o)(2), the restrictive intervention plan must also include documentation of the informed consent of the participant, or the participant's legal representative, if applicable, for the modification.

If the plan has succeeded in eliminating the behavior, the restrictive intervention plan will be removed from the support plan.

METHODS FOR DETECTING UNAUTHORIZED USE OF RESTRICTIVE INTERVENTIONS, INCLUDING RESTRAINTS

SDS, in cooperation with Residential Licensing, monitors the use of restrictive interventions, including restraints, through on-site reviews, application reviews, provider agency reports and training records, licensing inspection reports, investigative reports, care coordination activities, support plan and restrictive intervention plan reviews, critical incident reports, complaints, and referrals.

At least each calendar quarter, for all uses of restrictive interventions including restraints, providers are required to document each use, evaluate, analyze, take corrective actions based on the analysis, and record any program improvement. Providers must submit the evaluation and corrective action reports to SDS upon renewal certification or at SDS' request.

During the monthly contacts with the participant, the care coordinator reviews any use of restrictive intervention, including the use of restraints. If a restrictive intervention or restraints were used, the care coordinator discusses the event with the provider and verifies its use was for circumstances that presented imminent danger or met the requirements outlined in a restrictive intervention plan. The care coordinator must submit a critical incident report if they believe that the use of restrictive intervention or restraints was incorrectly administered or unauthorized.

When a Quality Assurance unit investigation reveals inappropriate use of restrictive interventions or restraints, unit staff contact the provider to request a corrective action plan that may include training and technical assistance and may progress up to revocation of certification. Unit staff monitor the corrective action plan until it is complete or until unit staff assess a low risk of reoccurrence.

PRACTICES TO ENSURE HEALTH AND SAFETY

State regulations guide the use of restrictive interventions, including the use of restraints. These regulations, found at 7 AAC 130.229 and 7 AAC 75, include safeguards to ensure participant health and safety. Safeguards include the limited circumstances when restrictive interventions can be authorized, prohibited use of several types of restraints, and reporting requirements to ensure that all instances of unauthorized restrictive intervention are reported to SDS for investigation.

Protocols for the authorized use of restrictive interventions require that providers have written policies and procedures that address the providers' use of restrictive interventions, training, documentation, supervision, monitoring, and evaluation of each use of restrictive intervention.

REQUIRED DOCUMENTATION

In accordance with 7 AAC 130.229, Use of restricted intervention, and as a requirement of certification, the providers must develop and implement a plan to manage and report the use of restrictive intervention,

including a plan for documenting and tracking the use of restrictive intervention, meeting reporting requirements regarding 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 certification under 7 AAC 130.220, Provider certification, or upon request.

The provider that uses restrictive interventions, including restraints, must maintain a record of documentation and 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;
- the type of care provided to the participant while a restrictive intervention is applied;
- the name of each staff member involved in the restrictive intervention; and
- the outcome for the participant and for the staff involved in the event.

EDUCATION AND TRAINING REQUIREMENTS FOR PERSONNEL

All providers must comply with education and training requirements in accordance with 7 AAC 130.222, Recipient safeguards, and with education and training requirements in the Provider Conditions of Participation for Home and Community-Based Waiver Services and the Conditions of Participation for each service the provider offers.

The provider must provide, and have on file, for each direct service worker, documentation of attendance and completion of training on the use of restrictive intervention and restraints that includes:
- describing actions that are considered to be restrictive interventions or restraints;
- specifying restrictive interventions and restraints that are prohibited by regulation;
- identifying restrictive interventions and restraints appropriate for use with the population served by the provider;
- outlining the requirements for documenting every use of restrictive intervention or restraints; and
- reporting as a critical incident any misuse of restrictive intervention or restraints and any use that results in medical intervention.

The provider must have written verification on file that each direct service worker has received training appropriate to the type of restrictive intervention or restraints the provider has allowed that direct service worker to use.

Residential Licensing is responsible for the licensure of assisted living homes and offers a new provider orientation training that includes information related to restrictive interventions, including restraints.

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:

METHODS FOR DETECTING UNAUTHORIZED USE OF RESTRICTIVE INTERVENTIONS, INCLUDING RESTRAINTS

SDS, in cooperation with Residential Licensing, monitors the use of restrictive interventions, including restraints, through on-site reviews, application reviews, provider agency reports and training records, licensing inspection reports, investigative reports, care coordination activities, support plan and restrictive intervention plan reviews, critical incident reports, complaints, and referrals.

At least each calendar quarter, for all uses of restrictive interventions including restraints, providers are required to document each use, evaluate, analyze, take corrective actions based on the analysis, and record any program improvement. Providers must submit the evaluation and corrective action reports to SDS upon renewal certification or at SDS' request.

During the monthly contacts with the participant, the care coordinator reviews any use of restrictive intervention, including the use of restraints. If a restrictive intervention or restraints were used, the care coordinator discusses the event with the provider and verifies its use was for circumstances that presented imminent danger or met the requirements outlined in a restrictive intervention plan. The care coordinator must submit a critical incident report if they believe that the use of restrictive intervention or restraints was incorrectly administered or unauthorized.

When a Quality Assurance unit investigation reveals inappropriate use of restrictive interventions or restraints, unit staff contact the provider to request a corrective action plan that may include training and technical assistance and may progress up to revocation of certification. Unit staff monitor the corrective action plan until it is complete or until unit staff assess a low risk of reoccurrence.

METHODS FOR OVERSEEING THE OPERATION OF THE INCIDENT MANAGEMENT SYSTEM, HOW DATA IS ANALYZED TO IDENTIFY TRENDS AND SUPPORT IMPROVEMENT STRATEGIES, AND FREQUENCY OF OVERSIGHT ACTIVITIES

Using the discovery methods mentioned above, the Quality Assurance unit collects and aggregates data regarding the use of restrictive interventions, including restraints, analyzes trends, and prepares a monthly discovery and remediation report for the Health and Welfare Review Task Committee.

