Table of Contents

State/Territory Name: Alaska

State Plan Amendment (SPA) #: 17-0006

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Seattle Regional Office
701 Fifth Avenue, Suite 1600, MS/RX-200
Seattle, WA 98104

Division of Medicaid & Children's Health Operations

March 22, 2018

Valerie Davidson, Commissioner
Department of Health and Social Services
3601 C Street, Suite 902
Anchorage, AK 99503-7167

RE: Alaska State Plan Amendment (SPA) Transmittal Number 17-0006

Dear Ms. Davidson:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of Alaska State Plan Amendment (SPA) Transmittal Number 17-0006. This SPA adds Long-Term Services and Supports (LTSS) to Targeted Case Management (TCM). This SPA is approved effective October 1, 2017, as requested by the state.

If there are additional questions please contact me, or your staff may contact Bill Vehrs at bill.vehrs@cms.hhs.gov or at (503) 399-5682.

Sincerely,

[redacted]

David L. Meacham
Associate Regional Administrator

cc:
Jon Sherwood, DHSS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 17-0006

2. STATE: AK

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2017

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 441.18

7. FEDERAL BUDGET IMPACT:
a. FFY 18 $183,000
b. FFY 19 $183,900

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Supplement 1 to Attachment 3.1-A pages 14-~~18~~19 (P&I)
Attachment 4.19-B page 11.a.2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
N/A

10. SUBJECT OF AMENDMENT:
Proposed SPA adds Long Term Services and Supports Targeted Case Management.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Does not wish to comment

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME: Jon Sherwood

14. TITLE: Deputy Commissioner - DHSS

15. DATE SUBMITTED: 12-29-17

16. RETURN TO:

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 12/29/17

18. DATE APPROVED: 3/22/18

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 10/1/17

20. SIGNATURE OF
[redacted]

21. TYPED NAME: David L.Meacham

22. TITLE: As

23. REMARKS:

P&I change to block #8 to reflect page numbering1419

FORM HCFA-179 (07-92)

TARGETED CASE MANAGEMENT SERVICES
Long Term Services and Supports

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

The target group includes individuals who reside in the community or are transitioning as described in the following paragraph who meet or are in the process of determining whether they meet one of the following institutional levels of care:

a. long-terms care hospital or nursing facility;
b. intermediate care facility for individuals with intellectual disabilities;
c. institution providing psychiatric services for individuals under twenty-one (21) years of age; or
d. institution for mental diseases (IMD) for individuals age sixty-five (65) and over.

☒ Target group includes individuals transitioning to a community setting. Case management services will be made available for up to 60 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 served in Institutions for Mental Disease or individuals who are inmates of public institutions. (State Medicaid Directors Letter, July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):

☒ Entire State
☐ Only in the following geographic areas:

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))

☒ Services are provided in accordance with §1902(a)(10)(B) of the Act.
☐ Services are not comparable in amount, duration, and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169):

Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational, and other services. Targeted Case Management includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social, or other services. These assessment activities include
  - taking client history;
  - identifying the individual's needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;
  - Assessments shall occur at least annually to ensure the participant has adequate supports. Assessments may occur more frequently than annually, up to monthly, when requested by the participant, or the care coordinator, a service provider, or the state identifies an issue.

- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - identifies a course of action to respond to the assessed needs of the eligible individual;

- Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
  - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

- Monitoring and follow-up activities:
  - The support plan includes a segment for the individual's personal goal(s). Development of the support plan requires that goals are identified and services are requested that match those goals. The person-centered support plan documents the outcomes of a structured discussion that addresses the participant's personal goals, needs, including health care needs, and preferences and how services and other supports will help achieve those goals.
  - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
    - services are being furnished in accordance with the individual's care plan;
    - services in the care plan are adequate; and
    - changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

    Monitoring shall occur at least annually to ensure the participant has adequate supports. The amount of monitoring is contingent upon the amount that the individual requested within the support plan. The individual may contact the care coordinator at any time for assistance.

☒ Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

A targeted case management provider must be certified as a provider of care coordination services under 7 AAC 130.220 (b) (2), meet the requirements of 7 AAC 130.238 and 7 AAC 130.240.

1) Requirements for certification:
   a) Care coordinators shall be at least eighteen (18) years of age and qualified through experience and education in a human services field or setting.
   b) Required education and additional experience or alternative to formal education for care coordinators, includes
      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 case management process.
      i) The care coordination knowledge base must include:
         (a) the medical, behavioral, habilitative, and rehabilitative conditions and requirements of the population to be served by the care coordinator;
         (b) the laws and policies related to senior and disabilities services programs;
         (c) the terminology commonly used in human services fields or settings;
         (d) the elements of the case management process; and
         (e) the resources available to meet the needs of participants.
      ii) The care coordinator skill set must include:
         (a) the ability to evaluate the needs and preferences of the participant and to develop a support plan, which meets the needs and preferences of the participant and complies with the requirements of the applicable Medicaid program;
         (b) the ability to organize, evaluate, and present information orally and in writing; and
         (c) the ability to work with professional and support staff.
   d) Training
      i) An individual who seeks certification to provide case management services, must:
         (a) enroll in the Department of Health and Social Services (department) approved beginning course for care coordinators;

(b) demonstrate comprehension of course content through examination; and
(c) provide proof of successful completion of the course when submitting an application for certification.

ii) A certified care coordinator, must:
(a) enroll in at least one department approved care coordination training course during the individual's one or two year period of certification; and
(b) provide proof of successful completion of that course when submitting an application for recertification; and
(c) demonstrate an understanding of the Medicaid State Plan services.

Freedom of choice (42 CFR 441.18(a)(1)):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1) Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2) Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

☐ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services:

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):

The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose**.**

Case Records (42 CFR 441.18(a)(7)):

Providers maintain case records that document for all individuals receiving case management as follows:

(i) The name of the individual;
(ii) The dates of the case management services;
(iii) The name of the provider agency (if relevant) and the person providing the case management service;
(iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved;
(v) Whether the individual has declined services in the care plan;
(vi) The need for, and occurrences of, coordination with other case managers;
(vii) A timeline for obtaining needed services; and
(viii) A timeline for reevaluation of the plan.

Limitations:

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

Additional Limitations:

None.

Long Term Services and Supports (LTSS) Targeted Case Management

Reimbursement to providers of long-term services and supports (LTSS) targeted case management services provided on or after October 1, 2017 is a monthly fee for service at rates based on:

- Salaries
- Fringe Benefits
- Allowable Indirect Costs
- Average caseload size

Payment Methodology: The Department of Health and Social Services (the department) will authorize case management as a service within the participant support plan. Payment will be made through MMIS and each encounter will be documented to support the billing. The department established regulations for the operation of long term services and supports targeted case management services in a manner that protects and promotes the health, safety, and welfare of participants.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both government and private providers. The fee schedule was last updated to be effective for services on or after October 1, 2017 and is available at http://dhss.alaska.gov/dsds/Documents/regspackage/LTSS-SupportsTargetedCaseManagement.pdf .