Section

7 AAC 130.200. Purpose

The purpose of 7 AAC 130.200 - 7 AAC 130.319 is to offer a choice between home and community-based waiver services and institutional care to aged, blind, physically or developmentally disabled, or mentally retarded persons who meet the eligibility criteria in 7 AAC 130.205.

History: Eff. 2/1/2010, Register 193

Authority: AS 47.05.010

AS 47.07.030

AS 47.07.045

7 AAC 130.202. Services provided by family members

Home and community-based waiver services covered under 7 AAC 130.200 - 7 AAC 130.319 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

Authority: AS 47.05.010

AS 47.07.030

AS 47.07.045

7 AAC 130.205. Recipient enrollment and eligibility

(a) Except as provided in 7 AAC 130.100 - 7 AAC 130.199, for the department to make payment under Medicaid for home and community-based waiver services provided to an individual, the

(1) individual must be

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

(B) enrolled in accordance with (e) of this section; and

(2) services must be provided in accordance with the applicable requirements of 7 AAC 130.200 - 7 AAC 130.319.

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

(1) while the individual is an inpatient of a nursing facility, acute care hospital, or intermediate care facility for the mentally retarded (ICF/MR); or

(2) if the individual's need for home and community-based waiver services, supports, devices, or supplies may be provided for entirely by services under 7 AAC 105 - 7 AAC 160 without services identified under 7 AAC 130.200 - 7 AAC 130.319.

(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 an applicant eligible to receive home and community-based waiver services under this section, the applicant must

(1) fall into one of the following recipient categories:

(A) children with complex medical conditions; the department will determine an applicant to be a child with a complex medical condition if the applicant

(i) is under 22 years of age;

(ii) would receive long-term care in a facility for more than 30 days per year if the applicant did not receive home and community-based waiver services;

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

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

(v) needs extraordinary supervision and observation; and

(vi) either needs frequent or life-saving administration of specialized treatment or is dependent on mechanical support devices;

(B) adults with physical disabilities; in this subparagraph, "adult" means an individual at least 21 years of age and less than 65 years of age;

(C) individuals with mental retardation and developmental disabilities;

(D) older adults; in this subparagraph, "older adult" means an individual 65 years of age or older; and

(2) require a level of care provided in a nursing facility or ICF/MR; the department will base a determination of eligibility under this paragraph on the level-of-care assessment under 7 AAC 130.230(b) , and will determine eligibility under

(A) 7 AAC 140.505 - 7 AAC 140.515, if the applicant falls within the recipient category of

(i) children with complex medical conditions;

(ii) adults with physical disabilities; or

(iii) older adults; or

(B) 7 AAC 140.600, if the applicant falls within the recipient category of individuals with mental retardation and developmental disabilities;

(e) An applicant determined eligible under (a)(1)(A) of this section will be enrolled for home and community-based waiver services 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.

(f) Except as provided in 7 AAC 130.240, home and community-based waiver services to be provided to a recipient are payable under 7 AAC 130.200 - 7 AAC 130.319 only after the department

(1) approves, under 7 AAC 130.230, the plan of care for the recipient; and

(2) determines that a home and community-based waiver services provider is available that

(A) is enrolled with the department in accordance with 7 AAC 130.220; and

(B) has the capacity to meet the service levels approved under (1) of this subsection as part of the plan of care.

(g) The earliest date that an individual may receive home and community-based waiver services is the first date when all of the requirements in (d) of this section have been met. Except as provided in 7 AAC 130.240, the department will not make payment for services that are payable under (f) of this section unless the recipient is enrolled under (e) of this section.

(h) The department will notify an applicant who meets the eligibility requirements of this section that the applicant may choose between home and community-based waiver services and institutional care in a nursing facility or ICF/MR. The applicant's choice of service must be documented on a form approved by the department.

(i) An applicant or recipient who is denied enrollment for home and community-based waiver services may appeal that decision under 7 AAC 49.