The Health and Welfare Review Task Committee is led by Adult Protective Services and Quality Assurance unit staff and includes other SDS staff. The committee evaluates the information for possible individual remediation, patterns or trends in the use of restrictive intervention, including the use of restraints, and makes a monthly quality report to the QIW. This quality report may include recommendations for remediation, including technical assistance and training or policy implementation strategies.

In turn, the QIW 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 QISC chaired by the department's deputy commissioner. This QISC has broad departmental membership and meets quarterly to review the quality monitoring report.

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:

METHODS FOR DETECTING UNAUTHORIZED USE OF SECLUSION

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 restrictive intervention 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, and referrals. Investigation reports conducted by Residential Licensing are entered into the 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)*

- **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.

RESPONSIBILITY, SCOPE, METHODS, AND FREQUENCY OF MONITORING PARTICIPANT MEDICATION

The state considers medication management as:
1.) administration of medication, meaning the direct delivery or application of medication into the body of a participant that is unable to administer medication independently.
2.) assistance with self-administration of medication, which may include:
- reminding the participant;
- opening a container;
- reading a medication label to the participant;
- providing food or liquids in accordance with the medication label;
- observing the participant taking the medication;
- checking the participant's self-administered dosage against the label;
- reassuring the participant that the dosage is correct; or
- directing or guiding the hand of the participant, at the participant's request.

The state further distinguishes between situations in which:
- medication management is provided in a licensed residential setting under AS 47.32 and AS 47.33, monitored by a registered nurse, who may delegate medication management activities to a non-medical waiver provider, or
- medication management conducted in a certified setting where a licensed health provider, the participant or the participant's representative, if applicable, may delegate medication management activities.

The state regulations related to medication management are:
- 7 AAC 67, Foster Home licensing standards;
- 7 AAC 75, Assisted Living Home;
- 7 AAC 130.224, Critical incident reporting;
- 7 AAC 130.227, Administration of medication and assistance with self-administration of medication;
- 12 AAC 44.965, Delegation of the administration of medication; and
- Provider Conditions of Participation adopted by referenced in 7 AAC 160.900.

WAIVER SERVICES IN NON-LICENSED AND CERTIFIED SETTINGS

In accordance with above regulations, certified home and community-based providers have ongoing responsibility for monitoring participant medication management while in the providers' care. The provider activities include, but are not limited to:
- developing and implementing written policies and procedures that address medication management;
- written delegation from the participant or the participant's legal representative or is in accordance with 12 AAC 44.965 or another applicable statute or regulation;
- ensuring all medications taken by the participant while in the provider's care are documented;
- ensuring that the individual providing administration of medication or assistance with self-administration has on file documentation of successful completion of the appropriate training.

WAIVER SERVICES IN LICENSED ASSISTED LIVING HOMES AND HOST CARE HOMES

Medication management in licensed assisted living home and host care homes are described in participant's residential care plan and include a physician's statement regarding the medication regimen that must be included in the plan. The participant or the participant's legal representative, if applicable, and a registered nurse must review the portion of the plan that describes how the participant's health-related services will be met.

A registered nurse may provide administration of medication or may delegate the administration of medication. Medication delegation may be made to certified home and community-based services providers, licensed assisted living home and host care home providers, and select certified nurse aides and medical assistants. Any direct service worker to whom the administration of medication has been delegated must meet the Board of Nursing training requirements. The delegating nurse must monitor the direct service worker and reevaluate the nursing delegation plan every 90 days.

All medication delegation is monitored by the registered nurse. The registered nurse monitors the appropriateness

of the medications, usage patterns, potential risks and side effects associated with the medications, and possible medication interactions, with particular attention paid to the participant if their medication regime is complex or includes behavior-modifying medications. The participant's care coordinator, through monthly contacts, also provides monitoring.

WAIVER SERVICES IN LICENSED FOSTER CARE HOMES

A foster home may administer medication only if the foster parent meets the following conditions:
- obtains written permission from the department or the child's legal guardian, as applicable, for the administration of prescription medication to a foster child;
- administers prescription medication or any special medical procedures only in the dosage, at the intervals, or in the manner prescribed by the person legally authorized to prescribe medication or medical procedures;
- administers nonprescription medication only if authorized by the child's caseworker; and
- for youth 17 or older, permission is not required for prescription birth control.

DETECTING POTENTIALLY HARMFUL PRACTICES

All home and community-based service certified providers must develop and implement a system to manage and report medication errors. This includes:
- tracking and documenting errors;
- reporting medication errors as critical incidents if the error resulted in medical intervention;
- analyzing medication errors each quarter and taking corrective actions based on that analysis;
- summarizing quarterly analysis; and
- submitting the summary to SDS upon renewal certification or upon SDS' request.

For licensed assisted living homes and host care homes, the residential care plan must address the need for health-related services and how that need will be met. A physician's statement regarding the medication regimen must be included in the plan. The resident or the resident's legal representative, if applicable, and the registered nurse must review the portion of the plan that describes how the resident's need for health-related services will be met. The care plan must be evaluated at three-month intervals. The registered nurse must report adverse events to the physician and based on the evaluation of the medication process in the licensed setting, may revise the care plan to stipulate more frequent provider monitoring or recommend additional training to direct service workers.

For licensed foster homes, a foster parent may not administer prescription medication without first receiving written permission from the participant's legal guardian or the Department of Family and Community Services. Informed parental consent is required for major medical care, including administration of psychotropic medication or any medications prescribed for mental illness or behavioral problems, unless parental rights have been terminated or there is a court order authorizing the specific medication or treatment. Informed consent includes information regarding alternative therapies or treatment. The Office of Children's Services and SDS meet regularly to share and discuss information regarding reports received, licensing actions, and systematic barriers.

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.

RESPONSIBILITY FOR OVERSIGHT AND FOLLOW-UP

SDS, Residential Licensing, the Department of Family and Community Services, and the Board of Nursing are responsible for oversight of medication management and follow-up.

