Home and Community-Based Waiver Services; Nursing Facility and ICF/IID Level of Care

Section

7 AAC 130.200. Purpose

The purpose of this chapter is to offer to individuals that meet the eligibility criteria in 7 AAC 130.205 the opportunity to choose to receive home and community-based waiver services as an alternative to institutional care.

History: Eff. 2/1/2010, Register 193; am 11/3/2012, Register 204; am 7/1/2013, Register 206

7 AAC 130.202. Services provided by family members

Home and community-based waiver services covered under this chapter do not include services provided by

(1) an immediate family member of a recipient to the recipient; or

(2) a guardian to a ward, unless a court has authorized the guardian to provide those services under AS 13.26.145 (c).

History: Eff. 2/1/2010, Register 193; am 11/3/2012, Register 204

7 AAC 130.205. Eligibility for home and community-based waiver services

(a) The department will pay for home and community-based waiver services provided in accordance with the applicable requirements of this chapter to an individual that is

(1) eligible for coverage under AS 47.07.020 , 7 AAC 100.002, and (d) of this section; and

(2) enrolled in accordance with 7 AAC 130.219.

(b) Home and community-based waiver services are not available to an individual

(1) while the individual is an inpatient of a nursing facility, a hospital, or an ICF/IID, except for screening under 7 AAC 130.211 or assessment under 7 AAC 130.213; or

(2) if the individual's services, supports, devices, or supplies may be provided for entirely by services under 7 AAC 105 - 7 AAC 160 without the services specified under this chapter.

(c) A recipient enrolled in the home and community-based waiver services program is eligible to receive other Medicaid services for which the recipient is otherwise eligible.

(d) For the department to determine whether an applicant is eligible to receive home and community-based waiver services under this section, the applicant must be found eligible for one of the following recipient categories:

(1) children with complex medical conditions; to qualify for this recipient category, the applicant must

(A) be under 22 years of age;

(B) have a medical condition that would require care in a general acute care hospital or a nursing facility for more than 30 days per year if the applicant did not receive home and community-based waiver services;

(C) has a severe, chronic physical condition that results in a prolonged dependency on medical care or technology to maintain health and well-being;

(D) experiences periods of acute exacerbation or life-threatening conditions;

(E) need extraordinary supervision and observation;

(F) either need frequent or life-saving administration of specialized treatment or be dependent on mechanical support devices; and

(G) require, as determined under 7 AAC 130.215, a level of care provided in a nursing facility;

(2) adults with physical and developmental disabilities; to qualify for this recipient category the applicant must

(A) be 21 years of age or older;

(B) meet the criteria specified in AS 47.80.900 (6); and

(C) require, as determined under 7 AAC 130.215, a level of care provided in a nursing facility;

(3) individuals with intellectual and developmental disabilities; to qualify for this recipient category the applicant must

(A) meet the criteria specified in 7 AAC 140.600(c) and (d); and

(B) require, as determined under 7 AAC 130.215, a level of care provided in an ICF/IID;

(4) older adults or adults with physical disabilities; to qualify for this recipient category the applicant must require, as determined under 7 AAC 130.215, a level of care provided in a nursing facility and must be

(A) 65 years of age or older; or

(B) 21 years of age or older and have a physical disability.

History: Eff. 2/1/2010, Register 193; am 11/3/2012, Register 204; am 7/1/2013, Register 206

Editor's note: As of Register 207 (October 2013), and acting under AS 44.62.125 (b)(6) and sec. 29, ch. 42, SLA 2013, the regulations attorney made technical changes to 7 AAC 130.205, to change "ICF/MR" to "ICF/IID." Chapter 42, SLA 2013 amended terminology in the Alaska Statutes to replace references to "mental retardation" and "mentally retarded" with more current terms. Section 29, ch. 42, SLA 2013 instructed that similar changes be made in the Alaska Administrative Code.

7 AAC 130.207. Application for home and community-based waiver services

(a) To apply for home and community-based waiver services under this chapter, an individual must submit a complete application for home and community-based waiver services and complete supporting documents to the department, using,

(1) for the recipient category of children with complex medical conditions, the department's *Screening Tool for Children with Complex Medical Conditions (CCMC) Waiver Program*, adopted by reference in 7 AAC 160.900;

(2) for the recipient category of adults with physical and developmental disabilities, the department's *Application for Alaskans Living Independently Waiver and Adults with Physical and Developmental Disabilities Waiver* form, adopted by reference in 7 AAC 160.900;

(3) for the recipient category of individuals with intellectual and developmental disabilities, the department's *Intellectual & Developmental Disabilities Registration and Review* form, adopted by reference in 7 AAC 160.900; and

(4) for the recipient category of older adults or adults with physical disabilities, the department's *Application for Alaskans Living Independently Waiver and Adults with Physical and Developmental Disabilities Waiver* form, adopted by reference in 7 AAC 160.900;

(b) Not later than 14 business days after the date it receives the application, the department will send the applicant and the applicant's care coordinator notice in writing of any missing information or documentation needed to make the application complete. Unless the department receives the missing information or documentation not later than 15 business days after the date of the notice of an incomplete application, the department will deny the application.

(c) Not later than 30 business days after the department determines that the application is complete, the department will

(1) conduct an assessment under 7 AAC 130.213;

(2) make a level-of-care determination under 7 AAC 130.215; and

(3) notify the applicant and care coordinator of the level-of-care determination, except that the department may extend the notification timeframe for an additional 30 business days if the department, under 7 AAC 130.213(f) , forwards a reassessment for review by an independent qualified health care professional in accordance withAS 47.07.045 (b) and 7 AAC 130.219(e) (4).

History: Eff. 7/1/2013, Register 206; am 7/1/2015, Register 214

7 AAC 130.209. Expedited application, assessment, level-of-care determination, and plan of care

(a) The department will conduct an expedited review of a complete application that is submitted in accordance with 7 AAC 130.207(a) if the applicant has no natural supports to meet the applicant's needs and the applicant qualifies because of

(1) a diagnosis of a terminal illness with a life expectancy of six months or less:

(2) imminent or recent discharge from a general acute care hospital or nursing facility; the applicant must submit the application not later than seven days after the date of discharge;

(3) an unplanned absence of a primary unpaid caregiver due to a medical or family emergency or hospitalization;

(4) the declining health of a primary unpaid caregiver that makes the caregiver unable to continue to provide care for the applicant;

(5) the death of a primary unpaid caregiver 30 or fewer days before the date of the application; or

(6) a referral from the office of the department responsible for adult protective services or the office of the department responsible for children's services.

(b) Not later than five business days after the date it receives the expedited application, the department will notify the applicant and the applicant's care coordinator in writing of any missing information or documentation needed to make the expedited application complete. Unless the department receives the missing information or documentation not later than five business days after the date of the notice of an incomplete application, the department will deny the expedited application. The applicant may submit another complete application that will be processed in accordance with 7 AAC 130.207.

(c) Not later than 10 business days after the department determines that the application is complete, the department will

(1) conduct an assessment under 7 AAC 130.213;

(2) make a level-of-care determination under 7 AAC 130.215; and

(3) notify the applicant and care coordinator of the level-of-care determination.

(d) Not later than 15 days after the date of the department's notice to the recipient and the recipient's care coordinator that the recipient meets the level-of-care requirement, the recipient's care coordinator shall submit a plan of care to the department for approval in accordance with 7 AAC 130.217.

(e) Not later than 10 days after the department receives the complete plan of care, the department will notify the recipient and the recipient's care coordinator of the department's approval or disapproval of specific services identified in the plan of care.

History: Eff. 7/1/2013, Register 206; am 7/1/2015, Register 214

7 AAC 130.211. Screening

(a) The department will pay for and review, in any 365-day period, one screening of an applicant for home and community-based waiver services to determine whether there is a reasonable indication that the applicant might need services at a level of care provided in a hospital, nursing facility, or ICF/IID in 30 or fewer days unless the applicant receives home and community-based waiver services under this chapter. The department will

(1) conduct the screening;

(2) contract with another organization to conduct the screening; or

(3) offer the applicant the opportunity to select a care coordinator or other provider approved by the department to conduct the screening.

(b) If a care coordinator conducts the screening, the care coordinator shall

(1) inform the applicant regarding the care coordinator's relationship as an employee of any provider certified under 7 AAC 130.220 and of any relationship described in 7 AAC 130.240(f) ; and

(2) provide to the department appropriate and contemporaneous documentation that

(A) addresses each medical and functional condition that places the applicant into a recipient category listed in 7 AAC 130.205(d) ; and

(B) indicates the applicant's need for home and community-based waiver services.

(c) Following a decision by the department that an applicant would not need services as specified in (a) of this section, the applicant may request, and the department will pay for and review, another screening if a material change in the applicant's condition occurred after a prior screening. In this subsection, "material change in the applicant's condition" means an alteration in the applicant's health, behavior, or functional capacity of sufficient significance that the department is likely to reach a different decision regarding the applicant's need for home and community-based waiver services.

History: Eff. 7/1/2013, Register 206

7 AAC 130.213. Assessment and reassessment

(a) If a screening under 7 AAC 130.211 and supportive diagnostic documentation reasonably indicate the need for services described in 7 AAC 130.211(a) , the department will conduct an assessment of the applicant's physical, emotional, and cognitive functioning to determine the

(1) recipient category under 7 AAC 130.205(d) for which the applicant is eligible; and

(2) level of care under 7 AAC 130.215 that the applicant requires.

(b) If an assessment indicates that an applicant meets the level-of-care requirement under 7 AAC 130.215, the department will send notice to the care coordinator for development of a plan of care in accordance with 7 AA C 130.217.

(c) To request a reassessment of a recipient's continuing need for home and community-based waiver services, the recipient must submit a new application with current information in accordance with 7 AAC 130.207 not later than 90 days before the expiration of the period covered by the preceding level-of-care approval A new application is required in order to continue to receive home and community-based services after the expiration of the previous period.

(d) If the new application indicates a need for continuing services, the department, not later than one year after the date of the previous assessment, will reassess a recipient to determine if the recipient continues to meet the eligibility requirements of 7 AAC 130.205(d) and level-of-care requirement under 7 AAC 130.215. After the reassessment, the department will notify the recipient, the recipient's representative, and the recipient's care coordinator of that determination. However, the department will perform an earlier reassessment if the department determines it necessary due to a material change related to the health, safety, and welfare of the recipient.

(e) Repealed 7/1/2015.

(f) If the department finds, based on the reassessment under this section, that the recipient no longer requires the level of care described in 7 AAC 130.215, the department will

(1) forward the reassessment for review by an independent qualified health care professional in accordance with AS 47.07.045 (b) and 7 AAC 130.219(e) (4); and

(2) notify the recipient and the recipient's care coordinator of the referral and extension of the notification timeframe under 7 AAC 130.207(c) (3).

(g) If the department determines that translation services for a non-English speaking applicant or interpretation services for a deaf applicant are necessary for an assessment or reassessment under this section, the department will secure and pay for those services.

