Provider Conditions of Participation for Home and Community-Based Waiver Services and Community First Choice Chore Services

Home and community-based waiver services and Community First Choice services are provided to assist a recipient to live a life that the recipient, and those who care about him or her, value. These services provide opportunities for the recipient to engage in community life to the same degree of access as individuals who do not receive waiver services and may be rendered in a recipient's home or settings that are integrated in, and support access to, the greater community.

The services that meet the recipient's needs and the providers selected by the recipient to render those services are specified in a support plan that is developed through a person-centered planning process directed by the recipient to the maximum extent possible. The recipient, the recipient's care coordinator, and a planning team chosen by the recipient collaborate to align services and supports resulting in a person-centered practice that will assist the recipient to meet his or her objectives and promote access to the full benefits of community living.

Service providers must be certified under 7 AAC 130.220 or 7 AAC 127.050 and operate in compliance with the Provider Conditions of Participation *and with the* Conditions of Participation *for each service offered to recipients.*

I. Program operations.

A. Certification requirements.

1. The provider must demonstrate readiness to provide services and comprehension of applicable Medicaid regulations and pertinent service Conditions of Participation through documents describing provider operations.
2. The provider must submit in a format provided by Senior and Disabilities Services (SDS)
   a. a complete application for certification with all required information and documentation, or
   b. a complete application to renew certification with all required information and documentation submitted not later than 60 days before the expiration date of the current certification period, in accordance with 7 AAC 130.220(d); and
   c. if requesting an exception under 7 AAC 130.220(j), a complete application to provide both care coordination and other home and community-based waiver services.
3. The provider must prepare in written form and implement the following policies and procedures and, when requested, submit the written policies and procedures to SDS within the required timeframe:
   a. background checks;
   b. complaint management;
   c. confidentiality of protected health information, including a Notice of Privacy Practices;
   d. conflicts of interest;
   e. critical incident reporting;
   f. emergency response training;
   g. evaluation of employees;
   h. financial accountability;
   i. independence and inclusion;
   j. medication management (not required of providers licensed under 7 AAC 75.010 – 75.140 or certified under 7 AAC 127.050, or care coordinators certified under 7 AAC 130.200);
   k. person-centered practice;
   l. quality improvement;
   m. restrictive interventions;
   n. termination of provider services; and
   o. training.
4. In addition to the required application forms, the provider must submit to SDS within the required timeframe

a. the following documents:
   i. State of Alaska business license;
   ii. Certificate of Insurance or similar documentation of coverage, as required under section C.1.
   iii. licenses for assisted living homes and foster homes;
   iv. building or use permits for site-based services, if required by state or local laws;
   v. vehicle permit for hire, if required by state or local laws;
   vi. vehicle registration;
   vii. food service permit; and
   viii. verification that agency staff have attended and completed SDS training on critical incident reporting and settings requirements;
b. the following personnel information:
   i. organization chart, including the names of individuals filling each position;
   ii. list of names of board members;
   iii. names of individuals with an ownership interest in the provider agency;
   iv. list of names of personnel and position for individuals not listed on the organization chart; and
   v. list of volunteers and contractors who work on-site and have unsupervised access to recipients or to protected health information;
c. other information regarding requirements specified in the service *Conditions of Participation*; and
d. a complete quality improvement report for an application to renew certification.

5. The provider must implement and abide by all policies and procedures that were submitted for the purposes of gaining certification or renewing certification.
6. The provider must grant to SDS, for certification, renewing certification, and oversight purposes, access to all service locations and to locations where the provider proposes to render services.