At SDS, the Quality Assurance unit and the Provider Certification and Compliance unit lead oversight and follow-up activities. They collaborate with Residential Licensing for oversight and follow-up of licensed assisted living homes and host care homes and with the Department of Family and Community Services for oversight and follow-up of licensed foster homes, and both agencies also conduct their own oversight activities. Additionally, Adult Protective Services may become involved when there is a concern about a vulnerable adult. The Long Term Care Ombudsman may also conduct oversight and follow-up activities when a vulnerable adult resides in a licensed residential setting.

The Alaska Board of Nursing governs the practice of nursing and certified nurse aides in Alaska. It makes final health-related licensing and certification decisions and takes disciplinary action against those who are in violation of licensing laws.

METHODS AND FREQUENCY FOR DETECTING POTENTIALLY HARMFUL PRACTICES

SDS' Quality Assurance and Provider Certification and Compliance units detect potentially harmful practices through:

- critical incident reporting, grievances, and complaints;
- on-site inspections;
- provider's certification application process;
- provider agency reports and training records; and
- Quality Assurance investigations.

SDS requires providers to 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. The report must be submitted to SDS with the provider's application for renewal certification, or upon SDS' request. The Provider Certification and Compliance unit considers these reports during the provider's renewal certification process.

The Office of Children's Services and Residential Licensing also conduct their own investigations of medication errors in licensed settings. The Office of Children's Services conducts on-site reviews, communicates deficiencies, and works with the licensed foster family to remediate any issues. Licensed foster homes are inspected during the initial licensure process and then on a biennial basis and as needed. The Office of Children's Services and SDS collaborate on investigations. Investigations that reveal deficiencies may result in the requirement for additional training, corrective action plans, loss of certification, termination from the Medicaid program, suspension or revocation of the license, or referral to other agencies as appropriate.

Residential Licensing monitors licensed residential settings with on-site inspections during initial licensure and on a biennial basis. The biennial evaluation may include review of participants' residential care plans to ensure that medication management activities have been completed by a registered nurse at three-month intervals and that any concerns have been documented, addressed, and resolved. In the intervening years, providers are required to submit an annual provider self-monitoring report that tracks provider compliance with regulatory requirements. Residential Licensing investigates reported medication management errors with an investigation of the circumstances that led to a medication error and takes action to correct the practices contributing to the error. An investigation may include review of the nursing delegation plan, documentation of medication administration delegation training, and review of staff files. Identified deficiencies may result in the progressive enforcement up to revocation of the license. Residential Licensing reports any substantiated findings or concerns regarding the performance of a nurse or a direct care worker directly to the Board of Nursing.

Quality Assurance, Provider Certification and Compliance unit, Adult Protective Services, and Residential Licensing may collaborate on shared investigations which are linked in the Harmony database, and each entity has access to the same information and history of actions taken on linked cases. The Provider Certification and Compliance unit may also be informed of and included in the investigations, when a provider's noncompliance with certification requirements is alleged. All provider-related records associated with an investigation are linked

to the provider's record in the Harmony database and are considered when the provider renews their certification.

QUALITY IMPROVEMENT

Using the discovery methods mentioned above, the Quality Assurance unit collects and aggregates data regarding medication errors, analyzes trends, and prepares a monthly discovery and remediation report for the Health and Welfare Review Task Committee.

The Health and Welfare Review Task Committee is led by Adult Protective Services and Quality Assurance unit staff and includes other SDS staff. The committee evaluates the information for possible individual remediation, patterns or trends in medication errors, and makes a monthly quality report to the QIW. This quality report may include recommendations for remediation, including technical assistance and training or policy implementation strategies.

In turn, the QIW 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 QISC chaired by the department's deputy commissioner. The QISC has broad departmental membership and meets quarterly to review the quality monitoring report.

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)*

• **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).

The state considers medication management as:
1.) administration of medication, meaning the direct delivery or application of medication into the body of a participant that is unable to administer medication independently.
2.) assistance with self-administration of medication, which may include:
- reminding the participant;
- opening a container;
- reading a medication label to the participant;
- providing food or liquids in accordance with the medication label;
- observing the participant taking the medication;
- checking the participant's self-administered dosage against the label;
- reassuring the participant that the dosage is correct; or
- directing or guiding the hand of the participant, at the participant's request.

The state further distinguishes between situations in which:
- medication management is provided in a licensed residential setting under AS 47.32 and AS 47.33, monitored by a registered nurse, who may delegate medication management activities to a non-medical waiver provider, or
- medication management conducted in a certified setting where a licensed health provider, the participant or the participant's legal representative may delegate medication management activities.

The state regulations related to medication management are:
- 7 AAC 67, Foster Home licensing standards;
- 7 AAC 75, Assisted Living Home;
- 7 AAC 130.224, Critical incident reporting;
- 7 AAC 130.227, Administration of medication and assistance with self-administration of medication;
- 12 AAC 44.965, Delegation of the administration of medication; and
- Provider Conditions of Participation adopted by referenced in 7 AAC 160.900.

WAIVER SERVICES IN NON-LICENSED AND CERTIFIED SETTINGS

In accordance with above regulations, certified home and community-based providers have ongoing responsibility for monitoring participant medication management while in the providers' care. The provider activities include, but are not limited to:
- developing and implementing written policies and procedures that address medication management;
- written delegation from the participant or the participant's legal representative or is in accordance with 12 AAC 44.965 or another applicable statute or regulation;
- ensuring all medications taken by the participant while in the provider's care are documented;
- ensuring that the individual providing administration of medication or assistance with self-administration has on file documentation of successful completion of the appropriate training.

WAIVER SERVICES IN LICENSED ASSISTED LIVING HOMES AND HOST CARE HOMES

Medication management in licensed assisted living home and host care homes are described in participant's residential care plan and include a physician's statement regarding the medication regimen that must be included in the plan. The participant or the participant's legal representative, if applicable, and a registered nurse must review the portion of the plan that describes how the participant's health-related services will be met.