History: Eff. 7/1/2013, Register 206; am 7/1/2015, Register 214

7 AAC 130.215. Level-of-care determination

The department will determine an applicant's level of care as follows, and will provide notice to the applicant, the applicant's representative, and the applicant's care coordinator of the department's determination:

(1) for the recipient category of children with complex medical conditions, the department will determine, based on the results of the department's *Nursing Facility Level of Care Assessment Form for Children*, adopted by reference in 7 AAC 160.900, whether

(A) under 7 AAC 140.515 the applicant requires a level of care provided in a skilled nursing facility; or

(B) under 7 AAC 140.510 the applicant requires a level of care provided in an intermediate care facility;

(2) for the recipient category of adults with physical and developmental disabilities, the department will determine, based on the results of the department's *Consumer Assessment Tool (CAT)*, adopted by reference in 7 AAC 160.900, whether the applicant has both a physical disability and a developmental disability, and whether

(A) under 7 AAC 140.515 the applicant requires a level of care provided in a skilled nursing facility; or

(B) under 7 AAC 140.510 the applicant requires a level of care provided in an intermediate care facility;

(3) for the recipient category of individuals with intellectual and developmental disabilities,

(A) if the applicant is three years of age or older, the department will determine, based on the results of the *Inventory for Client and Agency Planning (ICAP)*, adopted by reference in 7

AAC 160.900, whether under 7 AAC 140.600(c) and (d) the applicant requires a level of care provided in an ICF/IID;

(B) if the applicant is younger than three years of age, the department will determine, based on the results of an evaluation that is age-appropriate, standardized, and norm-referenced, and that compares skills attainment to that of the applicant's peers, whether under 7 AAC 140.600(c) and (d)(1) and (2) the applicant requires a level of care provided in an ICF/IID;

(4) for the recipient category of older adults or adults with physical disabilities, the department will determine, based on the results of the department's *Consumer Assessment Tool (CAT)*, adopted by reference in 7 AAC 160.900, whether

(A) under 7 AAC 140.515 the applicant requires a level of care provided in a skilled nursing facility; or

(B) under 7 AAC 140.510 the applicant requires a level of care provided in an intermediate care facility.

History: Eff. 7/1/2013, Register 206

7 AAC 130.217. Plan of care development and amendment

(a) Not less than once every 12 months, the care coordinator shall submit a plan of care based on the current needs of the recipient, the most recent assessment or reassessment conducted under 7 AAC 130.213, and the level-of-care determination made in accordance with 7 AAC 130.215. After an assessment or reassessment under 7 AAC 130.213, and after receiving the department's notice that the recipient meets the level-of-care requirement under 7 AAC 130.215, the care coordinator shall

(1) inform the recipient regarding

(A) the care coordinator's relationship as an employee of any provider certified under 7 AAC 130.220 and of any relationship described in 7 AAC 130.240(f) ;

(B) the full range of home and community-based waiver services and the names of all providers that offer those services; and

(C) the recipient's right to free choice of providers, including the option to choose another care coordinator to develop the recipient's plan of care; the care coordinator shall support the recipient in the recipient's exercising the right to free choice of providers;

(2) consult, in person or by electronic mail, telephone, or videoconference, with each member of a planning team that

(A) at a minimum, includes

(i) the recipient;

(ii) the recipient's representative; and

(iii) a representative of each provider certified under 7 AAC 130.220 that is expected to provide services to the recipient, except that a provider of specialized medical equipment, transportation services, or environmental modification services is not required to be represented on the planning team; and

(B) at the request of the recipient or the recipient's representative, includes the recipient's family members and others that provide informal supports for the recipient;

(3) prepare in writing, on a form provided by the department, a plan of care that

(A) identifies the individualized, comprehensive needs of the recipient;

(B) identifies the providers certified under 7 AAC 130.220 that are available to render services to the recipient;

(C) identifies the family and community supports available to the recipient;

(D) identifies the home and community-based waiver services to be provided to the recipient;

(E) identifies, for each home and community-based waiver service,

(i) the provider certified under 7 AAC 130.220 that has agreed to provide that service;

(ii) the number of units of that service;

(iii) the frequency of that service; and

(iv) the projected duration of that service; and

(F) includes an analysis of whether each service and amount of that service is consistent with

(i) the assessment or reassessment conducted under 7 AAC 130.213 and the level-of-care determination made in accordance with 7 AAC 130.215; and

(ii) any treatment plans developed for the recipient;

(4) secure the signature, either in person or electronically, of

(A) the recipient or recipient's representative indicating that the recipient or recipient's representative

(i) agrees to the plan of care;

(ii) is aware of any relationship between the care coordinator and any provider certified under 7 AAC 130.220 and of any relationship described in 7 AAC 130.240(f) ; and

(iii) has been informed of the recipient's right to free choice of providers;

(B) each provider representative indicating the provider agrees to render the services as specified in the plan of care; and

(C) each individual on the planning team to verify participation in the development of the recipient's plan of care; any disagreement among planning team members about outcomes or service levels, or any suggestion by a team member that an outcome or service level should be different than one established in the plan of care, must be documented and attached to the plan of care submitted to the department for consideration and approval; and

(5) submit the plan of care and supporting documentation to the department for approval; unless the care coordinator has submitted to the department written documentation of unusual circumstances that prevent timely completion of the plan of care, and the department has approved a later submission date, the care coordinator shall submit the plan of care not later than

(A) 60 days after the date of the department's notice to the recipient and the recipient's care coordinator that the recipient meets the level-of-care requirement in 7 AAC130.215;

(B) 30 days before expiration of the current plan year.

(b) The department will approve a plan of care if the department determines that

(1) the services specified in the plan of care are sufficient to prevent institutionalization and to maintain the recipient in the community;

(2) each service listed on the plan of care

(A) is of sufficient amount, duration, and scope to meet the needs of the recipient;

(B) is supported by the documentation required in this section; and

(C) cannot be provided under 7 AAC 105 - 7 AAC 160, except as a home and community-based waiver service under this chapter; and

(3) if nursing oversight and care management services are to be provided, a nursing plan in accordance with 7 AAC 130.235 is included.

(c) Not later than 30 business days after the department receives the complete plan of care, the department will notify the recipient, the recipient's representative, and the recipient's care coordinator of the department's approval or disapproval of specific services.

(d) A recipient's care coordinator shall

(1) prepare an amendment to the recipient's plan of care if

(A) a modification is required to meet the recipient's needs because of a change of circumstances related to the health, safety, and welfare of the recipient; or

(B) the recipient needs an increase or decrease in the number of service units approved under (a) –

(c) of this section or in a prior amendment to the plan of care;

(2) secure the signature, either in person or electronically, of

(A) the recipient or recipient's representative indicating that the recipient or recipient's representative agrees to the plan of care amendment; and

(B) a representative of each provider of services that are modified by the amendment indicating the provider agrees to render the services as specified in the plan of care amendment; and

(3) submit the plan of care amendment to the department not later than 10 business days after the date of a change in circumstances or a change in the number of service units, unless the care coordinator has submitted to the department written documentation of unusual circumstances that prevent timely completion of a plan of care amendment, and the department has approved a later submission date.

(e) Not later than 30 business days after the department receives a complete plan of care amendment, the department will notify the recipient, the recipient's representative, and the recipient's care coordinator of the department's approval or disapproval of specific services.

History: Eff. 7/1/2013, Register 206; am 7/1/2015, Register 214

7 AAC 130.219. Enrollment in home and community-based waiver services; disenrollment

(a) The department will enroll an applicant, determined eligible under 7 AAC 130.205, in the recipient category for which the recipient is qualified if the department determines that enrolling the applicant will not bring the department out of compliance with the terms of the waiver approved under 42 U.S.C. 1396n(c) by exceeding the

(1) number of recipients approved for participation in the waiver program for the applicable recipient category; or

(2) average per capita expenditure limit on home and community-based waiver services for the applicable recipient category.

(b) The department will notify

(1) an applicant, determined eligible under 7 AAC 130.205, that the applicant may choose between home and community-based waiver services and institutional care in a nursing facility or ICF/IID; the applicant's choice of service must be documented on a form approved by the department; and

(2) a recipient, determined eligible and enrolled in a recipient category for home and community-based waiver services under 7 AAC 130.205, that the recipient may choose to receive home and community-based waiver services from any provider that

(A) is certified under 7 AAC 130.220; and

(B) provides the home and community-based waiver service for which the recipient is eligible.

(c) The department will consider the recipient to be enrolled under this section after the recipient has

(1) applied under 7 AAC 130.207:

(2) been screened for assessment under 7 AAC 130.211;

(3) been assessed under 7 AAC 130.213;

(4) met the level-of-care requirement under 7 AAC 130.215; and

(5) received an approved plan of care under 7 AAC 130.217.

(d) The earliest date that an individual is eligible to receive home and community-based waiver services is the date when all of the requirements in (c) of this section have been met.

(e) The department will disenroll a recipient for any of the following reasons:

(1) the department terminates its participation in the waiver program under 42 U.S.C. 1396n(c);

(2) the department is unable to determine eligibility for home and community-based waiver services because the documentation required under 7 AAC 130.217 as part of a reassessment to determine the recipient's continuing eligibility for services was not submitted by the recipient, the recipient's representative, or the recipient's care coordinator at least 30 days before expiration of the current plan year;

(3) the recipient is no longer eligible for Medicaid coverage under AS 47.07.020 or 7 AAC 100.002;

(4) the recipient is no longer eligible for services because the recipient's reassessment, conducted in accordance with 7 AAC 130.213(c) - (f), indicates the condition that made the recipient eligible for services has materially improved since the previous assessment, and

(A) the annual assessment and determination have been reviewed in accordance with AS 47.07.045 (b)(2) using the department's

(i) *Material Improvement Reporting for CCMC Waivers*, adopted by reference in 7 AAC 160.900, if the recipient is in the recipient category of children with complex medical conditions;

(ii) *Material Improvement Reporting for IDD Participants Under The Age of Three*, adopted by reference in 7 AAC 160.900, if the recipient is younger than three years of age and in the recipient category of individuals with intellectual and developmental disabilities;

(iii) *Material Improvement Reporting for IDD Participants Age Three or Over*, adopted by reference in 7 AAC 160.900, if the recipient is three years of age or older and in the recipient category of individuals with intellectual and developmental disabilities; or

(iv) *Material Improvement Reporting for ALI/APDD Waivers*, adopted by reference in 7 AAC 160.900, if the recipient is in the recipient category of older adults or adults with physical disabilities or in the recipient category of adults with physical and developmental disabilities; and

(B) the reviewer confirms to the department that the condition that made the recipient eligible for services has materially improved;

(5) the recipient or the recipient's representative chooses to end the recipient's participation in the home and community-based waiver services program;

(6) the recipient or the recipient's representative misrepresents the recipient's physical, intellectual, developmental, or medical condition in an effort to obtain services that are not medically necessary or for which the recipient does not quality;

(7) the recipient has a documented history of failing to cooperate with the delivery of services identified in the plan of care prepared under 7 AAC 130.217, or of placing caregivers or other recipients at risk of physical injury, and no other providers are willing to provide services to the recipient; for the purposes of this paragraph, a documented history exists if a provider

(A) reports that the provider has been unable obtain cooperation with service delivery or to mitigate the risk of physical injury to a caregiver or other recipients through reasonable accommodation of the recipient's disability; and

(B) maintains records to support that report, and makes those records available to the department for inspection; the department will review those records before making a decision on disenrollment under this paragraph.

(8) the recipient or the recipient's representative fails to take an action or to submit documentation required under 7 AAC 130.209 - 7 AAC 130.217.

(f) An applicant or recipient that is denied enrollment for home and community-based waiver services, or a recipient that is disenrolled for reasons described in (e) of this section, may appeal that decision under 7 AAC 49.

History: Eff. 7/1/2013, Register 206; am 7/1/2015, Register 214

7 AAC 130.220. Provider certification

(a) The department will certify a provider agency as one or more of the following:

(1) as a home and community-based waiver services provider, for

(A) nursing oversight and care management services provided under 7 AAC 130.235;

(B) chore services provided under 7 AAC 130.245;

(C) adult day services provided under 7 AAC 130.250;

(D) day habilitation services provided under 7 AAC 130.260;

(E) residential habilitation services provided under 7 AAC 130.265;

(F) supported employment services provided under 7 AAC 130.270;

(G) intensive active treatment services provided under 7 AAC 130.275;

(H) respite care services provided under 7 AAC 130.280;

(I) transportation services provided under 7 AAC 130.290;

(J) meal services provided under 7 AAC 130.295;

(K) environmental modification services provided under 7 AAC 130.300;

(2) as a care coordination agency provider for care coordination services provided under 7 AAC 130.240; notwithstanding agency certification, each individual employed by that agency to

provide care coordination services must be certified separately and individually in accordance with 7 AAC 130.238;

(3) as a residential supported-living services provider for residential supported-living services provided under 7 AAC 130.255.