History: Eff. 2/1/2010, Register 193

Authority: AS 47.05.010

AS 47.07.030

AS 47.07.045

7 AAC 130.210. Recipient disenrollment

(a) The department will disenroll a recipient for one or more of the following reasons:

(1) the recipient is no longer eligible for Medicaid coverage under AS 47.07.020 , 7 AAC 100.002, and 7 AAC 130.205(d) ;

(2) the recipient or the recipient's representative chooses to end use of home and community-based waiver services;

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

(4) the recipient fails to take an action or submit documentation as required in 7 AAC 130.230;

(5) the recipient's care coordinator, on the behalf of the recipient, fails to take an action or submit documentation as required in 7 AAC 130.230, if the department has provided the recipient with written notice

(A) identifying the action the care coordinator did not take or the documentation the care coordinator did not provide;

(B) indicating that the recipient has 30 days to take the action or submit the documentation required;

(C) informing the recipient that the recipient may choose a new care coordinator; and

(D) indicating whether the department is not willing to assume the duties of care coordination under 7 AAC 130.230(i) ;

(6) 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 130.230(c) , or of placing caregivers at risk of physical injury; for purposes of this paragraph, a documented history exists if service providers

(A) report that they cannot obtain cooperation with service delivery or eliminate the risk of physical injury to caregivers through reasonable accommodation to a person's disability; and

(B) maintain records to support that report; those records must be available to the department for inspection; the department will review those records before making a decision on disenrollment under this paragraph.

(b) A recipient who is disenrolled from the home and community-based waiver services program, as documented by the department for reasons described in (a) of this section, may appeal that decision under 7 AAC 49.

History: Eff. 2/1/2010, Register 193

Authority: AS 47.05.010

AS 47.07.030

AS 47.07.045

7 AAC 130.220. Provider certification and enrollment

(a) To be certified by the department as a provider of a home and community-based waiver service, the provider must meet the applicable certification criteria, including provider qualifications and program standards, set out in the department's *Home and Community-Based Waiver Services Certification Application Packet*, adopted by reference in 7 AAC 160.900.

(b) The department will enroll the following provider types to provide home and community-based waiver services if the provider is certified by the department under (a) of this section as a provider of particular home or community-based waiver services, and if the provider has submitted a provider information submission under 7 AAC 105.210:

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

(A) chore services provided under 7 AAC 130.245;

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

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

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

(E) supported-employment services provided under 7 AAC 130.270;

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

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

(H) transportation services provided under 7 AAC 130.290;

(I) meals services provided under 7 AAC 130.295; or

(J) 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;

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

(4) as a durable medical equipment provider under 7 AAC 120.200 - 7 AAC 120.299, for specialized medical equipment and supplies provided under 7 AAC 130.305, unless the department has awarded a contract to a particular provider to act as the single source of a particular item under 7 AAC 120.200(n) ;

(5) as a private-duty nursing provider under 7 AAC 110.520, for specialized private-duty nursing services provided under 7 AAC 130.285.

(c) Notwithstanding (a) of this section,

(1) without requiring certification, the department will enroll a contractor licensed under AS 08.18 as a home and community-based waiver services provider, for environmental modification services provided under 7 AAC 130.300, if the

(A) department determines that the contractor is in compliance with the applicable provisions of 7 AAC 130.300; and

(B) contractor has submitted a provider information submission agreement under 7 AAC 105.210; and

(2) a provider of transportation that is enrolled under 7 AAC 120.400 - 7 AAC 120.490 to provide transportation under the Medicaid program need not be certified by the department in order to enroll under (b) of this section to provide transportation services under 7 AAC 130.290.

(d) If a recipient plans to obtain services out of state, the recipient's care coordination agency provider must document that the recipient has chosen the out-of-state provider freely, and must have a written agreement with the out-of-state provider setting out the quality assurance responsibilities of the care coordination agency provider and the out-of-state provider. Payment will be made directly to the out-of-state provider.