A registered nurse may provide administration of medication or may delegate the administration of medication. Medication delegation may be made to certified home and community-based services providers, licensed assisted living home and host care home providers, and select certified nurse aides and medical assistants. Any direct service worker to whom the administration of medication has been delegated must meet the Board of Nursing training requirements. The delegating nurse must monitor the direct service worker and reevaluate the nursing delegation plan every 90 days.

All medication delegation is monitored by the registered nurse. The registered nurse monitors the appropriateness of the medications, usage patterns, potential risks and side effects associated with the medications, and possible medication interactions, with particular attention paid to the participant if their medication regime is complex or includes behavior-modifying medications. The participant's care coordinator, through monthly contacts, also

provides monitoring.

WAIVER SERVICES IN LICENSED FOSTER CARE HOMES

A foster home may administer medication only if the foster parent meets the following conditions:
• obtains written permission from the department or the child's legal guardian, as applicable, for the administration of prescription medication to a foster child;
• administers prescription medication or any special medical procedures only in the dosage, at the intervals, or in the manner prescribed by the person legally authorized to prescribe medication or medical procedures;
• administers nonprescription medication only if authorized by the child's caseworker; and
• for youth 17 or older, permission is not required for prescription birth control.

- **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 service providers are required to record and report medication errors to SDS. If an error resulted in a medical intervention, the provider must submit within one business day a critical incident report to SDS using the Centralized Reporting system. 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 for renewal 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 to SDS as a critical incident, in accordance with 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:

- **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 resulted in the need for medical intervention.

The state requires reports from all individuals who have knowledge of an event. The Harmony database allows screeners to link reports together to compare reports or determine if a report of an involved party is missing or inaccurate. On-site inspections conducted by 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 certification, when providers' training and medication error reporting compliance is reviewed, or whenever necessary to address risks to participant health and safety.

The state acquires data to identify trends and patterns from critical incident reports. The Health and Welfare Review Task Committee reviews the critical incident data.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's 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.

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.***

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 abuse, neglect, and exploitation (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 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.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 = 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.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**

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.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 within 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 = 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.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**	☐ **Annually**	☐ **Stratified**

Specify:		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 restrictive interventions that followed state policy. Numerator: # of reports of restrictive interventions that followed state regulations. Denominator: # of 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 = 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: 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 = 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.d.9: # and % of waiver participants who receive education on available preventative care services at least annually. Numerator: # of waiver participants who receive education on available preventative care services at least annually. Denominator: # of all waiver participants

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, SDS' QIW and the department's QISC, to discover and identify problems and/or issues within the waiver program. The task committees that oversee quality improvement for this appendix are the Health and Welfare Review Task Committee and the Mortality Review Task Committee.

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

On a monthly or as-needed basis, this committee reviews 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 and makes recommendations to the QIW

and may rise to the QISC as described in Appendix H.

Mortality Review Task Committee:

The Mortality Review Task Committee identifies and reviews all deaths reported throughout the Centralized Reporting system. Membership includes: the Quality Assurance unit manager (chair) and SDS staff including a Qualified Intellectual Disability Professional (QIDP), a registered nurse, the SDS Mortality Review Coordinator, staff from the Adult Protective Services unit and representatives from the Division of Health Care Services' Residential Licensing and Health Facilities Licensing and Certification, and the Office of Long Term Care Ombudsman.

On a monthly or as needed basis, this committee reviews information on participant deaths obtained through the SDS critical incident reporting process. To determine if a death is the result of an action or omission (or inaction) on the part of a waiver provider agency or SDS, the review may include:

- medical records;
- provider notes;
- Residential Licensing investigation reports;
- Office of Long Term Care Ombudsman's records;
- death certificate information from the department's Health Analytics and Vital Records, the state Medical Examiner's office, or
- law enforcement reports.

The committee also compares SDS findings with information obtained from Health Analytics and Vital Records 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.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. 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 provider agencies, and preventing instances of abuse, neglect, and exploitation through protective placements, training and technical assistance.

When discovery activities reveal provider deficiencies, the Quality Assurance unit is responsible for overseeing remediation activities and may provide technical assistance, issue a provider a notice to correct, investigate and issue an investigative report, or collaborate with other jurisdiction partners to make referrals when issues fall outside of the Quality Assurance unit's scope.

If the Quality Assurance unit issues a report, it must include a description of the evidence supporting the finding of deficiencies, remediation action required, the date by which compliance is required, and the method of provider confirmation of compliance.

If there is an immediate risk to participant health, safety, or welfare, SDS' Adult Protective Services conducts an investigation and, if necessary, facilitates a change in service providers or develops a protective placement, or takes an appropriate action that ensures the health and safety of the participant.

SDS may also perform focused studies, conduct agency on-site surveys, monitor remediation requirements, and review complaints.

If discovery points to issues with individual staff performance, remediation activities may include: meeting with staff, prescribing additional training, or using the department's progressive discipline process.

If discovery points towards systemic issues, these are addressed and analyzed at the Health and Welfare Review Task Committee, which develops remediation recommendations and that are presented to the QIW. Systemic remediation activities may include: updated forms, Harmony database reports, training, procedures, or regulatory changes.

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 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 Section 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 (QIS) 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 QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, 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 QIS 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 QIS. 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.

PROCESS FOR TRENDING, PRIORITIZING, AND IMPLEMENTING SYSTEM IMPROVEMENTS

The Division of Senior and Disabilities Services (SDS) developed the Quality Improvement Strategy (QIS), a continuous quality improvement framework to measure and improve performance. The QIS is described in H.1.b. To carry out the QIS, SDS has ten intradepartmental task committees, one division-level workgroup, the Quality Improvement Workgroup (QIW), and one department-level steering committee, the Quality Improvement Steering Committee (QISC).