(b) To receive payment for home and community-based waiver services, a provider must enroll in the Medicaid program under 7 AAC 105.210 and must be certified under this section. To be certified by the department, a provider

(1) must submit an application, and meet the applicable certification criteria, including the provider qualifications and program standards, set out in the department's*Provider Conditions of Participation*, adopted by reference in 7 AAC 160.900; and

(2) for each service the provider plans to offer to recipients of home and community-based waiver services, must comply with the provisions of this chapter applicable to each service and with the conditions-of-participation document adopted by reference in 7 AAC 160.900 and applicable to that service.

(c) The department will certify a provider under this section for the following time periods:

(1) one year for a provider not previously certified by the department to provide home and community-based waiver services;

(2) two years for a currently certified provider that is renewing that provider's certification.

(d) Not later than 90 days before the expiration of a provider's certification, the department will send to the provider notice of the requirement to renew that certification. The provider must submit a new application for certification and all required documentation not later than 60 days before the expiration date of the current certification.

(e) A certified provider under this chapter shall comply with this chapter and the requirements of 7 AAC 105.200 - 7 AAC 105.280. The department will determine compliance through program monitoring, including audits, program reviews, and investigations, that may take place at the provider's place of business or at any site where services under this chapter are provided. To assure compliance, the department may

(1) request, in accordance with 7 AAC 105.240, records related to the services provided under this chapter; or

(2) take immediate custody of a provider's original records, maintained in accordance with 7 AAC 105.230, if the department has reason to believe, based on an audit, program review, or investigation, that those records are at risk of alteration; once records are in the custody of the department, the provider may make copies of those records only under the supervision of the department.

(f) In addition to the authority under 7 AAC 105.400 - 7 AAC 105.490 to take action in regard to certification, the department will deny an initial application or an application to renew certification or suspend certification of a provider if

(1) the provider fails to submit a complete application under (a) of this section so that it is received by the department not later than 30 days after the date of notice from the department that the application is incomplete;

(2) the provider's certification, license, or enrollment related to Medicaid or Medicare was denied, revoked, or rescinded;

(3) the provider's name appears on any state or federal exclusion list related to health care services;

(4) the department has documentation that indicates the provider is unable or unwilling to meet the certification requirements of this section or any other Medicaid requirement under 7 AAC 105 - 7 AAC 160;

(5) the department has evidence that the owner or the administrator of a provider agency does not operate honestly, responsibly, and in accordance with applicable laws in order to maintain the integrity and fiscal viability of the medical assistance program; or

(6) based upon evidence from an audit, provider review, or investigation, the department has probable cause to believe that the provider's noncompliance with the Medicaid program or this chapter causes immediate risk to the health, safety, or welfare of a recipient or would be considered to be fraud, abuse, or waste.

(g) If the department denies an initial application or an application to renew certification or suspends certification of a provider, the department will send, not later than 14 business days after the date of the decision, written notice of the action and information regarding the provider's right to appeal the decision under AS 44.64.

(h) Instead of decertification or suspension, the department may

(1) establish a corrective action plan that includes the method by which the provider will verify compliance and the date that compliance is required; and

(2) monitor the provider's progress toward meeting the requirements of the corrective action plan; if the department finds that the provider has not met the requirements of the corrective action plan on or before the date compliance is required, the department may decertify or suspend the provider as provided in (g) of this section.

(i) Notwithstanding the provisions of this section, if the department has reasonable cause to believe that the health, safety, or welfare of a recipient is at risk, the department may immediately suspend or revoke a provider's certification. If the department immediately suspends or revokes certification under this subsection, the department will

(1) give the provider initial notice, oral or written, of the suspension or revocation of certification, including information regarding the right to appeal; if no one is present to receive the notice, the department will post the notice on the main entrance to the building in which the provider agency is located; and

(2) not later than 14 business days after the date of the suspension or revocation of certification issue a formal report that includes information related to the action taken, the reason for the action, and the right to appeal.

History: Eff. 2/1/2010, Register 193; am 7/1/2013, Register 206; am 7/1/2015, Register 214

7 AAC 130.222. Recipient safeguards

A home and community-based waiver services provider certified under 7 AAC 130.220 shall

(1) protect a recipient's health, safety, and welfare while rendering a service under this chapter; and

(2) provide training for all employees regarding the reporting requirements of 7 AAC 130.224 and the mandatory reporting requirements of AS 47.17.020 for children and AS 47.24.010 for vulnerable adults.

History: Eff. 7/1/2013, Register 206

7 AAC 130.224. Critical incident reporting.

(a) A provider shall report to the department, on a form provided by the department, a critical incident involving a recipient not later than one business day after observing or learning of the critical incident.

(b) A provider shall develop and implement a system to manage and report critical incidents that includes

(1) methods for identifying a critical incident;

(2) a protocol for emergency response to a critical incident;

(3) procedures for investigating and analyzing a critical incident to determine its cause;

(4) a plan to ensure that each member of the provider's staff is trained in critical incident management and reporting; and

(5) a process that ensures timely reporting of a critical incident to the department.

(c) In this section,

(1) "critical incident" means

(A) a missing recipient;

(B) recipient behavior that resulted in harm to the recipient or others;

(C) misuse of restrictive interventions; in this subparagraph, "restrictive intervention" has the meaning given in 7 AAC 130.229(g) ;

(D) a use of restrictive intervention that resulted in the need for evaluation by or consultation with medical personnel; in this subparagraph, "restrictive intervention" has the meaning given in 7 AAC 130.229(g) ;

(E) death of a recipient;

(F) an accident, an injury, or another unexpected event that affected the recipient's health, safety, or welfare to the extent evaluation by or consultation with medical personnel was needed;

(G) a medication error that resulted in the need for evaluation by or consultation with medical personnel; in this subparagraph, "medication error" has the meaning given in 7 AAC 130.227(j) ;

(H) an event that involved the recipient and a response from a peace officer;

(2) "evaluation by or consultation with medical personnel" means analysis of the incident with respect to a recipient's health, safety, and welfare for the purpose of determining an appropriate treatment or course of action.

History: Eff. 7/1/2013, Register 206; am 7/1/2015, Register 214

7 AAC 130.225. Provider disenrollment and decertification Repealed.

History: Eff. 2/1/2010, Register 193; am 11/3/2012, Register 204; repealed 7/1/2013, Register 206

7 AAC 130.227. Administration of medication and assistance with self-administration of medication

(a) Except as provided in (i) of this section, a provider shall offer administration of medication and assistance with self-administration of medication as integral parts of the following home and community-based waiver services:

(1) adult day services under 7 AAC 130.250;

(2) day habilitation services under 7 AAC 130.260;

(3) residential habilitation services under 7 AAC 130.265;

(4) supported employment services under 7 AAC 130.270;

(5) intensive active treatment services under 7 AAC 130.275;

(6) respite care services under 7 AAC 130.280.

(b) A provider of the services listed in (a) of this section shall be responsible for administration of medication or assistance with self-administration of medication if

(1) a medication is

(A) time-sensitive and may not be delayed; or

(B) required as needed by a recipient;

(2) the recipient or the recipient's representative requests assistance with the recipient's self-administration of medication or requests administration of medication by the provider;

(3) the recipient's plan of care developed in accordance with 7 AAC 130.217 specifies that the recipient needs

(A) assistance with self-administration of medication; or

(B) administration of medication by the provider;

(4) no individual otherwise responsible for administration of medication or assistance with self-administration of medication for that recipient is available at the time when the recipient requires medication; and

(5) the individual that provides administration of medication or assistance with self-administration of medication has completed the training requirements of (f) of this section.

(c) The provider may employ, or make arrangements with, a registered nurse with an active license under AS 08.68 to

(1) administer medications to a recipient or to delegate administration of medication in accordance with 12 AAC 44.950 - 12 AAC 44.990 and this section; and

(2) provide the training specified in (f) of this section.

(d) A provider listed in (a) of this section shall develop and implement written policies and procedures that address

(1) administration of medication and assistance with self-administration of medication while a recipient is in the care of and receiving services from the provider;

(2) training in administration of medication and assistance with self-administration of medication under (f) of this section;

(3) documentation under (g) of this section;

(4) supervision of individuals that provide assistance with administration of medication or assistance with self-administration of medication;

(5) monitoring and evaluation of

(A) administration of medication; or

(B) assistance with self-administration of medication; and

(6) requirements for reporting medication errors.

(e) Before a provider may provide administration of medication or assistance with self-administration of medication under this section, the provider must

(1) have a written delegation for administration of medication or assistance with self-administration of medication from the recipient or recipient's representative, or a delegation in accordance with 12 AAC 44.965 or another applicable statute or regulation;

(2) have written information that identifies

(A) how to store each medication;

(B) the route of administration for each medication;

(C) potential interaction for each medication with other medications the recipient is taking;

(D) potential side effects of each medication;

(E) the individual to notify in the event of the recipient's adverse reaction to a medication; and

(F) if the medication is to be taken as needed,

(i) the circumstances in which the medication is to be administered; and

(ii) whether the delegating authority must be notified before the medication is administered or before assistance with self-administration is provided.

(f) Each individual that provides administration of medication or assistance with self-administration of medication must have on file, with the provider, written verification of attendance and successful completion of the following training appropriate to the task:

(1) if the individual is to provide assistance with the recipient's self-administration of medication, the individual must successfully complete training that addresses the activities listed in (j)(2) of this section;

(2) if the individual is to administer medication to a recipient without the assistance of the recipient, the individual must successfully complete training that has been approved under 12 AAC 44.965(c) .

(g) An individual providing administration of medication or assistance with self-administration of medication under this section must document, in the recipient's record for all medication taken by the recipient while the recipient is in the care of the individual,

(1) the name of the medication;

(2) the dosage administered;

(3) the time of administration;

(4) the name of the individual that assisted the recipient with the recipient's self-administration of medication or administered medication to the recipient; and

(5) the written delegation under (e)(1) of this section authorizing administration of medication or assistance with self-administration of medication.

(h) A provider of the services listed in (a) of this section shall develop and implement a system to manage and report medication errors that includes

(1) a plan for documenting and tracking medication errors;

(2) a requirement for reporting, as a critical incident under 7 AAC 130.224, any medication error that results in medical intervention;

(3) a protocol for analyzing medication errors each quarter;

(4) a procedure for taking corrective action based upon that analysis; and

(5) a process for summarizing the quarterly analyses and corrective action conducted under this subsection, and submitting that summary to the department with the application for recertification under 7 AAC 130.220 or upon request.

(i) The requirements of this section do not apply if

(1) the services are provided in a foster home or assisted living home licensed under AS 47.32, and medications are provided in accordance with 7 AAC 10.1070;

(2) the recipient administers the recipient's own medication without assistance; or

(3) the recipient or the recipient's representative gives the provider written notice designating an individual that will be responsible for administration of medication or assistance with self-administration of medication for the recipient, and the provider arranges with that individual to administer the medication or assist with self-administration at the time medication is required by the recipient.