History: Eff. 2/1/2010, Register 193

Authority: AS 47.05.010

AS 47.07.030

AS 47.07.045

7 AAC 130.225. Provider disenrollment and decertification

(a) The department may disenroll and decertify a provider of a home and community-based waiver service under 7 AAC 130.200 - 7 AAC 130.319

(1) if the department determines that the provider is no longer qualified for certification as required under 7 AAC 130.220 for a home and community-based waiver service;

(2) for grounds and under procedures set out in 7 AAC 105.400 - 7 AAC 105.490; or

(3) if the provider fails to meet applicable requirements in the department's *Home and Community-Based Waiver Services Certification Application Packet* adopted by reference in 7 AAC 160.900.

(b) Providers who are disenrolled or decertified by the department under this section may appeal that decision under 7 AAC 105.460.

History: Eff. 2/1/2010, Register 193

Authority: AS 47.05.010

AS 47.07.030

AS 47.07.045

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

(a) An applicant for home and community-based waiver services under 7 AAC 130.200 - 7 AAC 130.319 must obtain an initial, informal screening for use by the department to determine whether an assessment is warranted under (b) of this section. The department will offer the applicant a choice of care coordination agency providers. The applicant must obtain the screening from one of those providers. A care coordinator shall perform the screening.

(b) If warranted by the screening under (a) of this section and supportive diagnostic documentation, and to determine if the applicant meets the level of care required under 7 AAC 130.205(d) (2), the department will authorize the care coordinator to prepare a complete assessment of the applicant's physical, emotional, and cognitive functioning and need for care and services. If the assessment is to determine if the applicant falls within the recipient category for

(1) individuals with mental retardation and developmental disabilities, the

(A) department will make a level-of-care determination under 7 AAC 140.600(c) - (d); and

(B) level-of-care determination must incorporate the results of the *Inventory for Client and Agency Planning (ICAP)*, adopted by reference in 7 AAC 160.900, that is administered under 7 AAC 140.600(c) - (d); or

(2) adults with physical disabilities or older adults, the

(A) department will determine whether the applicant requires skilled care under 7 AAC 140.515 or intermediate care under 7 AAC 140.510; and

(B) level of care determination under (A) of this paragraph must incorporate the results of the department's *Consumer Assessment Tool (CAT*), adopted by reference in 7 AAC 160.900.

(c) After the level of care is established, the care coordinator shall

(1) prepare, in writing, a plan of care addressing

(A) the comprehensive needs of the recipient;

(B) the availability of enrolled providers;

(C) the types of services that have been agreed to by specific enrolled providers;

(D) family and community supports; and

(E) the number of units, frequency, projected duration, and projected cost of each home and community-based waiver service;

(2) include in the plan of care an analysis of whether the type, amount, duration, and scope of services in the plan of care are consistent with the findings of the assessment in (b) of this section and with any other treatment plan for the recipient;

(3) make a recommendation whether the services in the plan of care meet the identified needs of the recipient;

(4) support the plan of care with appropriate and contemporaneous documentation that

(A) relates to each medical condition that places the recipient into a recipient category listed in 7 AAC 130.205(d) (1); and

(B) describes, supports, or justifies the recipient's request and need for home and community-based waiver services; and

(5) present the plan of care to the department for consideration and approval, and for consideration and approval of the home and community-based waiver services requested in the plan of care.

(d) If a plan of care is for a recipient who falls within the recipient category for children with complex medical conditions or for individuals with mental retardation and developmental disabilities,

(1) the care coordinator shall convene a comprehensive planning team to participate in preparing the plan of care;

(2) the comprehensive planning team must consist of the

(A) recipient;

(B) recipient's

(i) family members, including parents, siblings, and others similarly involved in providing general oversight of the recipient; or

(ii) legal guardian, if any;

(C) care coordinator; and

(D) enrolled providers that are expected to provide services;

(3) each individual who participates on the comprehensive planning team shall verify that participation by signature on the recipient's plan of care; and

(4) any disagreement among participants about outcomes or service levels, or any suggestion by a participant for an outcome or service level that differs from what is in the plan of care, must be documented and attached to the plan of care when that plan of care is submitted to the department for consideration and approval.