SDS' intradepartmental committees review performance measure data, analyze trends, identify performance deficiencies, implement and report on corrective actions, and recommend system improvements to the QIW, which, in turn, makes recommendations to the department's QISC.

When performance measures fall consistently below 86 percent, the task committee responsible for the performance measure creates a Quality Improvement Plan (QIP) that identifies systemic root causes and implements improvement activities. The task committee seeks QIP approval through the QIW and tracks activities or develops new activities until compliance is achieved.

SYSTEM IMPROVEMENT: TASK COMMITTEES LEVEL OF CARE REVIEW TASK COMMITTEE
The Level of Care Review Task Committee discovers, reviews, and remediates issues related to the sub-assurances and performance measures in Appendix B, including the review of level of care determinations and other factors identified in the performance measures. Committee responsibilities include:
•Reviewing level of care performance data;
•Identifying deficiencies;
•Identifying corrective actions needed;
•Comparing findings of aggregated monthly, quarterly, and annual data;
•Making referrals for individual remediation;
•Developing recommendations for system improvements; and
•Reporting committee activity to QIW.

QUALIFIED PROVIDERS REVIEW TASK COMMITTEE

The Qualified Providers Review Task Committee gathers and reviews data related to the sub-assurances and performance measures in Appendix C, including review of provider qualifications, certification standards, and required training. Committee responsibilities include:
•Reviewing certification and training performance data;
•Identifying deficiencies;
•Identifying corrective actions needed;
•Comparing findings of aggregated monthly, quarterly, and annual data;
•Developing recommendations on the certification and training process;
•Developing recommendations for system improvements; and
•Reporting committee activity to QIW.

SUPPORT PLAN REVIEW TASK COMMITTEE

The Support Plan Review Task Committee gathers and reviews data related to the sub-assurances and performance measures in Appendix D, including assessing if support plans are timely, person-centered, identify personal goals, address needs identified in the annual assessment, and document participant choices. Committee responsibilities include:
•Reviewing support plan performance data;
•Identifying deficiencies;
•Identifying corrective actions needed;
•Comparing findings of aggregated monthly, quarterly, and annual data;
•Developing recommendations for systemic remediation; and
•Reporting committee activity to QIW.

HEALTH AND WELFARE REVIEW TASK COMMITTEE

The Health and Welfare Review Task Committee monitors data associated with Reports of Harm and other critical incidents related to the sub-assurances and performance measures in Appendix G. Committee responsibilities include:
•Reviewing health and welfare performance data;
•Reviewing central intake processes and identify trends;
•Reviewing investigation processes and identify trends;
•Identifying deficiencies;
•Identifying corrective actions needed;
•Comparing findings of aggregated monthly, quarterly, and annual data;
•Making referrals to units for individual remediation;
•Making recommendations to QIW for system improvement; and
•Reporting committee activity to QIW.

MORTALITY REVIEW TASK COMMITTEE
The Mortality Review Task Committee identifies and reviews all participant deaths related to the sub-assurances and performance measures in Appendix G, including the review of untimely participant deaths or deaths involving unusual circumstances that may trigger an investigation. Committee responsibilities include:
•Reviewing participant death information obtained through SDS' critical incident reporting process, medical records, the department's Health Analytics and Vital Records (HAVR), the Medical Examiner's office, and law enforcement reports;
•Identifying contributing factors that are the result of an action, omission, or inaction on the part of a provider agency or SDS;
•Determining if communication with the Medical Examiner, medical professionals or law enforcement is necessary;
•Comparing SDS findings and information obtained from HAVR to discover additional deaths not reported by providers;
•Reviewing aggregated data, including manner of death, demographic data, and historical data;
•Making recommendations to QIW for system improvement; and
•Reporting committee activity to QIW.

FINANCIAL ACCOUNTABILITY REVIEW TASK COMMITTEE

The Financial Accountability Review Task Committee ensures that Medicaid waiver claims for reimbursement are correctly coded and paid in accordance with the sub-assurances and performance measures in Appendix I. Committee responsibilities include:
•Reviewing financial accountability performance data;
•Drafting and monitoring regulations, policy and procedures regarding claims and service utilization;
•Reviewing reports generated by the department's Division of Health Care Services to identify provider billing compliance deficiencies;
•Monitoring provider-related billing, audit, and other surveillance methods used to maintain the financial integrity of programs;
•Providing updates and status on overpayment referrals from SDS to Medicaid Program Integrity; and
•Reviewing utilization and billing reports;
•Comparing findings of aggregated monthly, quarterly, and annual data;
•Making recommendations to QIW for system improvement; and
•Reporting committee activity to QIW.

INFORMATION TECHNOLOGY REVIEW TASK COMMITTEE

The Information Technology Review Task Committee monitors the coordination and integration of SDS' information technology (IT), collects data and provides reports and analysis activities for all the other task committees. This committee supports and coordinates the development and functionality of the various SDS information systems. While not directly responsible for any performance measures, this committee is responsible

for the data systems that allow for performance measure reporting. Committee responsibilities include:
•Supporting and coordinating efforts to improve SDS' IT;

•Coordinating IT aspects of the QIS implementation;
•Identifying and making recommendations to address deficiencies in SDS' IT systems and related components;
•Facilitating coordination of SDS' IT systems with other department and partner systems;
•Making recommendations to QIW for system improvement; and
•Reporting committee activity to QIW.

LONG TERM CARE (LTC) AND PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR) TASK COMMITTEE

The purpose of the LTC and PASRR Review Task committee is to monitor and assure PASRRs and authorizations for nursing home admissions and ensure continued stays are processed timely. While not directly responsible for any performance measures, the task committee works to implement the overall QIS by monitoring the performance of LTC admissions and PASRR. Committee responsibilities include:
•Reviewing of nursing home authorizations status reports;
•Reviewing PASRR status reports;
•Identifying timeliness compliance and deficiencies of LTC authorizations and PASRRs;
•Identifying corrective actions needed to cure deficiencies and improve processes;
•Identifying cases appropriate for potential diversion to home and community-based services;
•Monitoring provider related billing, audit, and other surveillance methods used to maintain the financial integrity of programs;
•Reviewing utilization and billing reports;
•Making recommendations to QIW for system improvement; and
•Reporting committee activity to QIW.