B. Operations requirements.

1. The provider must
   a. utilize the SDS secure electronic interface for submission of confidential and protected health information;
   b. subscribe to and review SDS electronic email;
   maintain all records, required under 7 AAC 105.320, in English and in a form that is legible and understandable to a reviewer;
   c. comply with all training requirements; and
   d. practice open communications and cooperate with other providers of services.
2. No owner, executive director, board member, authorized agent, employee, or contractor of a provider agency may provide services to recipients if that individual
   a. has been convicted of Medicaid fraud or has been suspended or terminated from the Medicaid program because of program abuse or abuse of a recipient;
   b. is named on any state or federal exclusion list related to health care services; or
   c. has had either a valid criminal history check or variance revoked under 7 AAC 10.945.
3. The provider must comply with the criminal history checks requirements of 7 AAC 10.910 – 10.990.
4. In the event a dispute arises with another provider and is not resolved by discussion between them, the providers must agree to mediation; the providers must retain an alternate dispute resolution organization to mediate the dispute and must share equally in the cost.
5. The provider must comply with the electronic visit verification (EVV) regulations under 7 AAC 130.285.
6. The provider must report to SDS the name of the electronic visit verification system vendor the provider uses. The provider must report the vendor name by sending an e-mail to DHSSEVV@alaska.gov on same day as the provider submits the application for provider certification.

C. Financial accountability.

1. The provider must maintain insurance that
   a. includes coverage for commercial general liability, commercial automobile liability, and workers' compensation, as is appropriate to the services the provider is certified to offer recipients, in the following amounts:
      i. *Workers' Compensation Insurance*: The provider shall provide and maintain, for all employees engaged in work, coverage as required by AS 23.30.045, and, where applicable, any other statutory obligations including but not limited to Federal U.S.L. & H. and Jones Act requirements. The policy must waive subrogation against the State.
      ii. *Commercial General Liability Insurance*: covering all business premises and operations used by the provider in the performance of services under this agreement with minimum coverage limits of $300,000 combined single limit per claim.
      iii. *Commercial Automobile Liability Insurance*: covering all vehicles used by the provider in the performance of services under this agreement with minimum coverage limits of $300,000 combined single limit per claim; and
   b. names Senior and Disabilities Services (SDS), Provider Certification and Compliance Unit, 1835 Bragaw Street, Suite 350, Anchorage, AK 99508-3487, as a certificate holder for that insurance; a copy of the Certificate of Insurance or similar document showing insurance coverage must be submitted with its application for certification or application to renew certification.
2. The provider may charge fees for services at rates no higher than those charged to private pay clients for comparable services.
3. The provider must
   a. maintain financial records to show the provider's capacity, at all times, to meet at least three months of operating expenses, including funds to
      i. pay employee salaries and employee-related tax obligations timely;
      ii. maintain current commercial general liability, commercial automobile liability, and worker's compensation insurance;
      iii. maintain operations in a physical office space; and
      iv. ensure service delivery to all recipients served by the provider;
   b. implement a financial system, based on generally accepted accounting principles, that ensures claims for payment are accurate;
   c. maintain, in accordance with 7 AAC 105.230, records that support claims for services;
   d. cooperate with all required audits;
   e. report to the Medicaid fiscal agent, and void or adjust, amounts identified as overpayments; and
   f. cooperate with investigation and remediation activities.
4. The provider may not submit a claim for reimbursement
   a. until services have been rendered;
   b. for services rendered by an individual who does not have documentation of a current, valid criminal history check or variance; or
   c. for services that are not specified in the recipient's support plan or documented in accordance with 7 AAC 105.230.
5. The provider must report suspected Medicaid fraud, abuse, or waste, or suspected financial exploitation of a recipient, to the Medicaid Fraud Control Unit by calling 1-907-269-6279, by sending a message to fax number 1-907-269-6202, or by submitting a Medicaid Fraud/Elder Abuse Complaint Form.