(j) In this section,

(1) "administration of medication" means the direct delivery or application of an oral, nasal, ophthalmic, otic, topical, vaginal, or rectal medication by a provider to or into the body of a recipient that is unable to administer medication independently, and the use of an epinephrine auto-injector for a severe allergic reaction;

(2) "assistance with self-administration of medication" means

(A) reminding the recipient to take medication;

(B) opening a medication container or prepackaged medication for the recipient;

(C) reading a medication label to the recipient;

(D) providing food or liquids if the medication label instructs the recipient to take the medication with food or liquids;

(E) observing the recipient while the recipient takes medication;

(F) checking the recipient's self-administered dosage against the label of the medication container;

(G) reassuring the recipient that the recipient is taking the dosage as prescribed; or

(H) directing or guiding the hand of the recipient, at the recipient's request, while the recipient administers medication;

(3) "medication" means a drug or product, including an over-the-counter product, that is intended to be taken by the recipient at a scheduled time or as needed, and that is prescribed for a recipient by an individual

(A) with an active license under AS 08 to practice as

(i) an advanced nurse practitioner;

(ii) a physician, including an osteopath;

(iii) a physician assistant; or

(iv) a dentist; or

(B) who is an employee of the federal government assigned to a tribal health care program, and who has an active license from a jurisdiction in the United States to practice as

(i) an advanced nurse practitioner;

(ii) a physician, including an osteopath;

(iii) a physician assistant; or

(iv) a dentist;

(4) repealed 7/1/2015;

(5) "medication error" means

(A) a failure to document medication administration;

(B) a failure to provide medication administration at, or within one hour before or one hour after, the scheduled time;

(C) the delivery of medication

(i) at a time other than when a medication was scheduled, if the time was outside the acceptable range in (B) of this paragraph;

(ii) other than by the prescribed route;

(iii) other than in the prescribed dosage;

(iv) not intended for the recipient; or

(v) intended for the recipient, but given to another individual.

History: Eff. 7/1/2013, Register 206; am 7/1/2015, Register 214

7 AAC 130.229. Use of restrictive intervention

(a) A home and community-based waiver services provider may use restrictive intervention only

(1) as a response when a recipient presents an imminent danger to the recipient's safety or to the safety of others;

(2) when other types of interventions have been tried, and documented as ineffective for safe management of the recipient's behavior that requires intervention; and

(3) if the type of intervention is safe, proportionate to the recipient's behavior, and appropriate to the recipient's chronological and developmental age, size, gender, and physical, medical, and psychological condition.

(b) The provider shall develop and implement written policies and procedures that address

(1) the use of restrictive intervention in regard to the recipient population served by the provider;

(2) a prohibition on the use of

(A) seclusion as a restrictive intervention; and

(B) prone restraint;

(C) chemical restraint;

(3) training in the use of restrictive intervention;

(4) documentation of each event that involves the use of restrictive intervention;

(5) supervision of individuals that use restrictive intervention while recipients are in the care of or receiving services from the provider; and

(6) monitoring and evaluation of each use of restrictive intervention.

(c) The provider must have on file written verification that each direct care worker has received training appropriate to the type of restrictive intervention the provider has allowed that direct care worker to use.

(d) A provider that uses restrictive intervention shall document in the recipient's record

(1) the date and time;

(2) the duration of time each type of restrictive intervention was used;

(3) a description of the behavior that led to the use of restrictive intervention;

(4) a rationale for, and a description of, each type of restrictive intervention used;

(5) the recipient's response to each type of restrictive intervention used; and

(6) the name of each staff member involved in the restrictive intervention.

(e) The provider shall maintain a record of restrictive intervention that documents

(1) the event or circumstances that necessitated the use of restrictive intervention;

(2) the type of restrictive intervention used;

(3) the type of care provided to the recipient while a restrictive intervention is applied; and

(4) the outcome for the recipient and for the staff involved in the event.

(f) The provider shall develop and implement a system to manage and report the use of restrictive intervention that includes

(1) a plan for documenting and tracking the use of restrictive intervention;

(2) requirements for reporting, as a critical incident under 7 AAC 130.224,

(A) the misuse of restrictive intervention; and

(B) the use of restrictive intervention that resulted in the need for medical intervention;

(3) a protocol for analyzing the use of restrictive intervention each calendar quarter;

(4) a procedure for taking corrective action based on the analysis; and

(5) a process for summarizing the quarterly analyses and corrective action taken under this subsection; the summary must be submitted to the department with the provider's application for recertification under 7 AAC 130.220, or upon request.

(g) In this section

(1) "restrictive intervention" means an action or procedure that limits an individual's movement or access to other individuals, locations, or activities;

(2) "seclusion" means the involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving.

(3) "chemical restraint"

(A) means the use of medication to restrict freedom of movement in order to manage or control behavior, for disciplinary purposes, or for the convenience of the provider;

(B) does not include medication prescribed for the purpose of managing behavior by an individual listed in 7 AAC 130.227(j) (3) and administered in accordance with the applicable requirements of 7 AAC 130.227.

History: Eff. 7/1/2013, Register 206; am 7/1/2015, Register 214

7 AAC 130.230. Screening, assessment, plan of care, and level-of-care determination

Repealed.

History: Eff. 2/1/2010, Register 193; am 11/3/2012, Register 204; repealed 7/1/2013, Register 206

7 AAC 130.231. Services during temporary absence

(a) The department will pay for home and community-based waiver services rendered to a recipient during a recipient's temporary absence from the recipient's community when the recipient travels to another location within the state or to an out-of-state destination, if the services

(1) are provided by a home and community-based waiver services provider that is certified under 7 AAC 130.220;

(2) are limited to the following:

(A) day habilitation services under 7 AAC 130.260;

(B) supported-living habilitation services under 7 AAC 130.265(e) ;

(C) in-home support habilitation services under 7 AAC 130.265(i) ;

(D) hourly respite care services under 7 AAC 130.280;

(E) adult day services under 7 AAC 130.250;

(3) are approved under 7 AAC 130.217 as part of the recipient's plan of care; and

(4) receive prior authorization.

(b) A request for services for a recipient under this section must show that

(1) the services are necessary to maintain the recipient's current level of functioning or to prevent placing the recipient at risk of institutionalization;

(2) the services provided during the recipient's temporary absence are the same as those provided when the recipient is in the recipient's community, and are at the level approved in the recipient's plan of care;

(3) the absence is justified as

(A) a medical necessity documented by a physician licensed under AS 08.64;

(B) an educational opportunity of limited duration that is not available in the recipient's community or in the state, and that will enhance the recipient's capacity to attain the goals outlined in the recipient's plan of care; or

(C) a vacation;

(4) the absence will be for a period of at least 24 hours; the total period for which the recipient may receive services under this section may not exceed 30 days during the period that a plan of care is in effect;

(5) the recipient meets the requirements of 7 AAC 100.064 if travel is to be out-of-state; and

(6) the home and community-based waiver services provider will

(A) maintain an employer relationship with any employee traveling with and providing services to a recipient during a temporary absence; and

(B) supervise that employee during the provision of those services.

(c) Notwithstanding (b)(4) of this section, the department may approve a temporary absence of more than 30 days during the period that a plan of care is in effect, if

(1) a physician licensed under AS 08.64 justifies a longer temporary absence as a medical necessity under (b)(3)(A) of this section; or

(2) the department determines in advance that the benefits to the recipient of an educational opportunity under (b)(3)(B) of this section justify a longer temporary absence.

(d) The department will not pay for

(1) transportation, room and board, or any other expenses for any individual providing services under this section; or

(2) services provided in a location other than this or another state.

History: Eff. 7/1/2013, Register 206

7 AAC 130.233. Provider termination of services to a recipient

(a) Not later than 30 days before a home and community-based waiver services provider terminates services to a recipient, the provider shall send written notice of service termination to the department, the recipient, and the recipient's care coordinator.

(b) provider may terminate services to a recipient without the notice required in (a) of this section if the provider has evidence that

(1) continuing services for the recipient will

(A) jeopardize the safety of the provider, an employee of the provider, or an individual receiving services from the provider; or

(B) endanger the health, safety and welfare of the recipient; and

(2) documents measures that the provider took to address the recipient behavior that resulted in immediate termination.

(c) A home and community-based waiver services provider that terminates services to a recipient under (b) of this section shall

(1) comply with the requirements of (a) of this section, except for the 30-day time frame for notice of termination; and

(2) refer the recipient to the state agency responsible for adult protective services or child protective services as appropriate, if the provider has any concern that the immediate termination of services will place the recipient at risk of harm.

(d) A provider that intends to close, sell, or change ownership of a business certified under 7 AAC 130.220 shall send written notice of that intention to the department and to each affected recipient and that recipient's care coordinator not later than 60 days before the closure, sale, or change in ownership.

History: Eff. 7/1/2013, Register 206; am 7/1/2015, Register 214

7 AAC 130.235. Nursing oversight and care management services

(a) The department will require nursing oversight and care management services for a recipient that is eligible under the recipient category of

(1) children with complex medical conditions; or

(2) individuals with intellectual and developmental disabilities if the recipient meets, except for the age requirement in 7 AAC 130.205(d) (1)(A), the criteria for the recipient category for children with complex medical conditions under 7 AAC 130.205(d) (1).

(b) The department will pay for nursing oversight and care management services that

(1) are approved under 7 AAC 130.217 as part of the recipient's plan of care;

(2) receive prior authorization; and

(3) are provided by a registered nurse that is

(A) licensed to practice under AS 08.68; and

(B) employed by a home and community-based waiver services provider.

(c) For a home and community-based waiver services provider to qualify for payment for nursing oversight and care management services, a registered nurse must

(1) conduct a nursing assessment of the recipient's medical care needs;

(2) develop, for inclusion in the recipient's plan of care, a nursing plan that addresses the

(A) recipient's health and safety;

(B) recipient's medical care needs; and

(C) training required for paid and unpaid caregivers to perform delegated nursing duties under this section;

(3) participate in planning the recipient's care in accordance with 7 AAC 130.217;

(4) provide oversight by evaluating whether services

(A) are delivered in accordance with the nursing plan and in a manner that protects the health, safety, and welfare of the recipient; and

(B) are reasonable and necessary for the recipient's medical condition and the complexity of the care required to treat that condition; and

(5) remain in contact with the recipient in a manner and with a frequency appropriate to the medical condition of the recipient and to the complexity of the care to be delivered; at a minimum, the contact must include at least one on-site evaluation every 90 days during which the recipient and any individual to which nursing duties were delegated shall be in attendance.

(d) The department will not pay separately for services under this section that duplicate

(1) specialized private-duty nursing services under 7 AAC 110.525 or 7 AAC 130.285;

(2) private-duty nursing services under 7 AAC 110.525; or

(3) intensive active treatment services under 7 AAC 130.275.

History: Eff. 2/1/2010, Register 193; am 7/1/2013, Register 206

7 AAC 130.238. Certification of care coordinators

(a) An individual may not provide care coordination services unless

(1) the department certifies the individual under this section;

(2) the individual is enrolled in the Medicaid program under 7 AAC 105.210; and

(3) the individual is an owner of or employed by a care coordination services provider agency certified under 7 AAC 130.220(a) (2).

(b) For the department to certify an employee as a care coordinator,

(1) that employee must

(A) submit a complete application for certification to the department, using the department's *Care Coordinator Certification Application*, adopted by reference in 7 AAC160.900; and

(B) meet the applicable certification criteria, including the care coordination qualifications and program standards set out in the department's *Care Coordination Conditions of Participation*, adopted by reference in 7 AAC 160.900; and

(2) the provider must certify in writing to the department that the employee

(A) meets and complies with the requirements of the department's *Care Coordination Conditions of Participation*, adopted by reference in 7 AAC 160.900;

(B) is employed by that provider; and

(C) meets that provider's employment standards to provide care coordination services.

(c) The department will certify a care coordinator under this section for the following time periods:

(1) one year for a care coordinator not previously certified by the department;

(2) two years for a currently certified care coordinator that is renewing that care coordinator's certification.

(d) Not later than 90 days before the expiration of a care coordinator's certification, the department will send to the care coordinator notice of the requirement to renew that certification. The care coordinator must submit a new application for certification in accordance with (b)(l)(A) of this section not later than 60 days before the expiration date of the current certification.

(e) The department will deny certification of an employee or renewal of a care coordinator's certification, or will decertify a care coordinator if

(1) the individual failed to submit a complete application in accordance with (b)(1)(A) of this section so that it is received by the department not later than 30 days after the date of any notice from the department that the application is incomplete;

(2) the individual's certification, license, or enrollment related to Medicaid or Medicare was denied, revoked, or rescinded;

(3) the individual's name appears on any state or federal exclusion list related to health services; or

(4) the department has documentation that indicates that the individual

(A) is unable or unwilling to meet the certification requirements of this section or any other Medicaid requirement under 7 AAC 105 - 7 AAC 160; or

(B) creates a risk to the health, safety, or welfare of a recipient.