LONG TERM SERVICES AND SUPPORTS ACCESS REVIEW TASK COMMITTEE

The Long-Term Services and Supports (LTSS) Access Review Task Committee monitors service access and barriers identified through the Central Intake unit as well as through regular meetings with provider and stakeholder groups. While not directly responsible for any performance measures, the committee works to implement the QIS by ensuring access to services. Committee responsibilities include:
•Identifying barriers that prevent individuals from accessing LTSS;
•Collecting data from providers that documents barriers to accessing LTSS and report findings;
•Determining causes of access barriers;
•Strategizing systems changes to address barriers and allow greater access to LTSS;
•Making recommendations to QIW for system improvements; and
•Reporting committee activity to QIW.

POLICY AND PROGRAM DEVELOPMENT REVIEW TASK COMMITTEE

The Policy and Program Development Review Task Committee develops and reviews regulations, statutes, policies, and procedures with input from SDS staff. The committee ensures that proposed amendments to regulations and waivers are reviewed by participants, stakeholders, providers, and the public through a public comment process. Committee responsibilities include:
•Drafting regulations, policy and procedures;
•Ensuring public input in accordance with SDS policy;
•Monitoring the policy and procedure process, including updated forms;
•Ensuring development of implementation, training, and communication plans pertaining to new or revised policy and procedures; and
•Reporting committee activity to QIW.

THE QUALITY IMPROVEMENT WORKGROUP (QIW)

The SDS 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 meets monthly. Additional responsibilities include making recommendations for system change activities and issues to present to the QISC. Committee responsibilities include:
•Drafting updates to the QIS;

•Reviewing findings and task committee remediation activities to determine the need for a QIP;
•Comparing monthly, quarterly, and annually aggregated data to identify trends and the need for potential system improvement;
•Identifying resources necessary to meet the quality assurance measure requirements and submit resource recommendations to QISC;
•Assisting in coordinating efforts and exchanging information with external parties, partners, self-advocates, and other advocates; and
•Reporting task committee status to the QISC.

QUALITY IMPROVEMENT STEERING COMMITTEE (QISC)

The department's QISC meets quarterly to provide oversight of the QIS, including continuous quality improvement activities, and reports results to the department's leadership. The deputy commissioner of the Department of Health, who also serves as the State Medicaid Director, is responsible for overseeing the QISC functions. Committee responsibilities include:
•Overseeing the development and implementation of the QIS;
•Reviewing QIW reports and recommendations and determine the need for system improvement;
•Identifying important areas for study by the QIW and make recommendations for incorporating knowledge gained to improve standards and practices;
•Advocating for resources to carry out the QIS;
•Assisting with department-level activities to reduce duplication of efforts and to streamline processes;
•Coordinating efforts and exchange information with external stakeholders; and
•Advising the office of the commissioner on the status of quality improvement measures.

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.

SDS developed the QIS to measure and improve performance. The QIS incorporates discovery and remediation activities for all five Medicaid waivers administered by SDS: AK.0260 (IDD), AK.0261(ALI), AK.0262 (APDD), AK.0263 (CCMC), and AK.1566 (ISW).

The QIS uses a continuous quality improvement framework and is responsible for the following:
1.) Providing for systematic evaluation of waiver activities to ensure the health, safety, and welfare of participants;
2.) Conducting discovery activities through the collection of data for necessary remediation of individual problems and implementing system improvements; and
3.) Providing a reporting mechanism for each waiver's performance to department leadership.

To carry out the QIS, the department has ten intradepartmental task committees, one division-level workgroup (QIW), and one department-level steering committee (QISC). Each task committee is responsible for the collection, discovery, remediation of quality issues, review of performance measures, and implementation of the QIS. Data is aggregated separately for each individual waiver.

Task committee chairs and vice chairs, if applicable, attend the QIW each month to report on performance measure data and compliance.

Issues discussed in QIW that require additional departmental support to remediate or apply system improvements are elevated to the QISC. The QISC meets once each quarter and includes membership from the State Medicaid Director and SDS leadership team. SDS leadership communicates QISC decisions about systemic remediation and improvement activities to the task committees to implement.

COMMUNICATION OF SYSTEM IMPROVEMENTS

System improvements, performance measure progress, and quality improvement strategies are communicated regularly to stakeholder groups such as: 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. SDS regularly offers webinars supported by SDS' Training unit and regularly communicates program improvements and issues related to quality indicators by e-Alert, the SDS listserv that reaches over 1,700 stakeholders.

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

The QISC provides oversight of the SDS QIS, including continuous quality improvement activities, and reports results to department leadership.

While the commissioner of the Department of Health holds ultimate responsibility for quality improvement activities, the department's deputy commissioner, who also serves as the 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 corrective actions to the commissioner, and in collaboration 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 and State Medicaid Director, committee chair
- Director, SDS
- Deputy Director, SDS
- Chief of Quality, SDS
- Chief of Programs, SDS
- Chief of Developmental Programs, SDS
- Administrative Operations manager, SDS
- Research and Analysis unit manager, SDS
- Medicaid Program Integrity manager, and
- Additional SDS or department staff at the invitation of the committee.

The QISC meets quarterly to address SDS concerns and to review the quarterly reports submitted by the QIW. The quarterly QIW reports provide the status of performance measures, remediation efforts, system improvement efforts, and action plans. The QISC reviews QIW reports, evaluates the results, approves the actions of the QIW, makes recommendations for augmenting SDS' implemented remediation or system improvement efforts, and monitors system improvement efforts.

