

**Home and Community-Based Waiver Review
Environmental Modifications -7 AAC 43.1054
October 1, 2009**

7 AAC 43.1054	<p>EMOD contractors need better communication, training, manuals, ongoing information on events and opportunities to connect with SDS.</p> <p>Need SDS “ombudsman” to mediate disagreements between contractor and agency.</p> <p>Send EMOD contractors draft regulations for review</p>
	<p>SDS should set up a committee of building experts who know codes, rules, licensing regulations.</p>
	<p>Agency holds contractors to codes they do not understand, yet allow things to be built with materials that do not meet codes. SDS middle management not providing adequate information, guidance</p>
	<p>13 AAC 50 – may be tying our hands.</p>

	International Building Code – exceeds standards set by ADA
(c)	Caps on 3-year EMOD totals not changed since 1994. Freight added for rural, if DME
	Provider reimbursement: currently 2% total cost or \$50, whichever is greater
(d)(2)(B) “the department will not reimburse under this section for....	Clarify language – double negative
(d)(6)	Need to understand role of Medicare in SME
	Clarify availability of EMODs in rental properties in regulations

	Different needs in urban and rural areas – do we need a different set of regs?
	Set up ongoing workgroups – one for urban, one for rural. Acknowledge and plan for different areas
(c)(5)(B)	Definition of “rural” needs work.
	<p>Need explanation of subcontracting rules.</p> <p>Subcontractor definition?</p> <p>State law requires contractors to be licensed in order to hire subcontractors.</p> <p>Need clarification – “grant administrator” or “contractor” as the terms are used in statute and regulation.</p> <p>Statute change to include exceptions to contractor rule for rural areas.</p>

	<p>Make contractors Medicaid providers</p> <p>SDS should employ a contractor to recruit, train and support contractors.</p>
	<p>Contractors afraid they will not get paid.</p> <p>Reimbursement too low</p> <p>SDS should improve administrative process</p>
EMOD process	<p>Need sufficient reimbursement.</p>
Need for EMOD should be identified by assessor	<p>Need for EMOD is based on functional needs – should be linked to assessment first, not POC. Difficult for care coordinator to secure EMODs after the assessment is complete.</p> <p>EMODs are needed to safely serve clients – the assessment should cover that</p> <p>When client has significant change in health status that requires an EMOD, SDS should trust care coordinators/field staff to accurately assess the client's needs.</p>

	<p>SDS too rigid in accepting care coordinators assessment of client needs for services and EMODs. Constant struggle for providers.</p>
	<p>Change definition for why you can get EMOD – “improved functionality” “accessibility improvements”</p>
	<p>Change focus from denying to enhancing accessibility. Things are denied without regulatory authority. Allow items client needs</p>
	<p>Health and safety – is the state in compliance if they deny items considered necessary?</p>
	<p>Length of time for processing and approval is too long – a health and safety issue.</p>
	<p>Estimates – Native Housing Authorities available to do estimates. Need to pull in various local resources and funding sources.</p>
	<p>Plan of care can indicate client priorities – when they say no, SDS should offer alternatives</p>

	<p>Initial assessments brief – care coordinator provides better assessment of client’s needs</p>
	<p>43.1030 – care coordinator assessment – SDS should trust them to know the client’s needs. Care coordinators have to justify requests. POC lists client needs.</p>
<p>Plan of Care</p>	<p>Lengthy process to get EMOD bids so usually does not make it into POC. Bidders take time and money just to ensure the job can be done – submitted as amendment.</p> <p>5 – 8 weeks for processing</p>
	<p>Care coordinators hate EMODs – never goes smoothly. Lack of expertise.</p>
	<p>SDS should get out of the business of EMODs.</p> <p>Set aside funds to contract out development of scope of work. Lock it down and have all providers bid to that scope.</p>

	<p>Send scope to 3 bidders – after 30 days, we have met the requirement.</p> <p>Offer \$200 - \$300 to perform development of single scope of work used by all bidders</p>
	<p>SDS should list what EMODs each contractors will do.</p>
	<p>POC needs to list priorities for client – safety, accessibility.</p>
	<p>SDS needs to develop more information on the EMOD process</p>
	<p>SDS not holding contractors accountable for inadequate work - should file against a contractor who does not adhere to code.</p>
	<p>Inspections – only 5 municipalities require them. Otherwise, SDS is signing off on the job</p>

	<p>Regulation on inspections not being followed – situation where no inspection was done in Anchorage.</p>
	<p>Provider agencies could develop a single scope of work with contractor assistance.</p> <p>SDS should offer grants, contracts or other funding sources for funding the scope of work.</p> <p>SDS should be proactive in announcing projects to local resources in rural areas.</p> <p>Post project on the web for all contractors to bid. Specify length of time for bidding. Announce winning bid, cost of EMOD.</p> <p>All costs are in the bid – including materials and freight – the entire cost of the job</p>
	<p>CDCs and RuralCAP could do scope of work in rural areas.</p>

	<p>Scope of work lays foundation for quality of work. Allow for unexpected needs, such as additions for code compliance, underlying rot, etc.</p>
	<p>Communication with care coordinator needed when bidding process is going on to ensure vulnerable people are notified and privacy safeguarded.</p> <p>Must respect client's wishes on choice of contractor.</p>
<p>Bids have to come from certified providers</p>	<p>Change regs to allow contractors to become EMOD providers after providing a bid.</p> <p>If not EMOD certified and has a "residential ticket" could change regs to allow them to provide the service, then get certified.</p> <p>SDS approves the project, based on the lowest bid. Contractors/agencies do the scoping and bidding work, but the project can be disallowed by SDS.</p>
<p>Prior authorization</p>	<p>Care coordinator submits plan of care or amendment. 6 – 8 weeks to PA (used to be 2 weeks). Depends on type of waiver – MRDD & CCMC takes longer</p>