(f) A care coordinator may appeal, under 7 AAC 105.460, a decision by the department to

(1) deny the care coordinator's application for certification, recertification, or re-enrollment; or

(2) decertify the care coordinator.

History: Eff. 7/1/2013, Register 206; am 7/1/2015, Register 214

7 AAC 130.240. Care coordination services

(a) The department will pay for care coordination services that

(1) are provided in accordance with the department's *Care Coordination Conditions of Participation*, adopted by reference in 7 AAC 160.900; and

(2) are approved under 7 AAC 130.217 as part of the recipient's plan of care.

(b) The department will pay for the following care coordination services for a recipient:

(1) one plan of care in any 365-day period, if the plan of care is accompanied by the form required under 7 AAC 130.219(b) (1) documenting the recipient's choice of home and community-based waiver services; the plan of care must be developed in accordance with 7 AAC 130.217, except that the department will pay for a plan of care that was developed based on the choice-of-service form required under 7 AAC 130.219(b) (1), but that the department cannot approve because home and community-based waiver services are not available under 7 AAC 130.205(b) ;

(2) a monthly care coordination service rate, established in accordance with 7 AAC 145.520, if the care coordinator

(A) remains in contact with the recipient or the recipient's representative in a manner and with a frequency appropriate to the needs and the communication abilities of the recipient, but at a minimum makes two contacts each month with the recipient or the recipient's representative; one of the two contacts must be an in-person visit with the recipient, unless the department waives the visit requirement under (d) of this section;

(B) notwithstanding the granting of a visit waiver under (d) of this section, meets the recipient in person to

(i) monitor service delivery at least once per calendar quarter; and

(ii) develop the annual plan of care; the annual plan of care may be developed during one of the quarterly visits; and

(C) after each visit with the recipient, completes and retains, as documentation of each visit, a recipient contact report in accordance with the department's *Care Coordination Conditions of Participation*, adopted by reference in 7 AAC 160.900.

(c) The department will pay a care coordinator, beginning with the first month that the recipient is enrolled under 7 AAC 130.219 and has a plan of care approved under 7 AAC 130.217, for the following ongoing care coordination services provided in accordance with (b) of this section:

(1) routine monitoring and support;

(2) monitoring quality of care;

(3) evaluating the need for specific home and community-based waiver services;

(4) reviewing and revising the plan of care under 7 AAC 130.217;

(5) coordinating multiple services and providers;

(6) assisting the recipient to apply for reassessment under 7 AAC 130.213;

(7) assisting the recipient in case terminations.

(d) The department will waive the monthly in-person visit requirements for a recipient that lives in a remote community or location if the plan of care documents, to the department's satisfaction, that

(1) the projected cost of travel to visit the recipient is 50 percent or more of the payment for all care coordination services for all recipients that receive those services from the provider employing the care coordinator and that reside in the destination community or location for the 12-month period of the request;

(2) in the remote community or location,

(A) a care coordinator is not available; or

(B) each care coordinator that is available is unwilling or unable to provide services to the recipient; and

(3) infrequent in-person contacts will not compromise the health, safety, or welfare of the recipient.

(e) Repealed 7/1/2015.

(f) A care coordinator must disclose, to the department on a form provided by the department, any close familial relationship or close business relationship with a home and community-based waiver services provider.

(g) The department will not pay for care coordination services provided by the recipient, a member of the recipient's immediate family, the recipient's representative, a holder of power of attorney for the recipient, or the recipient's personal care assistant.

(h) The department will recoup under 7 AAC 105.260 any payment for other home and community-based waiver services provided to a recipient by a care coordinator while that care coordinator provided ongoing care coordination under this section.

(i) The care coordinator shall notify the department not later than seven days after

(1) the date of a recipient's planned admission to a hospital or to a nursing facility; and

(2) the date of a recipient's discharge from a hospital or from a nursing facility.

(j) Notwithstanding (b) of this section, the department will pay for additional assessments or plans of care that have received prior authorization.

(k) In this section,

(1) "close business relationship" means

(A) a five percent or greater ownership, partnership, or equity interest in another home and community-based waiver services provider or its owner; or

(B) a five percent or greater ownership, partnership, or equity interest in any other business or commercial activity in which another home and community-based waiver services provider or its owner or administrator also has a five percent or greater ownership, partnership, or equity interest;

(2) "close familial relationship" means a relationship in which the care coordinator is

(A) the spouse, parent, sibling, or child of

(i) a home and community-based waiver services provider who is a natural person; or

(ii) an owner, administrator, or employee of a home and community-based waiver services provider agency; or

(B) spouse of the parent, sibling, or child of a natural person who is

(i) a home and community-based waiver services provider; or

(ii) an owner, administrator, or employee of a home and community-based waiver services provider agency;

(3) "owner" means a person having a five percent or greater ownership, partnership, or equity interest.

(4) "remote community or location"

(A) means a community or location that is not accessible by road from Anchorage or Fairbanks or that is accessible only by crossing international boundaries;

(B) does not include a community or location that is on a road system that connects two or more communities or locations, if the services are available in one of them.

History: Eff. 2/1/2010, Register 193; am 7/1/2013, Register 206; am 7/1/2015, Register 214

7 AAC 130.245. Chore services

(a) The department will pay for chore services that

(1) are provided in accordance with the department's *Chore Services Conditions of Participation*, adopted by reference in 7 AAC 160.900;

(2) are approved under 7 AAC 130.217 as part of the recipient's plan of care;

(3) receive prior authorization; and

(4) do not exceed

(A) 10 hours for each week during the period that a plan of care is in effect, up to a maximum of 520 hours for a one-year plan of care, for a recipient in one of the following recipient categories:

(i) adults with physical and developmental disabilities;

(ii) older adults or adults with physical disabilities;

(B) five hours for each week during the period that a plan of care is in effect, up to a maximum of 260 hours for a one-year plan of care, for a recipient in one of the following recipient categories:

(i) children with complex medical conditions; however, if a recipient in that category has a documented history of respiratory illness, the department will pay for chore services not to exceed 10 hours each week during the period that a plan of care is in effect, up to a maximum of 520 hours for a one-year plan of care;

(ii) individuals with intellectual and developmental disabilities.

(C) the number of hours that are allowed under (A) and (B) of this paragraph and that the department approves as necessary to maintain a clean, sanitary, and safe environment for each recipient, if more than one recipient lives in the residence where services are to be provided; the department will base the number of hours allowed on

(i) the recipient category of each recipient;

(ii) the degree to which the tasks listed in (b) of this section are necessary for each recipient or benefit all recipients in the residence;

(iii) whether the services would duplicate services received by any recipient under 7 AAC 125.010 - 7 AAC 125.199; and

(iv) the justification for the number of hours provided in each recipient's plan of care.

(b) The department will consider the following services to be chore services:

(1) routine cleaning within the recipient's residence;

(2) performing heavy household chores, including

(A) washing floors, windows, and walls;

(B) securing loose rugs and tiles;

(C) moving heavy items of furniture;

(D) snow removal sufficient to provide safe access and egress for the recipient;

(E) hauling water for use in the recipient's residence;

(F) disposing of human excreta;

(G) chopping or collecting firewood, if firewood is used as the primary source of energy for heating or cooking in the recipient's residence;

(3) food preparation and shopping for a recipient in the recipient category of older adults or adults with physical disabilities;

(4) other services that the department determines necessary to maintain a clean, sanitary, and safe environment with respect to the recipient's residence.

(c) The department will either deny or limit the time authorized for chore services if

(1) an individual that lives in the recipient's home is responsible for performing the chores described in (b) of this section, and the individual is an adult member of the recipient's immediate family or a caregiver for the recipient;

(2) a community or voluntary agency is willing to perform those chores for the recipient;

(3) a third party is responsible for paying for the performance of those chores for the recipient;

(4) the recipient's residence is a rental property, and the department determines those services to be the responsibility of the landlord under the lease or applicable law; or

(5) a provider certified under 7 AAC 130.220 to provide chore services designates an individual to provide chore services, and that individual resides in the same residence as the recipient of chore services.

(d) If a recipient is eligible for chore services under this section and eligible for personal care services under 7 AAC 125.010 - 7 AAC 125.199, the recipient must choose to receive the chore services described in this section or to have similar chores performed as personal care services.

History: Eff. 2/1/2010, Register 193; am 7/1/2013, Register 206; am 7/1/2015, Register 214

7 AAC 130.250. Adult day services

(a) The department will pay for adult day services that

(1) are provided to a recipient in one of the following recipient categories:

(A) older adults or adults with physical disabilities;

(B) adults with physical and developmental disabilities;

(2) are provided in accordance with the department's *Adult Day Services Conditions of Participation*, adopted by reference in 7 AAC 160.900;

(3) are approved under 7 AAC 130.217 as part of the recipient's plan of care; and

(4) receive prior authorization.

(b) The department will consider health, social, and related support services to be adult day services if the services are

(1) provided in a non-institutional community setting on a regular basis for not more than 10 hours per day, not including transportation to and from the setting; however, the department will allow more than 10 hours per day if the department determines that the recipient is unable to benefit from

(A) other home and community-based waiver services; or

(B) services provided by family members or community supports; and

(2) planned to promote the optimal functioning of the recipient by meeting both health and social service needs.

(c) The department will not pay for adult day services that duplicate

(1) services performed by personal care assistants under 7 AAC 125.010 - 7 AAC 125.199; or

(2) other home and community-based waiver services.

(d) In this section, "non-institutional community setting" means a setting other than a hospital, nursing facility, or ICF/IID.

History: Eff. 2/1/2010, Register 193; am 7/1/2013, Register 206; am 7/1/2015, Register 214

7 AAC 130.255. Residential supported-living services

(a) The department will pay for residential supported-living services that

(1) are provided to a recipient in one of the following recipient categories:

(A) older adults or adults with physical disabilities;

(B) adults with physical and developmental disabilities;

(2) are provided in accordance with the department's *Residential Supported-Living Services Conditions of Participation*, adopted by reference in 7 AAC 160.900;

(3) are approved under 7 AAC 130.217 as part of the recipient's plan of care;

(4) receive prior authorization; and

(5) are provided in an assisted living home licensed under AS 47.32.

(b) The department will consider services to be residential supported-living services if the services

(1) are provided in a residential setting staffed 24 hours a day by on-site personnel capable of

(A) meeting both scheduled and unpredictable resident needs; and

(B) providing supervision, safety, and security;

(2) assist a recipient in the assisted living home with

(A) activities of daily living described in 7 AAC 125.030(b) ; and

(B) supportive services, including social and recreational activities; and

(3) are designed for a recipient that

(A) can no longer live alone, but whose need for institutional level of care can be met though the support provided in the 24-hour residential supported-living setting; and

(B) without the services, would require placement in a nursing facility for lack of alternate placements.

(c) If a recipient is eligible for residential supported-living services, the department will not make separate payment for

(1) chore services under 7 AAC 130.245;

(2) meals services under 7 AAC 130.295, unless the meals are provided in a congregate setting other than an assisted living home licensed under AS 47.32;

(3) respite care services payable under 7 AAC 130.280;

(4) the recipient's room and board;

(5) the cost of facility maintenance, upkeep, or improvement; or

(6) activities or supervision for which a source other than Medicaid makes payment.

(d) A provider of residential supported-living services under this section may not compel a recipient to be absent from the assisted living home for the convenience of the provider.