The QISC is responsible for approving, implementing, and monitoring the QIS and has ultimate responsibility for the proper implementation of SDS policies and procedures affecting the health, safety and welfare of waiver participants.

The QISC reviews and approves the development and implementation of performance measures, identifies provider needs for training and technical assistance based on reports from QIW or other sources, and ensures that information obtained from performance measure data analysis is disseminated, as appropriate, to 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).*

AGENCY RESPONSIBLE FOR CONDUCTING THE AUDIT PROGRAM

Medicaid Program Integrity within the Department of Health is the entity responsible for conducting the financial audit program.

TYPES OF POST PAYMENT REVIEW AND AUDITS

- *Annual independent provider audits required by Alaska Statute 47.05.200;*
- *Unified Program Integrity Contractor (UPIC) audit;*
- *Single Audit Act of 1984 and 2 CFR part 200 audit;*
- *Medicaid provider self-audits;*
- *Surveillance Utilization Review Subsystem (SURS); and*
- *Focused review or audit by Medicaid Program Integrity.*

ANNUAL INDEPENDENT PROVIDER AUDITS

Alaska Statute at 47.05.200, Annual audits, addresses annual provider audits. Each year the 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 department's commissioner, shall select the providers to be audited and decide the ratio of desk audits and on-site audits to the total number selected.

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.

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.

UNIFED PROGRAM INTEGRITY CONTRACTOR (UPIC) AUDIT PROCESS

In addition to audits conducted under state statute, a home and community-based services 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 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 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.

SINGLE AUDIT ACT OF 1984 AND 2 CFR PART 200 AUDIT

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.

MEDICAID PROVIDERS SELF-AUDITS

Alaska Statute 47.05.235, Duty to identify and repay self-identified overpayments, 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. The next round of self-audits is due no later than December 31, 2026. All overpayments identified through the self-audit process must be identified and returned to the state in accordance with regulation.

SURVEILLANCE UTILIZATION REVIEW SUBSYSTEM (SURS)

Section 42 CFR part 456, Utilization Control, requires states to include a Statewide Utilization Review Subsystem (SURS) in the Medicaid Management Information System (MMIS). SURS is used to analyze post-payment data for multiple claims at a time to identify suspicious provider billing patterns by developing and reviewing beneficiary utilization profiles, provider service profiles, and exceptions criteria. The SURS unit identifies patterns, conducts reviews and preliminary investigations, refers potential cases to Medicaid Program Integrity, the Medicaid Fraud Control Unit, and assists in criminal investigations.

FOCUSED REVIEW OR AUDIT BY MEDICAID PROGRAM INTEGRITY (MPI)

Under 7 AAC 106.100, Program integrity, the department is required to conduct program integrity activities that support the economical and effective administration of the Medicaid program. Medicaid Program Integrity (MPI) audit activities are designed to investigate fraud, waste, abuse, or Medicaid program compliance by providers. MPI coordinates with the Department of Law, the United States Department of Justice, and the United States Office of Inspector General.

Additionally, 7 AAC 160.140, Quality assurance program, requires the department to conduct program reviews of providers. If the department proposes adverse action as a result of the review, a written report of the findings is issued to the provider, and the case is referred to MPI for further review and potential recovery of overpayments.

POST PAYMENT REVIEW AND AUDIT: SCOPE, METHODS, AND FREQUENCY OF REVIEW

The scope of review is typically the providers' universe of Medicaid claims for a one-year period or the agreed upon timeframe. The sample of claims is selected either through a statistically valid random sample with a 95% confidence level of +/-5% margin of error from the universe of claims or through a judgement-based sample. Documentation supporting the paid claims is requested from the provider for desk review testing procedures and may include on-site reviews.

All audits start as desk reviews. Desk procedures are performed at the auditor's location; on-site procedures are conducted at the agency's location. On-site reviews are conducted for 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. Those providers with higher apparent error rates are generally the ones where on-site reviews are conducted.

Methods may include:

• Claims Documentation Testing:
o Review participant 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 participant, place of service, date of service, and procedure code billed to the Medicaid program.
• Medicaid Payment Testing:
o 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:
o 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.
• Review of Risk Factors:
o 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.
o Provider Specific Payment Level: A logarithmically adjusted factor that represents Medicaid payments relative to all other Medicaid providers.
o 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.
o Average Claim Amount: A logarithmically adjusted factor that represents the relative payment amount per claim compared to other Medicaid providers of the same type.
o Average Payments Per Recipient: A logarithmically adjusted factor that represents the relative payment per Medicaid participant compared to other Medicaid providers of the same type.
o 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.

The frequency of post payment review activity or audit is specific to the type of activity or audit. Annual independent provider audits required by Alaska Statute 47.05.200 are carried out by a contractor and include 50 provider audits per year. SURS reviews target 25 providers per quarter. Focused reviews and other audits are conducted by MPI in response to division quality assurance referrals and investigation activities.

PROCEDURES FOR SUSPECTED FRAUD ACTIVITY

Documentation is reviewed by MPI and a meeting is scheduled with the Medicaid Fraud Control Unit and Senior and Disabilities Services (SDS) to discuss the case. Based on the outcome of the meeting, a determination is made on how to proceed, which may include corrective actions, recovery of overpayments, potential provider sanctions, or the initiation of a credible allegation of fraud.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's 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.

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

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 =*
☐ ***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:*

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 =*
☐ ***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:*

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:*
	☐ ***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 or issues within the waiver program. The task committee that oversees quality improvement for this appendix is the Financial Accountability Review Task Committee.

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: Quality Assurance unit manager (chair) and SDS staff from the: Assessment unit, Review unit, Grants unit, Intellectual and Developmental Disabilities unit, Policy and Program Development unit, and representatives from the department's MPI and the Division of Health Care Services (DHCS).