(e) Before the submission of a plan of care to the department for consideration and approval, the recipient or recipient's representative must indicate by signature that individual's agreement with the plan of care.

(f) The department will approve a plan of care if the department determines that each service listed on the plan of care

(1) is of sufficient amount, duration, and scope to prevent institutionalization;

(2) is supported by the documentation required in (c)(4) of this section; and

(3) cannot be provided under 7 AAC 105 - 7 AAC 160, except as a home and community-based waiver service under 7 AAC 130.200 - 7 AAC 130.319.

(g) A recipient's need for home and community-based waiver services must be reviewed annually using the same criteria used to determine initial eligibility under 7 AAC 130.205. A new assessment must be prepared in accordance with (b) of this section, and the recipient's plan of care must be changed accordingly, unless the department determines that an earlier review is necessary due to changing and significant events in the health and welfare of the recipient. The care coordinator shall submit in writing, for the department's consideration and approval, any change to a recipient's plan of care, shall document the need for changes to the plan of care, and shall relate those changes to findings in the current assessment. If a comprehensive planning team is required

under (d) of this section, the team must participate in preparing, in accordance with that subsection, any subsequent changes to the plan of care. If the department determines that adequate documentation is not provided, the department may cap service levels at prior year levels, or reduce service levels to reflect the recipient's historical usage. Before the submission of any change to a plan of care to the department for consideration and approval, the recipient or the recipient's representative must indicate by signature that individual's agreement with that change. The department will approve changes to a plan of care if the department determines that

(1) the amount, scope, and duration of services to be provided will reasonably achieve the purposes of the plan of care, and are sufficient to prevent institutionalization;

(2) each service to be provided is supported by documentation as required by (c)(4) of this section; and

(3) the services to be provided are not otherwise covered under 7 AAC 105 - 7 AAC 160, except as a home and community-based waiver service under 7 AAC 130.200 - 7 AAC 130.319.

(h) The plan of care required in (c) of this section must be completed no more than 60 days after completion of an initial assessment required in (b) of this section, or no more than 30 days after the completion of a new assessment required in (g) of this section, unless the care coordinator submits written documentation of unusual circumstances that would prevent timely completion of the plan of care.

(i) Notwithstanding (a), (b), (c), or (g) of this section, the department may perform the screening, assessment, or plan-of-care development for an applicant or recipient itself.

(j) Screenings, assessments, and plans of care under this section must be completed on a form or in a format approved by the department.

History: Eff. 2/1/2010, Register 193

Authority: AS 47.05.010

AS 47.07.030

AS 47.07.045

7 AAC 130.235. Nursing oversight

(a) The department will require nursing oversight in the form and frequency required under (b) of this section if

(1) in the course of receiving a home and community-based waiver service, a recipient is to perform self-care of a medical nature or receive care of a medical nature from an individual, regardless of whether the individual is a home and community-based waiver services provider or employed by that provider;

(2) the individual to perform care under (1) of this subsection is not licensed under AS 08 in a health care profession in which the competent delivery of that form of care is a prerequisite for licensure; and

(3) the recipient is within the recipient category for

(A) children with complex medical conditions; or

(B) individuals with mental retardation and developmental disabilities, but would be eligible under the recipient category for children with complex medical conditions if the individual were under 22 years of age.