History: Eff. 2/1/2010, Register 193; am 7/1/2013, Register 206

7 AAC 130.260. Day habilitation services

(a) The department will pay for day habilitation services that

(1) are provided to a recipient in one of the following recipient categories:

(A) children with complex medical conditions, if the recipient is three years of age or older;

(B) adults with physical and developmental disabilities:

(C) individuals with intellectual and developmental disabilities, if the recipient is three years of age or older;

(2) are provided in accordance with the department's *Day Habilitation Services Conditions of Participation*, adopted by reference in 7 AAC 160.900;

(3) are approved under 7 AAC 130.217 as part of the recipient's plan of care; and

(4) receive prior authorization.

(b) The department will consider habilitation services to be day habilitation services if the services

(1) are provided in a nonresidential setting, separate from the recipient's private residence or another residential setting, to a recipient individually or as a member of a group;

(2) include round-trip transportation for the recipient between the site where services are provided and the personal residence, assisted living home, or foster home where the recipient resides if the

recipient's plan of care reflects that transportation will be provided by the day habilitation services provider;

(3) assist the recipient with acquisition, retention, or improvement of skills in the areas of self-help, socialization, appropriate behavior, and adaptation;

(4) promote the development of the skills needed for independence, autonomy, and full integration into the community;

(5) reinforce the skills taught in school, therapy, or other settings;

(6) do not duplicate or supplant services provided in accordance with 7 AAC 130.265(b) ; and

(7) do not replace, enhance, or supplement educational services for which the recipient is eligible under 4 AAC 52.

(c) If the recipient of day habilitation services is also provided group-home habilitation services under 7 AAC 130.265(f) , the department will not pay for more than 15 hours per week of day habilitation services from all providers combined, unless the department determines that the recipient is unable to benefit from any other community service or activities.

(d) Notwithstanding (b)(1) of this section, the department will waive the requirement for provision of day habilitation services in a nonresidential setting if the provider documents to the department's satisfaction, on a form provided by the department,

(1) the unavailability of a suitable non-residential setting in the community or location in which the services are to be provided, except that services under this section may not be provided in the private residence of a recipient; and

(2) the setting where day habilitation services are to be provided will

(A) offer opportunities for activities appropriate for the recipient population to be served; and

(B) be delivered in a manner that protects recipient health, safety, and welfare.

History: Eff. 2/1/2010, Register 193; am 7/1/2013, Register 206

7 AAC 130.265. Residential habilitation services

(a) The department will pay for residential habilitation services that

(1) are provided to a recipient in one of the following recipient categories:

(A) children with complex medical conditions;

(B) adults with physical and developmental disabilities;

(C) individuals with intellectual and developmental disabilities;

(2) are provided in accordance with the department's *Residential Habilitation Services Conditions of Participation*, adopted by reference in 7 AAC 160.900;

(3) are approved under 7 AAC 130.217 as part of the recipient's plan of care;

(4) receive prior authorization; and

(5) meet the requirements specified in this section for

(A) family home habilitation services described in (b) of this section;

(B) supported-living habilitation services described in (d) of this section;

(C) group-home habilitation services described in (f) of this section; or

(D) in-home support habilitation services described in (h) of this section

(b) The department will consider residential habilitation services to be family home habilitation services if

(1) the family home habilitation services site

(A) is a residence licensed as an assisted living home or a foster home under AS 47.32; and

(B) provides 24-hour care;

(2) the recipient's primary caregiver

(A) lives with the recipient in the same residence;

(B) is not a member of the recipient's immediate family; and

(C) provides the oversight, care, and support needed by the recipient to prevent risk of institutionalization of that recipient; and

(3) the health, safety, and welfare of a recipient living in a family home habilitation services site for the purpose of receiving services under this subsection are not at risk because of the primary caregiver's other obligations.

(c) The department will pay for family home habilitation services under (b) of this section subject to the following limitations:

(1) a recipient's care coordinator must demonstrate, to the department's satisfaction in the recipient's plan of care developed under 7 AAC 130.217, that the following criteria were evaluated to determine that a family home habilitation services site is appropriate to provide services to the recipient:

(A) the needs of the recipient, including the need for specialized medical technology;

(B) the capacity of the primary caregiver to provide services for the specific needs of the recipient;

(C) the adequacy of the provider's plan for primary caregiver training, recipient safety, service monitoring, and oversight regarding the number of individuals living at the site;

(D) the suitability of the physical site for the recipient;

(E) the number and the relationship to the primary caregiver of other individuals living at the site, and whether any medical conditions or behavioral characteristics of

(i) those individuals could create a risk to the health, safety, and welfare of the recipient; and

(ii) the recipient could create a risk to the health, safety, and welfare of those individuals;

(F) the ability of other individuals living at the site to provide self-care;

(G) the degree to which any adults and children living at that site, regardless of whether those individuals receive any form of financial support from a public or private source, are dependent upon the primary caregiver for their health, safety, and welfare; and

(H) the nature of any complaints regarding the physical site, quality of care, the primary caregiver, or others living at the site, and how the provider certified in accordance with 7 AAC 130.220(a) (l)(E) resolved those complaints.

(2) the department will authorize payment for services in a family home habilitation services site for not more than three recipients, if each recipient was evaluated and approved to receive services in accordance with the criteria in this subsection, and unless the director of the departmental division responsible for home and community-based waiver services waives the limit on the number of recipients

(A) to allow siblings of the recipient to live at the same site; or

(B) because the provider certified in accordance with 7 AAC 130.220(a) (1)(E) demonstrates to the department's satisfaction that the primary caregiver's obligations to a larger number of individuals, including any adults or children dependent upon the caregiver, will not jeopardize the health, safety, and welfare of the recipient or other dependents; the director will base the decision to waive the limit on the number of recipients in the home on an evaluation of the criteria in (1) of this subsection;

(3) when family home habilitation services are authorized for a recipient, the department will not make separate payment for

(A) chore services under 7 AAC 130.245;

(B) family-directed respite care services under 7 AAC 130.280;

(C) transportation services under 7 AAC 130.290;

(D) meal services under 7 AAC 130.295; or

(E) services provided by another resident of a family home habilitation service site;

(4) a provider certified in accordance with 7 AAC 130.220(a) (1)(E) shall

(A) notify the department, the recipient's care coordinator, and the recipient or recipient's representative

(i) 30 days before moving a recipient from, or replacing the primary caregiver at, a family home habilitation services site that was evaluated using the criteria under this subsection; and

(ii) not later than one business day after any unplanned relocation or replacement of the primary caregiver, if the provider determined that the relocation or replacement was necessary to protect the recipient's health, safety, and welfare;

(B) consult with the recipient's care coordinator and the recipient or recipient's representative to evaluate whether the criteria specified in this subsection will be met if the recipient is relocated or the primary caregiver is replaced, or are met in the event of an unplanned relocation of the recipient or unplanned replacement of the primary caregiver; and

(C) demonstrate to the department's satisfaction, in an amendment to the plan of care under 7 AAC l30.217(d), that

(i) the criteria in this subsection were evaluated in regard to the needs of the recipient;

(ii) the relocation site meets the needs of the recipient; and

(iii) the primary caregiver at the relocation site or the primary caregiver replacement is capable of providing family home habilitation services to the recipient.

(d) The department will consider residential habilitation services to be supported-living habilitation services if the services are provided on a one-to-one basis to a recipient 18 years of age or older living full-time in that recipient's private residence.

(e) The department will pay for supported-living habilitation services under (d) of this section subject to the following limitations:

(1) the department will not pay for more than 18 hours per day of supported-living habilitation services from all providers combined, unless the department determines that the recipient is unable to benefit from

(A) other home and community-based waiver services; or

(B) services provided by family members or community supports;

(2) the department will approve other direct care services for a recipient under (d) of this section, if the recipient's care coordinator confirms in writing and the department is satisfied that those services do not supplant or duplicate services provided by family members or community supports; for purposes of this paragraph, "direct care services" includes

(A) personal care services under 7 AAC 125.010 - 7 AAC 125.199;

(B) chore services under 7 AAC 130.245;

(C) transportation services under 7 AAC 130.290; and

(D) meal services under 7 AAC 130.295;

(f) The department will consider residential habilitation services to be group-home habilitation services if those services are provided to a recipient 18 years of age or older living full-time in a residence licensed as an assisted living home for two or more residents under AS 47.32 that provides 24-hour care.

(g) The department will pay for group-home habilitation services under (f) of this section subject to the following limitations:

(1) a recipient of group-home habilitation services is subject to the limitation in 7 AAC 130.260(c) on day habilitation services;

(2) services rendered by the group-home habilitation staff, whether in the group home or in the community, may not be billed separately as day habilitation services under 7 AAC 130.260;

(3) if a recipient is eligible for group-home habilitation services, the department will not make separate payment for

(A) chore services under 7 AAC 130.245;

(B) respite services under 7 AAC 130.280;

(C) transportation services under 7 AAC 130.290;

(D) meal services under 7 AAC 130.295; or

(E) services provided by another resident of the group home.

(h) The department will consider residential habilitation services to be in-home support habilitation services if they are provided on a one-to-one basis to a recipient younger than 18 years of age living full-time in that recipient's private residence where an unpaid primary caregiver resides.

(i) The department will pay for in-home support habilitation services under (h) of this section, subject to the following limitations:

(1) the department will not pay for more than 18 hours per day of in-home support habilitation services from all providers combined unless the department determines that the recipient is unable to benefit from

(A) other home and community-based waiver services; or

(B) services provided by family members or community supports;

(2) when in-home support habilitation services are authorized for the recipient, the department will not make separate payment for

(A) personal care services under 7 AAC 125.010 - 7 AAC 125.199;

(B) chore services under 7 AAC 130.245;

(C) transportation services under 7 AAC 130.290;

(D) meal services under 7 AAC 130.295; or

(E) services provided by another resident of the home or by the primary unpaid caregiver.

(j) A provider of residential habilitation services under this section may not compel a recipient to be absent from an assisted living home, foster home, or group home for the convenience of the provider.

History: Eff. 2/1/2010, Register 193; am 7/1/2013, Register 206; am 7/1/2015, Register 214

7 AAC 130.267. Acuity payments for qualified recipients

(a) The department will pay for additional services under this section that

(1) are provided for a recipient who is qualified under (b) of this section and is receiving

(A) residential supported-living services under 7 AAC 130.255 that are assigned the procedure code described in 7 AAC 145.520(m) ; or

(B) group-home habilitation services under 7 AAC 130.265(f) that are assigned the procedure code described in 7 AAC 145.520(m) ;

(2) are requested in accordance with (c) of this section;

(3) the department determines to be necessary, based upon evaluation of the supporting documentation submitted in accordance with (d) or (e) of this section; and

(4) receive prior authorization.

(b) For purposes of this section, a qualified recipient is one that

(1) needs services that exceed those authorized in the recipient's current plan of care under 7 AAC 130.217; and

(2) because of the recipient's physical condition or behavior, needs direct one-to-one support from direct care workers whose time is dedicated solely to providing services under (a)(1) of this section to that one recipient 24 hours per day, seven days per week, in all environments in which the recipient functions.

(c) To request additional services under this section, the care coordinator responsible under 7 AAC 130.217 for the recipient's plan of care must submit

(1) written documentation that

(A) describes how the recipient's physical condition or behavior justifies the support described in (b) of this section;

(B) lists each intervention tried or in use to address the recipient's physical condition or behavior, and whether the intervention was successful or unsuccessful;

(C) indicates how additional services under this section would be consistent with services approved as part of the recipient's plan of care under 7 AAC 130.217; and

(D) addresses how the acuity payment under this section would be used to improve management of the recipient's physical condition or behavior; and

(2) the supporting evidence required under (d) or (e) of this section, as appropriate.

(d) If the recipient needs the support described in (b)(2) of this section because of the recipient's physical condition, in whole or in part, the request for additional services must include, in addition to the information required under (c) of this section,

(1) a copy of the recipient's most recent medical evaluation conducted as part of an assessment under 7 AAC 130.213 specific to the recipient's plan of care under 7 AAC130.217;

(2) a record of the recipient's dates of hospital admission and discharge or of other medical interventions during the 30 days immediately preceding the date of the request;

(3) a copy of the recipient's clinical record under 7 AAC 105.230(d) (6) documenting 24 hours of activity for each of the 30 days immediately preceding the date of the request; and

(4) a description of how administration of medication is managed, and how other recurring medical treatments are managed.