	Need to factor in contingencies to bid – if contractor finds underlying problems, has to fix it, but SDS will not pay for such “maintenance” costs.
	SDS disallows costs for items that have to be worked on as part of the EMOD – contractor has to absorb those costs.
	Use Medicaid administrative claiming to fund development of scope of work, QA, inspections.
	Have SDS back up for people on leave
(a)(1) approved as part of POC	Include as aspect of assessment. Differentiate between waivers – ICAP and CAT
(b)	What is considered an EMOD? Should include meeting the needs of the client for accessibility as well as health and safety.
(c)	Contractor registration and bonding: contractors should have residential endorsement because they should have knowledge of how to deal with

underlying problems in the structure. But another layer in rural areas – Native Housing Authorities, who do not have bonding requirements, should also be allowed to do EMODS.

Don't need residential endorsement. Bonding and licensing covers state for contractors who fail to complete work.

More restrictive requirements will be a disincentive to become an EMOD provider, especially in rural areas.

Still, EMOD providers need education and experience, just as care coordinators are required to have.

SDS should have specific, mandatory training for EMOD providers on SDS policy, codes, best practices, etc.

Is there a national certification?

(b)(2)	How does provider know if project is in compliance?
(c)(4) solicit, not get, 3 bids	<p>3 bids are difficult to get</p> <p>Need definitions for “bid”, “scope of work”, “cost estimate.”</p> <p>\$1,000 limit, raise to \$2,000.</p> <p>Award mechanism for a standard cost for certain EMODs – survey for average costs, and set a fixed rate for the job, e.g., handrails. Set different rates for different areas – urban vs. rural.</p>
	<p>SDS requests scripts that require \$50 co-pay, and will require a second script if time lapses.</p> <p>SDS require services to be medically necessary, then disregards the opinion of the professional</p>
	Inconsistent response from SDS on how many bids are required. SDS should create checklist.

	<p>Cost estimate vs. amount PAed? Define as estimate or bid – can the project be modified as needed – unexpected construction needs, price of materials</p>
	<p>Cost of freight – SME provider can charge for additional costs for freight, EMOD provider cannot. Should be able to charge for total cost of project.</p>
<p>(c)(5) cost of EMOD - \$10,000 every 3 years</p>	<p>1994 – Hospitals have received an inflation-related rate increases. If EMOD had, would be \$15,598.</p> <p>Raise the limit to \$18 – \$20,000, build in inflation factor.</p>
	<p>Client cannot get what they need to stay independent, forced into nursing homes</p>
	<p>Care coordinators need information about additional resources for EMOD.</p>
<p>36-month period, beginning with the month the recipient is enrolled</p>	<p>Should there be another methodology for this?</p>

Policy workgroup	Ramps – sonet tubes 48 inches into the ground
(5)(A) repair and replacement	Allowable costs need to be adjusted
	Should have more flexibility as needs change – need mechanism for exception to limit.
	Repairs need to be done in a reasonable amount of time by available person.
	Need provision for contingency planning -
(B)(i) definition of rural	Due to time lags on authorization, needs to be a mechanism for cost changes. May miss barge, raising prices

	No less than 25 people – not needed; discriminates against those in very small villages.
	People have to leave their homes during EMOD – not a “privilege” but a need. SDS should help expedite. Costs should not come out of EMOD funds
	SME providers can bill for freight to rural areas under both SME and EMOD
	Costs for overhead and expenses in rural areas should be charged against project funds Bid process does not allow for overhead and profit, specifically. SDS method for listing materials separately is not standard procedure

(c)(6) administrative fees	Fees too low
(c)(7)provider responsible for any additional work necessary to complete the EMOD	Scope of work must be well-defined or contingency funds available.
	Once SDS has paid the PA amount, provider has to find additional funds.
	No provision for client death, client vacating premises during process of EMOD – provider has no way of getting paid, may have to complete the job at their expense.
(7)(d)	Different standard for different waivers
	Could be collaborating with other providers doing additions, remodeling and weatherization projects.

<p>(7)(d)(2)(A)</p>	<p>Floor coverings should be removed from the list – floor coverings routinely upgraded during EMOD.</p> <p>Safety issue – need slip-resistant flooring</p>
	<p>Cabinets and shelves should be removed from list – often a modification that makes a home functional and accessible for the individual. Give care coordinator discretion to decide what is needed.</p> <p>May have to lower cabinets for ADA accessibility.</p>
	<p>Include access as part of purpose or EMODs</p>
	<p>Clarify language to reveal intent of regulation. Do we allow these improvements if needed to reduce risk of serious illness or injury?</p>
<p>(d)(3)</p>	<p>Will only pay for adaptations when it is often impossible to make adaptations and require new construction, i.e., stairs.</p>

	Some provisions should be taken out of regulations and policy developed
(d)(4)	Needs change requiring subsequent or upgraded modifications – SDS interpreting different accessibility modifications as duplicate accessibility modifications, i.e., walk-in to roll-in showers.
(d)(6)	Clarify language – or remove Could be advantageous to use other sources to obtain equipment
	No provision for client loss of Medicaid eligibility.
	What happens when client changes their mind – who owns the equipment? Clarify in policy
(6)(f)	Difficult to coordinate Clarify – relationship between EMOD and SME, DME

<p>(6)(h)</p>	<p>Should develop a way to recycle, reuse the equipment.</p> <p>Develop program to donate equipment for a tax credit.</p>
<p>Next steps</p>	<p>Compile information garnered today for participants and public</p>
	<p>Provide organization chart for public</p>
	<p>Develop work groups for specific tasks</p>