D. Person-centered practice.

1. Planning services.
   The provider must
   a. participate on the planning team to the extent requested by the recipient;
   b. provide information about the provider's services and activities
      i. in plain language and in a manner accessible to the recipient, taking into consideration disabilities or limited English proficiency;
      ii. sufficient for the recipient to make informed choices regarding services and activities;
   c. inform the recipient of the provider's processes for
      i. discussing or requesting changes to the provider's services and activities; and
      ii. solving conflicts or disagreements with the provider.
2. Interactions with recipients.
   The provider must
   a. optimize recipient initiative, autonomy, and independence in making choices;
   b. facilitate recipient choices regarding daily activities and the direct care workers that the recipient prefers;
   c. support recipient choices regarding cultural interests and access to community activities; and
   d. meet with the recipient at times and locations convenient for the recipient with regard to discussing or requesting changes to services or activities, and to solving conflicts or disagreements.

E. Quality management.

1. Complaint management process.
   a. The provider must develop and implement a protocol for handling and resolving written and oral complaints about services or personnel.
   b. In addition to addressing complaints as they arise, the provider must analyze the complaints each calendar quarter to determine whether issues raised represent single incidents or a pattern, and take appropriate action to resolve issues brought to light by the quarterly analysis.
2. Quality improvement process.
   a. The provider must engage in monitoring and data collection activities related to the delivery of services and recipient satisfaction with the services, analyze findings, and identify problems and opportunities for improvement.
   b. The provider must develop and implement a process for taking action to remedy problems, whether the issues relate to a single individual or to systemic program operations.
   c. The provider must utilize its findings from data collection and analysis activities to engage in actions (e.g., policy development, management changes, staff training, or other system level interventions) that lead to continuous improvements in its delivery of services.
3. Self-assessment.
   a. The provider must conduct a self-assessment of its quality improvement process annually, at a minimum, for each year of its certification period. The provider will use the self-assessment findings to develop the quality improvement report.
   b. The process must include evaluation of the findings from, and corrective actions taken with regard to,
      i. the complaint management process;
      ii. critical incident reports, including reports of harm;
      iii. analyses of medication errors;
      iv. analyses of the use of restrictive interventions;
      v. consumer satisfaction surveys; and
      vi. internal reviews of recipient services to determine services were provided in accordance with individual support plans and meet the recipient's needs.
4. Quality improvement report.
   a. The provider must submit with its application to renew certification a complete quality improvement report, in a format provided by the department, based on the self-assessment. A complete quality

improvement report includes:
i. a summary of the data collection activities;
ii. the findings;
iii. the corrective actions taken; and
iv. the resulting program improvements.

b. A complete quality improvement report will also include the certification period covered (i.e., certification period start and end dates) and the address/location.

c. The provider must be able to support the quality improvement report with original data and provide that data to SDS within the required timeframe, if requested.

F. Reporting changes in provider status.

1. The provider must report the following changes in provider status in writing to the SDS unit responsible for provider certification within the timeframe specified:
   a. one business day of
      i. an unforeseen termination of association with a care coordinator;
      ii. an unplanned change of program administrator; or
      iii. learning that an agency owner or administrator has been charged with or convicted of a criminal offense;
   b. ten days prior to
      i. a change in mailing address, email address, or telephone or fax number;
      ii. termination of an association with a care coordinator; or
      iii. any change related to a family home habilitation, group-home habilitation, or residential supported living site, including the addition or removal of a site as a location where residential habilitation services are provided, and any primary contact changes;
   c. thirty days prior to a planned change of program administrator; and
   d. sixty days prior to
      i. a change of agency name;
      ii. a change in physical location;
      iii. a change in the form of organization of its business;
      iv. a change of ownership; or
      v. an agency sale or closure.
2. The provider must report all EVV vendor systems changes by e-mail to the SDS unit responsible for EVV systems. Providers must send the e-mail to DHSSEVV@alaska.gov within the timeframe specified:
   a. one business day of an unplanned change to the EVV vendor system; or
   b. thirty days prior to a planned change of EVV vendor system.