(e) If the recipient needs the support described in (b)(2) of this section because of the recipient's behavior, in whole or in part, the request for prior authorization must include, in addition to the information required under (c) of this section, a copy of the recipient's

(1) most recent medical and psychological evaluations conducted as part of an assessment under 7 AAC 130.213 specific to the recipient's plan of care under 7 AAC130.217; and

(2) clinical record under 7 AAC 105.230(d) (6) documenting 24 hours of activity for each of the 30 days immediately preceding the date of the request.

(f) The department will not approve additional services under this section for more than 12 consecutive months.

(g) The department may terminate authorization for services under this section at any time if the department verifies that the recipient's physical condition or behavior no longer requires additional services under this section.

(h) A provider who receives an acuity payment under this section shall

(1) provide workers to provide the services described in (b)(2) of this section; and

(2) ensure that at least one worker is awake at all times to provide those services.

History: Eff. 4/1/2012, Register 201; am 7/1/2013, Register 206; am 7/1/2015, Register 214

7 AAC 130.270. Supported-employment services

(a) The department will pay for supported-employment services that

(1) are provided in accordance with the department's *Supported Employment Conditions of Participation*, adopted by reference in 7 AAC 160.900;

(2) are provided to a recipient in one of the following recipient categories:

(A) children with complex medical conditions;

(B) adults with physical and developmental disabilities;

(C) individuals with intellectual and developmental disabilities;

(3) are provided to a recipient individually or as a member of a group;

(4) are approved under 7 AAC 130.217 as part of the recipient's plan of care; if a recipient is under 22 years of age, the plan of care must document that the supported employment services do not duplicate or supplant educational services for which a recipient is eligible under 4 AAC 52; and

(5) receive prior authorization.

(b) The department will consider services to be supported employment services if the services

(1) prepare a recipient for work;

(2) provide support, if needed to enable a recipient to be employed, at a worksite where

(A) individuals without disabilities are employed; or

(B) the recipient is self-employed;

(3) assist a recipient to develop the skills needed to obtain or maintain employment;

(4) develop a job for the recipient or assist the recipient to locate suitable employment;

(5) assist a recipient to become self-employed, and the services

(A) aid the recipient to identify potential business opportunities;

(B) assist in the development of a business plan, including potential sources of business financing and other assistance in developing and launching a business;

(C) identify the supports that are necessary in order for the recipient to operate the business; and

(D) provide ongoing assistance, counseling, and guidance once the business has been launched;

(6) include only the adaptations, supervision, and training needed to compensate for the recipient's disabilities; and

(7) are provided to the recipient because the recipient

(A) is unlikely to obtain competitive employment at or above the minimum wage; and

(B) needs intensive ongoing support, including supervision and training, to perform in a work setting because of the recipient's disability.

(c) The department will not pay for

(1) an expense associated with starting up or operating a business;

(2) supervisory activities normally provided in the business setting;

(3) services described in (b)(1) of this section while a recipient receives services under (b)(2) of this section;

(4) more than three months of services under (b)(1) of this section during a recipient's term of eligibility for home and community-based waiver services, unless the home and community-based waiver services provider demonstrates that the recipient

(A) needs additional preparation for employment; or

(B) is preparing for a new job placement;

(5) accommodations routinely provided by the employer to employees;

(6) transportation for a recipient, unless it is to or from an employment site where the recipient works in a paid position, and no other transportation is available for the recipient; or

(7) a service that is available under a program funded under 20 U.S.C. 1400 - 1482 (Individuals with Disabilities Education Act) or 29 U.S.C. 730 (Rehabilitation Act).

History: Eff. 2/1/2010, Register 193; am 7/1/2013, Register 206; am 7/1/2015, Register 214

7 AAC 130.275. Intensive active treatment services

(a) The department will pay for intensive active treatment services

(1) that are provided to a recipient in one of the following recipient categories:

(A) children with complex medical conditions;

(B) adults with physical and developmental disabilities;

(C) individuals with intellectual and developmental disabilities;

(2) that are approved under 7 AAC 130.217 as part of the recipient's plan of care;

(3) that receive prior authorization; and

(4) for which the professional providing or supervising the services

(A) assesses the recipient's need for services for a problem or disorder specified in (b)(2) of this section;

(B) develops a written plan for time-limited treatment or therapy that addresses that problem or disorder; and

(C) in addition to the written plan, submits documentation to the department indicating that the recipient needs immediate intervention for that problem or disorder, and that the problem or disorder, if left untreated, would place the recipient at risk of institutionalization.

(b) The department will consider a service to be an intensive active treatment services if the service

(1) provides specific treatment or therapy that will maintain or improve the ability of the recipient to function effectively;

(2) is in the form of time-limited interventions that address

(A) the recipient's personal, social, behavioral, or mental problem;

(B) the recipient's substance use disorder; or

(C) a family problem related to the recipient's problem or disorder;

(3) requires the knowledge possessed only by professionals specially trained in specific disciplines, and the services of those professionals are not otherwise covered as Medicaid services, as day habilitation services under 7 AAC 130.260, or as residential habilitation services under 7 AAC 130.265; and

(4) provides treatment or therapy that is planned and rendered by

(A) an individual certified under AS 14.20.010 with a special education endorsement obtained under 4 AAC 12.330; or

(B) a professional licensed under AS 08 with expertise specific to the diagnosed problem or disorder, or by a paraprofessional supervised by that professional and licensed under AS 08 if required.

(c) The department will not pay for intensive active treatment services that

(1) are intended as therapy or treatment for problems or disorders specified in (b)(2) of this section that are ongoing rather than time-limited problems or disorders, or that do not place the recipient at risk of institutionalization; or

(2) involve training, oversight, or monitoring of

(A) a caregiver; or

(B) another individual who provides the recipient a health-related service.

History: Eff. 2/1/2010, Register 193; am 3/1/2011, Register 197; am 7/1/2013, Register 206; am 7/1/2015, Register 214

7 AAC 130.280. Respite care services

(a) The department will pay for respite care services that

(1) are provided in accordance with the department's *Respite Care Services Conditions of Participation*, adopted by reference in 7 AAC 160.900;

(2) are approved under 7 AAC 130.217 as part of the recipient's plan of care;

(3) receive prior authorization; and

(4) do not exceed the maximum number of hours and days specified in (c) of this section.

(b) The department will consider services to be respite care services if the services are provided

(1) in one or more of the following locations, for hourly respite care services:

(A) the recipient's home;

(B) the private residence of the respite care provider;

(C) a licensed facility specified in (d)(l) of this section;

(D) another community setting if that setting is appropriate for the needs of the recipient and the recipient's health, safety, and welfare will not be placed at risk;

(2) in one or more of the following locations, for daily respite care services:

(A) the recipient's home;

(B) a licensed facility specified in (d)(l) of this section;

(3) because of the absence or need for relief of the following caregivers only:

(A) a primary unpaid caregiver;

(B) a provider of family home habilitation services under 7 AAC 130.265(b) , except that the department will not pay claims for daily respite care services under (c)(2) of this section and family home habilitation services for the same time period; and

(4) to replace the caregiver's oversight, care, and support needed by the recipient to remain in the recipient's community and to prevent risk of institutionalization; in this paragraph, "institutionalization" does not mean the temporary arrangement for respite care services in a facility specified in (d)(1) of this section.

(c) 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 except that under this paragraph the department will not pay more than the daily rate established in 7 AAC 145.520 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; for purposes of this paragraph, daily respite care services for the time that includes the recipient's usual nightly sleep period must be provided in the recipient's home or in the types of facilities specified in (d)(l) of this section.

(d) The department will pay under this section for respite care services subject to the following limitations:

(1) the department will pay for room and board expenses incurred during the provision of respite care services only when the room and board are provided in

(A) a nursing facility;

(B) a general acute care hospital;

(C) an intermediate care facility for individuals with intellectual or developmental disabilities (ICF/IID);

(D) an assisted living home licensed under AS 47.32, if that home is not the recipient's residence; or

(E) a foster home licensed under AS 47.32, if that home is not the recipient's residence;

(2) the department will not pay for daily respite care services provided in a facility specified in (1) of this subsection at a rate in excess of the rate established for Medicaid providers under 7 AAC 105 - 7 AAC 160;

(3) the department will not pay for respite care services to

(A) allow a primary unpaid caregiver to work;

(B) relieve paid providers of Medicaid services, except providers of family home habilitation services under 7 AAC 130.265(b) ; or

(C) provide oversight for minor children, other than a recipient of home and community-based waiver services, in the home; for purposes of this subparagraph, "minor children" means unemancipated individuals under 18 years of age;

(4) the department will not pay for respite care services that are provided at the same time as

(A) other home and community-based waiver services that include care and supervision of the recipient; or

(B) personal care services under 7 AAC 125.010 - 7 AAC 125.199;

(5) the department will pay for hourly respite care services provided at the same time as one or more of the following services, except that an individual may not provide another service identified in this paragraph while rendering respite care services:

(A) chore services under 7 AAC 130.245;

(B) transportation services under 7 AAC 120.290;

(C) meal services under 7 AAC 130.295;

(6) the department will not pay for hourly respite care services provided to recipients receiving residential supported-living services under 7 AAC 130.255.

(e) The department will pay for family-directed respite care services if the services are

(1) provided for a recipient in one of the following recipient categories:

(A) children with complex medical conditions;

(B) individuals with intellectual or developmental disabilities;

(2) provided through a home and community-based waiver services provider that

(A) is certified under 7 AAC 130.220 to provide respite care services;

(B) has on file with the department a current letter of agreement acknowledging responsibility for

(i) complying with the requirements of AS 47.05.017 with respect to an individual retained and directed by a family to provide respite care services under this subsection; and

(ii) ensuring that the retention and direction of an individual by a family to provide respite care services under this subsection is in accordance with municipal, state, and federal law pertaining to employment of that individual, including applicable provisions of 26 U.S.C. (Internal Revenue Code), and to protection of the health, safety, and welfare of the recipient;

(C) submits claims for family-directed respite care services; and

(D) pays the individuals retained by the family to provide family-directed respite care services;

(3) directed by a primary unpaid caregiver that

(A) in regard to the individuals selected to provide family-directed respite care services

(i) identifies and trains the individuals that meet the requirements for respite care services direct care workers specified in the department's *Respite Care Services Conditions of Participation,* adopted by reference in 7 AAC 160.900; and

(ii) completes and signs timesheets for individuals;

(B) provides, to the home and community-based waiver services provider that has prior authorization for the family-directed respite care services, written assurance that the primary unpaid caregiver understands the risk that the primary unpaid caregiver assumes for family-directed respite care services; and

(C) does not identify, train, or sign timesheets for individuals that provide family-directed respite care services for other recipients; and

(4) consistent with the following limitations:

(A) daily respite care services in a facility specified in (d)(l) of this section may not be provided as family-directed respite care services;

(B) family-directed respite care services may not be provided to relieve providers of family home habilitation services under 7 AAC 130.265(b) .

(f) In this section,

(1) "daily respite care services" means respite care services not less than 12 hours and not more than 24 hours in duration;

(2) "family-directed respite care services" means respite care services provided by an individual that is

(A) retained by the family of the recipient; and

(B) paid by a home and community-based waiver services provider.

History: Eff. 2/1/2010, Register 193; am 7/1/2013, Register 206; am 7/1/2015, Register 214

Editor's note: As of Register 207 (October 2013), and acting under AS 44.62.125 (b)(6) and sec. 29, ch. 42, SLA 2013, the regulations attorney made technical changes to 7 AAC 130.280(d) , to change "intermediate care facility for the mentally retarded" and "intermediate care facility for the mentally retarded or persons with related conditions" to "intermediate care facility for individuals with an intellectual disability or related condition," and to change "(ICF/MR)" to "(ICF/IID)." Chapter 42, SLA 2013 amended terminology in the Alaska Statutes to replace references to "mental retardation" and "mentally retarded" with more current terms. Section 29, ch. 42, SLA 2013 instructed that similar changes be made in the Alaska Administrative Code.