(b) Nursing oversight must

(1) be provided by a registered nurse licensed under AS 08.68 who is

(A) a care coordinator enrolled under 7 AAC 130.240(a) , and employed by a care coordination agency provider;

(B) employed by a home and community-based waiver services provider, and who provides nursing oversight as a component of another Medicaid service; or

(C) employed by a private health care provider, and who submits verification of nursing oversight through written reports of scope and frequency that are approved under 7 AAC 130.230 as part of the recipient's plan of care; and

(2) include contacts between the registered nurse, the recipient, and any individual described in (a)(1) and (2) of this section, during which the registered nurse shall confirm that the care is being delivered in a manner that protects the health and safety of the recipient; the department will determine the number and frequency of required contacts, not to exceed one contact per month, and as appropriate to the medical condition of the recipient and the complexity of the care to be delivered.

History: Eff. 2/1/2010, Register 193

Authority: AS 47.05.010

AS 47.07.030

AS 47.07.045

7 AAC 130.240. Care coordination services

(a) An employee of a care coordination agency rendering care coordination services must be separately enrolled under this subsection as a care coordinator with the department. Before an employee of a care coordination agency can provide care coordination services, the care coordination agency must

(1) be certified and enrolled with the department in accordance with 7 AAC 130.220;

(2) certify, in writing, to the department, that the employee

(A) meets the minimum requirements listed in the "Care Coordinator Provider Standards" text on pages 13 - 14 of the department's *Home and Community-Based Waiver Services Certification Application Packet*, adopted by reference in 7 AAC 160.900;

(B) is employed by the care coordination agency; and

(C) meets the agency's employment and certification standards to provide care coordination services; and

(3) provide documentation as listed for the employee in the "Required Attachments" text on pages 14 - 15 of the department's *Home and Community-Based Waiver Services Certification Application Packet*, adopted by reference in 7 AAC 160.900.

(b) The department will pay for the following services:

(1) for an applicant, one screening per calendar year under 7 AAC 130.230(a) , except that the department will pay for a second screening if the applicant was determined, based on the first screening, ineligible for home and community-based waiver services;

(2) for an applicant or recipient, one initial assessment under 7 AAC 130.230(b) per calendar year;

(3) for a recipient, one development of a plan of care per calendar year, if that plan of care is accompanied by the form required under 7 AAC 130.205(h) documenting the recipient's choice of home and community-based waiver services; the plan of care must be developed in accordance with 7 AAC 130.230, except that the department will pay for a plan of care

(A) for which agreement of the recipient or the recipient's representative was not obtained under 7 AAC 130.230(e) , if the department would have approved the plan of care had agreement been obtained; or

(B) that was developed in reliance on the form required under 7 AAC 130.205(h) , but that the department cannot approve because home and community-based waiver services were subsequently determined not to be available under 7 AAC 130.205(b) .

(c) The department will pay a care coordinator for ongoing care coordination services provided to each recipient, beginning with the first month that the recipient is enrolled under 7 AAC 130.205(e) and has a plan of care approved under 7 AAC 130.205(f) (1). Ongoing care coordination services include

(1) routine monitoring and support;

(2) review and revision of a plan of care under 7 AAC 130.230(g) ;

(3) case terminations;

(4) two contacts each month with the recipient, one of which must be face-to-face; however, the department will waive the monthly face-to-face requirement if the plan of care documents, to the department's satisfaction, that the recipient lives in a rural community as defined in 7 AAC 130.300(c) (5)(B); if the department waives the

monthly face-to-face requirement, the care coordinator must document a minimum of one face-to-face visit per calendar quarter with each recipient whom the care coordinator serves, to monitor service delivery; notwithstanding a waiver under this paragraph, if the purpose of a contact is to develop the annual plan of care for the recipient, that contact must be face-to-face;

(5) evaluation of the need for specific home and community-based waiver services;

(6) coordination of multiple services and providers; and

(7) monitoring of the quality of care.

(d) The department will pay a care coordinator for one new assessment under 7 AAC 130.230(g) during the 12-month period following the month that the recipient is enrolled under 7 AAC 130.205(e) , and for no more than two new assessments during each subsequent 12-month period.

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

(f) No more than seven days after a recipient's admission to or subsequent discharge from a general acute care hospital, the recipient's care coordinator shall notify the department of the date of the admission or discharge, to assist the department in determining the correct payment amount payable to providers of home and community-based waiver services to that recipient.