II. Program administration

A. Personnel.

1. The provider must ensure that the employment and education history offered by a potential employee is verified and resulted in the acquisition of the knowledge base and skills required for the position.
2. Program administrator.
   a. The provider must verify that any individual hired for a program administrator position meets the qualifications specified in the service Conditions of Participation.
   b. The provider may accept an applicant whose education was completed in a country other than the United States if the applicant can show that the applicant's foreign education is comparable to that received in an accredited educational institution in the United States.
      i. The provider may accept a copy of a State of Alaska license issued under AS 08 as showing an applicant's foreign education is comparable to education in the United States.
      ii. For applicants not licensed under AS 08, the provider must inform the applicant that the applicant is responsible for providing

(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.

iii. The provider must keep documents showing a program administrator's foreign education comparability to that of the United States on file and make them available to SDS upon request.

c. The provider may employ an individual to serve as program administrator for more than one service
   a. if necessitated by the location of an agency office; and
   b. if, given the size of the recipient population served and the number of direct care workers employed by the provider, that administrator is capable of being actively engaged in the management of each service.

d. The provider may use a term other than program administrator for this position (e.g., program director, program manager, or program supervisor), but the individual filling the position must meet the requirements for program administrator that are specified in the Conditions of Participation for the services the provider offers.

3. Direct service workers.
   a. The provider must identify the specific skill set needed by direct service workers to render the services the provider offers. To identify the basic knowledge needed by a direct service worker, the provider may use as a resource the online program, *Alaska Core Competencies for Direct Care Workers in Health and Human Services*, periodically offered by the Center for Human Development, University of Alaska Anchorage.
   b. The provider must develop and implement a performance evaluation based on the skill set determined to be needed by its direct service workers.
   c. The provider must assess the performance of direct service workers to ensure they have the ability to work effectively and to identify skills that need further development.

B. Training.

1. CPR and first aid training.
   The provider must have on file, for each direct service worker, individual providing chore services, and individual providing agency-based congregate meals or transportation services, documentation showing successful completion of cardiopulmonary resuscitation (CPR) training and first aid training, that meets the standards of the American Heart Association or the American Red Cross, at least every two years.
2. Orientation and training.
   The provider must provide, and have on file, for all employees and volunteers, documentation of
   a. orientation to the agency and its relationship to the department; and
   b. skills and knowledge training necessary to render services to recipients.
3. Critical incident reporting training.
   a. The provider must have on file, for all staff, documentation of attendance and completion of, at least every two years, training on how to report critical incidents to SDS.
   b. The provider may
      i. arrange for staff to attend SDS critical incident report training; or
      ii. appoint staff who have attended the SDS training to train additional staff.
   c. At a minimum, the following agency employees must complete, every two years, critical incident reporting training by attending and completing the course offered by SDS:
      i. the program administrator; and
      ii. the individuals who supervise each home and community-based service the agency is certified to offer.
4. Medication management training.

a. Assistance with self-administration of medication.
   i. Except for the staff of providers subject to the requirements of 7 AAC 75.240 and 7 AAC 127.087, the provider must train all staff responsible for assisting recipients with self-administration of medications and have on file documentation of attendance and completion of the training.
   ii. The provider must develop and submit to SDS a training policy that includes
      (A) coverage of the topics in 7 AAC 130.227(j)(2);
      (B) training goals;
      (C) plans and activities to enable trainees to achieve those goals;
      (D) methods of assessing trainee achievement of the training goals; and
      (E) processes for evaluating the effectiveness of the training methods.

b. Administration of medication.
   The provider must ensure that all staff responsible for administration of medication to a recipient have on file documentation of attendance and completion of training approved by the Alaska Board of Nursing.

5. Restrictive intervention training.
   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 that includes
   a. describing actions that are considered to be restrictive interventions;
   b. specifying restrictive interventions that are prohibited by regulation;
   c. identifying restrictive interventions appropriate for use with the population served by the provider; and
   d. outlining the requirements for
      i. documenting every use of restrictive intervention; and
      ii. reporting as a critical incident any misuse of restrictive intervention and any use that results in medical intervention.