As of Register 207 (October 2013), and acting under AS 44.62.125 (b)(6), the regulations attorney made a technical change to 7 AAC 130.280(e) .

7 AAC 130.285. Specialized private-duty nursing services

(a) The department will pay for specialized private-duty nursing services that

(1) are provided to a recipient 21 years of age or older that meets the requirements of 7 AAC 110.525(a) (2) - (4) and that is in one of the following recipient categories:

(A) adults with physical and developmental disabilities;

(B) individuals with intellectual and developmental disabilities;

(C) older adults or adults with physical disabilities;

(2) are approved under 7 AAC 130.217 as part of the recipient's plan of care; and

(3) receive prior authorization.

(b) The department will consider services to be specialized private-duty nursing services if the services

(1) provide individualized care that is tailored to the specific needs of the recipient on a part-time, intermittent, or continuous basis;

(2) are provided by an individual licensed under AS 08.68 other than a certified nurse aide;

(3) are prescribed by a physician, a physician assistant, or an advanced nurse practitioner, licensed under AS 08, that specifies in writing the scope of care to be provided, including the type, frequency, and duration of that care; and

(4) are included in the recipient's plan of care.

(c) The department will not pay for a service as a specialized private-duty nursing service if

(1) the service does not meet the requirements and limitations of 7 AAC 110.520 - 7 AAC 110.530; or

(2) an individual that is an employee of the home and community-based waiver services provider is not enrolled individually and separately in accordance with 7 AAC110.520(b) .

History: Eff. 2/1/2010, Register 193; am 7/1/2013, Register 206

7 AAC 130.290. Transportation services

(a) The department will pay for transportation services that

(1) are provided in accordance with the department's *Transportation Services Conditions of Participation*, adopted by reference in 7 AAC 160.900;

(2) are approved under 7 AAC 130.217 as part of the recipient's plan of care;

(3) receive prior authorization; and

(4) are provided in a vehicle that is owned or commercially leased by a home and community-based waiver services provider agency, unless otherwise approved under (b) of this section; the department will not certify, as a provider of services under 7 AAC 130.220(b) (l)(I), an agency that uses only employee- or volunteer-owned vehicles for that service.

(b) Notwithstanding (a)(4) of this section, the department will approve transportation services in an employee- or volunteer-owned vehicle if the department determines that no other transportation options, including natural supports, are available for a recipient; a home and community-based waiver services provider agency that authorizes an employee or volunteer to transport a recipient in an employee- or volunteer-owned vehicle must ensure and document that

(1) the vehicle is safe and suitable for the transportation needs of the recipient;

(2) the driver is capable of transporting the recipient in a safe manner; and

(3) either the agency or the driver has automotive liability insurance for the employee- or volunteer-owned vehicle that includes coverage, in the event of an accident, for any recipient.

(c) The department will consider services to be transportation services under this section if the services enable a recipient and, if necessary, an escort that receives prior authorization under (a)(3) of this section, to travel to and return from locations where

(1) home and community-based waiver services are provided; or

(2) other services and resources are available.

(d) The department will pay for trip segments that

(1) transport a recipient from one location to another location, except that incidental stops do not constitute a location where a trip segment begins or ends; and

(2) are documented in a travel log that includes

(A) the name of the recipient and any escort;

(B) the date the service is provided;

(C) the time at the beginning and end of each trip segment;

(D) the pick-up point and drop-off location for each trip segment; and

(E) if the vehicle operator waits for the recipient, the time at the beginning and end of that waiting period.

(e) The department will not pay under this section for

(1) medical transportation services that are authorized under 7 AAC 120.400 - 7 AAC 120.490;

(2) transportation under 7 AAC 130.260 or 7 AAC 130.265;

(3) transportation to destinations that are over 20 miles from the recipient's residence, unless approved by the department in the recipient's plan of care;

(4) transportation to run errands for a recipient without the recipient's presence in the vehicle; or

(5) transportation that involves stops during which time the vehicle operator waits for a recipient longer than 15 minutes, except at the rate established under 7 AAC145.520 for trip segments less than 20 miles.

(f) In this section,

(1) "escort" means an individual that

(A) accompanies a recipient on travel described in (c) and (d) of this section in order to meet the recipient's mobility needs; and

(B) is not another recipient, the driver of the vehicle, or another individual employed by the provider, unless that individual is providing another home and community-based waiver service or personal care services under 7 AAC 125.010 - 7 AAC 125.199 at the time that the individual acts as an escort;

(2) "incidental stop" means an interval of 15 minutes or less during which the recipient may or may not leave the vehicle and the vehicle operator waits for the recipient or disembarks to run an errand for that recipient while the recipient remains in the vehicle;

(3) "trip segment" means travel to a location where the recipient disembarks for an approved purpose, and the vehicle operator

(A) leaves the recipient at that location for pickup at a later time by that or another vehicle operator; or

(B) remains at that location because the distance involved in travel to that location makes it unfeasible for that or another vehicle operator to pick up the recipient at a later time.

History: Eff. 2/1/2010, Register 193; am 7/1/2013, Register 206; am 7/1/2015, Register 214

7 AAC 130.295. Meal services

(a) The department will pay for meal services that

(1) are provided to a recipient 18 years of age or older;

(2) are provided in accordance with the department's *Meal Services Conditions of Participation*, adopted by reference in 7 AAC 160.900;

(3) are approved under 7 AAC 130.217 as part of the recipient's plan of care; and

(4) receive prior authorization.

(b) The department will consider services to be meal services if the meals

(1) are provided in a congregate setting other than an assisted living home licensed under AS 47.32, or are delivered to the recipient's residence; and

(2) enable the recipient to remain in the recipient's residence by meeting the recipient's nutrition needs.

History: Eff. 2/1/2010, Register 193; am 7/1/2013, Register 206

7 AAC 130.300. Environmental modification services

(a) The department will pay for environmental modification services that

(1) are provided in accordance with the department's *Environmental Modification Services Conditions of Participation*, adopted by reference in 7 AAC 160.900;

(2) are approved under 7 AAC 130.217 as part of the recipient's plan of care; and

(3) receive prior authorization.

(b) The department will consider services to be environmental modification services if the services

(1) result in physical adaptations to

(A) a recipient's residence that the recipient owns;

(B) rental property that is the recipient's residence, if the owner of the property consents to the physical adaptations; or

(C) the residence of each parent or guardian that has joint custody of a recipient, if the recipient lives in each residence for any period of time;

(2) are necessary to

(A) meet the recipient's needs for accessibility identified in the recipient's plan of care;

(B) protect the health, safety, and welfare of the recipient; and

(C) further the independence of the recipient in the recipient's residence and community;

(3) are rendered by a home and community-based waiver services provider that is, or may subcontract with,

(A) a construction contractor registered and bonded under AS 08.18; or

(B) an Alaska Native entity or a nonprofit subsidiary of one or more Alaska Native entities that operates as a housing authority; the Alaska Native entity must provide a resolution approved by its governing body that waives the entity's sovereign immunity from suit with respect to claims by the state arising out of activities related to the environmental modification services; and

(4) include the purchase and installation of all materials, supplies, and equipment required for the environmental modification.

(c) The department will pay not more than a total of $18,500 for all environmental modifications for a recipient during the three-year period, the first day of which is July 1, 2013 and the last day of which is June 30, 2016, regardless of the approval, beginning, or completion date of the recipient's first environmental modification during that period. After that period ends, the department will pay not more than a total of $18,500 for all environmental modifications for a recipient during each

subsequent three-year period, the first day of which is July 1 of the first year and the last day of which is June 30 of the third year.

(1) is for the repair or replacement of a previous environmental modification authorized by the department, does not exceed $500, and is approved by the department before the expenditure is made; or

(2) results solely from the cost of shipping to a remote community or location, by the least expensive method, the materials and supplies needed for an environmental modification; for purposes of this paragraph, a site is in a remote community or location if it is not connected by road or the Alaska marine highway system to Anchorage, Fairbanks, or Juneau, except that a site is not a remote community or location if it is on a road system that connects two or more communities or locations, and the materials or supplies are available in one of them.

(d) The department will pay for an environmental modification in excess of a limit established in (c) of this section if the expenditure

(e) The provider must complete the environmental modification project not later than 90 days after the start of construction or the initial payment made on a claim for services, whichever is first. If the project has not been completed during the 90-day period and the department has not authorized an extension of time for completion, the provider shall repay each amount of money received from the department for the project. The department will consider an environmental modification project to be complete when the department makes final payment to the provider that received prior authorization. The department will pay for an environmental modification project only upon completion, except that to allow for the purchase of materials, supplies, and equipment for the project, the department will authorize payment of

(1) 25 percent or less of the total amount approved for the project; and

(2) the cost of shipping that is allowed under (d)(2) of this section.

(f) In addition to payment for the environmental modification services, the department will pay an administrative fee under 7 AAC 145.520(e) to a home and community-based waiver services provider that is acting in an administrative capacity in providing the environmental modification services, if that provider

(1) is an organized health care delivery system under 42 C.F.R. 447.10;

(2) oversees the purchase of an environmental modification for a recipient; and

(3) upon completion of the environmental modification, verifies that the environmental modification is in compliance with the applicable requirements of AS 18.60.705(a), 8 AAC 70.025, 8 AAC 80.010, 13 AAC 50, 13 AAC 55, and any similar municipal codes.

(g) Any money approved by the department for environmental modification services but unused when the environmental modification is completed will not be credited to, and is not available for another use by, the recipient or the home and community-based waiver services provider.

(h) The department will not authorize an environmental modification service for a recipient that resides in an assisted living home or foster home licensed under AS 47.32 unless the recipient is receiving family home habilitation services under 7 AAC 130.265(b) .

(i) The department will not be responsible for removal of an environmental modification if the recipient ceases to reside at a residence to or in which physical adaptations have been made under this section.

(j) The department will not pay for the following services under this section:

(1) an environmental modification that

(A) increases the square footage of an existing residence;

(B) is part of a larger renovation to an existing residence; or

(C) is included in construction of a new residence;

(2) any modification to a residential facility that is owned or leased by a home and community-based waiver services provider;

(3) a general-utility adaptation, modification, or improvement to the existing residence, unless necessary to reduce the risk of serious injury or illness to the recipient and another practical modification is not available; for purposes of this paragraph, general-utility adaptations, modifications, or improvements include

(A) routine maintenance of, or improvements to, flooring, bathroom furnishings, roofing, appliances, and central air conditioning;

(B) heating system or sewer system replacement;

(C) changes or additions to cabinets or shelves that are not necessary to make the cabinet or shelf accessible or functional for a recipient as part of an environmental modification;

(4) an adaptation, modification, or improvement to the exterior of the dwelling, or to an outbuilding, yard, driveway, or fence, except for an adaptation, modification, or improvement to a door, exterior stairs, or a porch, if necessary for ingress or egress for the recipient;

(5) duplicate accessibility modifications to the same residence;

(6) a hot tub, spa, sauna, or permanently installed hydrotherapy device;

(7) an installed backup generator system;

(8) elevator installation, repair, or maintenance;

(9) a modification that

(A) supplants equipment or items already provided through any other means; and

(B) is primarily for the convenience of the recipient or caregiver.

(k) Notwithstanding (a) of this section, the department will not pay for an environmental modification that has prior authorization if

(1) a recipient plans to move or has moved from a residence or has died; or

(2) a residence in which the recipient lives for any period of time is for sale.

History: Eff. 2/1/2010, Register 193; am 7/1/2013, Register 206; am 7/1/2015, Register 214

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040 AS 47.07.045