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

History: Eff. 2/1/2010, Register 193

Authority: AS 47.05.010

AS 47.07.030

AS 47.07.040

AS 47.07.045

7 AAC 130.245. Chore services

(a) The department will pay for chore services that

(1) are approved under 7 AAC 130.230 as part of the recipient's plan of care;

(2) receive prior authorization; and

(3) do not exceed

(A) 10 hours per week for recipients within the following recipient categories:

(i) adults with physical disabilities;

(ii) older adults; or

(B) five hours per week for recipients within the following recipient categories:

(i) children with complex medical conditions; however, if a recipient in that recipient category has a documented history of respiratory illness, the department will pay for chore services not to exceed 10 hours per week;

(ii) individuals with mental retardation and developmental disabilities.

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

(1) regular cleaning within the residence used by the recipient;

(2) performing heavy household chores, including

(A) washing floors, windows, and walls;

(B) tacking down loose rugs and tiles;

(C) moving heavy items of furniture; and

(D) snow shoveling in order to provide safe access and egress;

(3) food preparation and shopping for recipients in the following recipient categories:

(A) adults with physical disabilities;

(B) older adults;

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

(c) The department will not authorize chore services if

(1) the recipient or anyone else in the household is capable of performing or financially providing for them;

(2) any other relative or caregiver of the recipient, or any community or volunteer agency or third-party payer is capable of or responsible for the provision of those services; or

(3) 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.

History: Eff. 2/1/2010, Register 193

Authority: AS 47.05.010

AS 47.07.030

AS 47.07.040

AS 47.07.045

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) adults with physical disabilities;

(B) older adults;

(2) are approved under 7 AAC 130.230 as part of the recipient's plan of care;

(3) receive prior authorization; and

(4) are provided to a recipient who does not experience a developmental disability.

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

(1) they are provided in a protective setting, other than a nursing facility, during any part of a day, but less than 24 hours per day; and

(2) recipients attend those services on a planned basis during specified hours.

(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.

History: Eff. 2/1/2010, Register 193

Authority: AS 47.05.010

AS 47.07.030

AS 47.07.040

AS 47.07.045

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) adults with physical disabilities; however, the department will pay only if a recipient in that recipient category does not experience a developmental disability;

(B) older adults;

(2) are approved under 7 AAC 130.230 as part of the recipient's plan of care;

(3) receive prior authorization; and

(4) 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 they

(1) assist, in a residential setting, a recipient with the activities of daily living; and

(2) are designed for a recipient who can no longer live alone and who does not need 24-hour care provided by a nursing facility, but who would be placed in a nursing facility for lack of alternate placements.

(c) The department will not pay

(1) for residential supported-living services that are provided the same day as the recipient receives

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

(B) chore services payable under 7 AAC 130.245;

(C) meals services payable 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; or

(D) respite care services payable under 7 AAC 130.280; or

(2) under this section for

(A) payment of the recipient's room and board;

(B) the cost of facility maintenance, upkeep, or improvement, except for actual costs for modifications or adaptations to a facility required to assure the health and safety of residents or to meet the life safety requirements of 13 AAC 50, 13 AAC 55, or an applicable municipal code; or

(C) activities or supervision for which a source other than Medicaid makes payment; or

(3) for residential supported-living services that are subject to the restrictions in 7 AAC 130.310.

History: Eff. 2/1/2010, Register 193

Authority: AS 47.05.010

AS 47.07.030

AS 47.07.040

AS 47.07.045

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;

(B) adults with physical disabilities; however, the department will pay only if a recipient in that recipient category is also diagnosed as experiencing a developmental disability:

(C) individuals with mental retardation or developmental disabilities;

(2) are approved under 7 AAC 130.230 as part of the recipient's plan of care; and

(3) receive prior authorization.