C. Supervision.

1. The provider must monitor direct service workers and volunteers
   a. to ensure the health, safety, and welfare of recipients;
   b. to provide training to upgrade the skills needed to work with recipients; and
   c. to identify and report fraud, abuse, or waste.
2. The provider must ensure that an employee or a volunteer who transports a recipient in an employee-owned or volunteer-owned vehicle
   a. has personal vehicle automotive liability insurance that includes coverage for a recipient in the event of an accident; or
   b. is insured under provisions of the provider agency insurance policy.
3. When a Report of Harm is made to Adult Protective Services (APS) or the Office of Children's Services (OCS) alleging abuse, neglect, or exploitation against an employee or a volunteer, the provider must bar that individual from contact with recipients until the investigation is complete or the allegation is found to be unsubstantiated.

III. <u>Recipient relationships.</u>

A. Conflicts of interest.

No owner, executive director, board member, authorized agent, employee, or contractor of a provider agency may

1. exploit a relationship with any recipient for personal or business benefit;
2. engage in or allow any financial transaction with, or on the behalf of, any recipient if that transaction could result in personal or financial benefit to anyone other than the recipient;
3. solicit as clients any recipients known to be receiving services from another provider;
4. seek to influence the eligibility determination process by

a. providing false or misleading information about an applicant or recipient; or
b. coaching an applicant or recipient to misrepresent the applicant's or recipient's needs; or

5. represent a recipient during any hearing or appeal process.

B. Recipient health, safety, and welfare.

1. The provider must implement procedures for reporting to the recipient's care coordinator information regarding how the provider's activities are contributing to the recipient's progress toward meeting service goals and whether alternative activities would be more effective if progress is limited.
2. When the provider notices any material changes or registers concerns regarding a recipient's emotional, physical, or psychological condition, the provider must report immediately the changes or concerns to the recipient's care coordinator and recipient representative, and, as appropriate, to other providers of services.
3. In the event a recipient experiences an accident, incident, or injury that requires evaluation by or consultation with a medical professional or the individual providing services believes emergency assistance is needed because of circumstances that create a risk to the health, safety, and welfare of a recipient or to others, the individual providing services must
   a. contact the appropriate emergency responder and provide emergency care and support, appropriate to the provider's skill and experience, until the responder arrives; and
   b. cooperate with the responder as requested, including providing current health, diagnostic, and medication information as needed and as available on-site or accessible through a database or contact known to the provider.
4. The provider must communicate and cooperate with other providers to prevent placing recipients at risk; if disagreements or disputes regarding a recipient arise, the recipient's health, safety, and welfare must be the primary factor in reaching a resolution.

C. Interactions with recipients.

The provider must

1. treat all recipients respectfully;
2. encourage recipient involvement in the planning of their care;
3. cooperate with recipients who elect to change service providers;
4. collaborate with other providers to deliver an integrated program of services;
5. provide information regarding fees for services to recipients;
6. address recipient complaints about services;
7. evaluate whether services are appropriate and effective for achieving recipient goals; and
8. render quality care by employing competent, trained staff.

D. Termination of recipient services.

The provider must implement a termination or discharge procedure for ending involvement with a recipient that

1. factors in the health, safety, and welfare of the recipient;
2. requires documentation showing
   a. failure to cooperate with the delivery of services;
   b. risks of physical injury to the provider's employees or to other recipients; or
   c. suspected recipient misrepresentation or fraud that creates a financial risk for the provider;
3. includes supervisory review to determine whether
   a. reasonable accommodation measures have been considered and tried, and
   b. termination is appropriate;
4. provides written notice of the reasons for termination to the recipient and to SDS; and
5. informs the recipient about the provider's process for appealing a decision to terminate services and other possible sources for the services being terminated.