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 DHCS to discover deficiencies in provider billing compliance. The committee plans and implements remediation activities and makes recommendations to QIW and may rise to the QISC as described in Appendix H.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. 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 Financial Accountability Review Task Committee chair 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 Subsystem, DHCS will refer the issue to the Quality Assurance unit manager for remediation discussions. The Quality Assurance 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 Quality Assurance unit which 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 Medicaid Program Integrity.

If SDS discovers any systemic problems regarding the MMIS, they are brought to the QIW which will report any issues to the director of DHCS 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 and Program Development Review Task Committee who facilitates changes through the state's 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).

DEPARTMENT RATE SETTING, RATE REBASING, AND INFLATION ADJUSTMENTS

The department's Office of Rate Review is responsible for setting and reviewing Medicaid rates for home and community-based waiver services.

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 department's commissioner determines through regulation when an inflation adjustment cannot be made in a specific fiscal year.

On May 1, 2023, the department established new rates for home and community-based waiver services. The department used 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, the reestablished rates set using costs 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. This stop loss does not apply to some rate setting under a modeled methodology such as care coordination or transportation. 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 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.

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 information, regulations, templates, training video, and the annual target lists can be found at: https://health.alaska.gov/en/resources/payment-rates-and-cost-survey-information/

PUBLIC INPUT PROCESS

The public has regular opportunities 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.

SERVICE RATES 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 as behavioral health, federally qualified health center services, etc.

The following services have their rates set using provider costs:
- *Day Habilitation;*

- *Employment Services;*
- *Intensive Active Treatment;*
- *Residential Habilitation - 15 Minutes: In-Home Support and Supported Living; and*
- *Respite.*

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].

RATE FOR CARE COORDINATION

The methodology to set care coordination rates establish wages, fringe benefits, administrative costs, 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.

RATE FOR HOST HOME CARE

The Host Home Care service methodology uses a similar service (Family Home Habilitation (Adult)) as a benchmark and reviewed the differences between the two services (respite service allowance and program administrator qualifications) to determine the daily rate variance.

The benchmark rate, the Family Home Habilitation's base rate, was last rebased in May 2023, using a cost-based methodology that included aggregated costs and units of service for six different providers. Costs and units of service were aggregated for all these providers and costs were divided by units of service. Rate components include wages, fringe benefits, program support, building/maintenance, and admin/general.

The providers chosen were the providers who were required to submit cost information as part of the family home habilitation rate methodology. These six providers represented greater than 50% of the total Medicaid units of the service provided, creating a representative sample for the service.

RATE FOR TRANSPORTATION

The methodology to set transportation rates establishes 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 state's approved 1915(c) waivers.

UNALLOWABLE COSTS

The Office of Rate Review utilizes the list and guidelines for unallowable costs outlined in 7 AAC 150.170, Allowable reasonable operating costs, which follow CMS PUB 15-1, chapter 21 guidelines.

PAYMENT RATE CHARTS

Any time a rate chart is updated the public is noticed through the SDS e-Alert notification system.

All rate charts are publicly available on the Division of Senior and Disabilities Services (SDS) Payment Rates and Cost Survey Information webpage here:

https://health.alaska.gov/en/resources/payment-rates-and-cost-survey-information/

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 the frequency, scope, and duration of service by signing the participant's support plan.

SDS requests service authorizations that match the service frequency, scope, and duration documented on the participant's support plan.

The home and community-based services agency provides the service to the participant named on the service authorization and documents that the service was actually rendered on the date shown on the provider billing. Documentation must meet the requirements in 7 AAC 105.230, Requirements for provider records.

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:
- *participant was eligible for service on the date of service;*
- *participant was not admitted to a nursing facility or hospital on the date of service;*
- *provider certification was current;*
- *participant'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 section 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 section 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 section 1915(b)/section 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 section 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 section 1115/section 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 section 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 text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 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 section 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	12033.29	13408.94	25442.23	393670.26	10270.52	403940.78	378498.55
3	12533.07	13931.88	26464.95	415322.13	10671.07	425993.20	399528.25
4	13052.02	14475.23	27527.25	438164.85	11087.24	449252.09	421724.84
5	13560.34	15039.76	28600.10	462263.91	11519.64	473783.55	445183.45

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	
Host Home Care	
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**	
Host Home Care Total:						**0.00**
Host Home Care	daily	0	0.00	1.00	**0.00**	
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***	
Host Home Care Total:						***9090.60***
Host Home Care	*daily*	*1*	*60.00*	*151.51*	***9090.60***	
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: 7460641.30

Total Estimated Unduplicated Participants: 620

Factor D (Divide total by number of participants): 12033.29

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***	
Host Home Care Total:						***28335.60***
Host Home Care	*daily*	*3*	*60.00*	*157.42*	***28335.60***	
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: ***7770500.78***

Total Estimated Unduplicated Participants: ***620***

Factor D (Divide total by number of participants): ***12533.07***

Average Length of Stay on the Waiver: *342*

Appendix J: Cost Neutrality Demonstration

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***	
Host Home Care Total:						***49068.00***
Host Home Care	*daily*	*5*	*60.00*	*163.56*	***49068.00***	
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					***31389.60***	

GRAND TOTAL: 8092254.70

Total Estimated Unduplicated Participants: 620

Factor D (Divide total by number of participants): 13052.02

Average Length of Stay on the Waiver: *342*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
than 20 miles	Per trip	12	110.00	23.78		

GRAND TOTAL: 8092254.70
Total Estimated Unduplicated Participants: 620
Factor D (Divide total by number of participants): 13052.02
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**	
Host Home Care Total:						**50982.00**

GRAND TOTAL: 8407413.30
Total Estimated Unduplicated Participants: 620
Factor D (Divide total by number of participants): 13560.34
Average Length of Stay on the Waiver: 342

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Host Home Care	daily	5	60.00	169.94	50982.00	
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: 8407413.30

Total Estimated Unduplicated Participants: 620

Factor D (Divide total by number of participants): 13560.34

Average Length of Stay on the Waiver: 342