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

(1) take place in a nonresidential setting, separate from the home, assisted living home licensed under AS 47.32, or foster home licensed under AS 47.32 in which the recipient resides; for purposes of this paragraph, day habilitation services include transportation of the recipient between the home, assisted living home, or foster home where the recipient resides and the site where the services are provided; and

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

History: Eff. 2/1/2010, Register 193

Authority: AS 47.05.010

AS 47.07.030

AS 47.07.040

AS 47.07.045

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 disabilities; however, the department will pay only if a recipient in that recipient category is also diagnosed as experiencing a developmental disability;

(C) individuals with mental retardation or developmental disabilities;

(2) are approved under 7 AAC 130.230 as part of the recipient's plan of care; and

(3) receive prior authorization.

(b) Payment for residential habilitation services will be limited to the following habilitation services, and is subject to the following limitations:

(1) family habilitation home services; the department will consider habilitation services to be family habilitation home services if they are provided to a recipient who spends more than 50 percent of the time in an assisted living home or foster home licensed under AS 47.32, and if the home has a paid primary caregiver in residence who is not a member of the recipient's immediate family; payment under this paragraph is subject to the following limitations:

(A) the total number of individuals receiving care in the home, regardless of whether they receive home and community-based waiver services, may not exceed

(i) two, for a recipient in the recipient category of children with complex medical conditions; however, the total number may be exceeded to allow the placement of siblings with the same primary caregiver in residence;

(ii) three, for a recipient in the recipient category of adults with physical disabilities; or

(iii) three, for a recipient in the recipient category of individuals with mental retardation or developmental disabilities; however, the total number may be exceeded to allow the placement of siblings with the same primary caregiver in residence;

(B) the department will not make separate payment for

(i) chore services under 7 AAC 130.245;

(ii) transportation services under 7 AAC 130.290; or

(iii) meals services under 7 AAC 130.295;

(2) shared-care services; the department will consider habilitation services to be shared-care services if they are provided to a recipient who spends more than 50 percent of the time in the home of an unpaid primary caregiver and the remainder in an assisted living home or foster home licensed under AS 47.32;

(3) supported-living services; the department will consider habilitation services to be supported-living services if they are provided to a recipient 18 years of age or older and in the recipient's private residence, subject to the following limitations:

(A) the department will not pay for more than 18 hours per day of supported-living services, unless the department determines that the recipient is unable to benefit from other home and community-based waiver services;

(B) other persons also may furnish direct care services after providing written assurance to the department that those services do not supplant services provided by informal community supports; for purposes of this subparagraph, "direct care services" includes

(i) personal care assistants under 7 AAC 125.010 - 7 AAC 125.199;

(ii) chore services under 7 AAC 130.245;

(iii) transportation services under 7 AAC 130.290; and

(iv) meals services under 7 AAC 130.295;

(4) group-home habilitation services; the department will consider habilitation services to be group-home habilitation services if they are provided to a recipient 18 years of age or older living full-time in an assisted living home licensed under AS 47.32;

(5) in-home support services; the department will consider habilitation services to be in-home support services if they are provided in the recipient's private residence where an unpaid primary caregiver resides; if a recipient receives in-home support services, the department will not make separate payment for

(A) personal care assistants 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; or

(D) meals services under 7 AAC 130.295.

History: Eff. 2/1/2010, Register 193

Authority: AS 47.05.010

AS 47.07.030

AS 47.07.040

7 AAC 130.270. Supported-employment services

(a) The department will pay for supported-employment 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 disabilities; however, the department will pay only if a recipient in that recipient category is also diagnosed as experiencing a developmental disability;

(C) individuals with mental retardation or developmental disabilities;

(2) are approved under 7 AAC 130.230 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 to be received do not duplicate or supplant educational services for which a recipient is eligible under 4 AAC 52; and

(3) receive prior authorization.

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

(1) they are provided at a work site in which individuals without disabilities are employed;

(2) they include only the adaptations, supervision, and training required by individuals receiving home and community-based waiver services as a result of their disabilities; and

(3) the recipient is unlikely to obtain competitive employment at or above the minimum wage and, because of the recipient's disability, needs intensive ongoing support, including supervision and training, to perform in a work setting.

(c) The department will not pay for

(1) services otherwise available under a program paid for with money provided under 20 U.S.C. 1400 - 1482 (Individuals with Disabilities Education Act) or 29 U.S.C. 730 (Rehabilitation Act);

(2) supervisory activities rendered as a normal part of the business; or

(3) accommodations routinely provided to employees.

History: Eff. 2/1/2010, Register 193

Authority: AS 47.05.010

AS 47.07.030

AS 47.07.040

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 disabilities; however, the department will pay only if a recipient in that recipient category is also diagnosed as experiencing a developmental disability;

(C) individuals with mental retardation or developmental disabilities;

(2) that are approved under 7 AAC 130.230 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 submits supporting documentation to the department that the recipient needs immediate intervention to decelerate a condition or behavior regression that, if left untreated, would place the recipient at risk of institutionalization.

(b) The department will consider services to be intensive active treatment services if

(1) the department determines them to provide specific treatment or therapy, in the form of time-limited interventions to address a family problem or a personal, social, behavioral, mental, or substance abuse disorder in order to maintain or improve effective functioning of the recipient;

(2) each intervention requires the precision and knowledge possessed only by specifically trained professionals in specific disciplines, whose services are not covered under Medicaid or as habilitation services under 7 AAC 130.260 - 7 AAC 130.265; and

(3) the treatment or therapy is designed and provided by a professional licensed under AS 08 with expertise specific to the diagnosed condition, or by a paraprofessional licensed under AS 08 if necessary and supervised by that professional.

History: Eff. 2/1/2010, Register 193

Authority: AS 47.05.010

AS 47.07.030

AS 47.07.040

7 AAC 130.280. Respite care services

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

(1) are approved under 7 AAC 130.230 as part of the recipient's plan of care;

(2) receive prior authorization; and

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

(b) The department will consider services to be respite care services if they provide alternative caregivers, regardless of whether the services are provided in the recipient's home or at another location, to relieve

(1) primary unpaid caregivers, including family members and court-appointed guardians;

(2) providers of family habilitation home services under 7 AAC 130.265(b) (1), except as provided in (e)(4) of this section; or

(3) foster parents licensed under AS 47.32.

(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 lack of additional care or support would result in risk of institutionalization because

(A) the recipient has inadequate supports from unpaid caregivers; or

(B) appropriate out-of-home daily respite care services are unavailable;

(2) 14 days of daily respite care services per year.

(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 if the room and board are provided in

(A) a nursing facility;

(B) a general acute care hospital;

(C) an intermediate care facility for the mentally retarded (ICF/MR);

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

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

(2) the department will not pay more than daily rate established in 7 AAC 145.520 for respite care services, whether provided singly or in combination, other than out-of-home daily respite care services;

(3) the department will not pay for out-of-home daily respite care services at a rate in excess of the rate established for Medicaid providers under 7 AAC 105 - 7 AAC 160;

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

(A) allow a primary caregiver to work;

(B) relieve other paid providers of Medicaid services, except providers of family habilitation home services under 7 AAC 130.265(b) (1); or

(C) provide oversight for additional minor children in the home; for purposes of this subparagraph, "additional minor children" means unemancipated individuals under 18 years of age other than recipients;

(5) the department will pay for respite care services provided at the same time as personal care assistants under 7 AAC 125.010 - 7 AAC 125.199 or habilitation services provided under 7 AAC 130.260 - 7 AAC 130.265 only if the lack of additional care or support would result in risk of institutionalization because

(A) the recipient has inadequate supports from unpaid caregivers; or

(B) appropriate out-of-home daily respite care services are unavailable;

(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 under this section for family-directed respite care services subject to the following additional limitations:

(1) family-directed respite care services will be paid only for a recipient in one of the following recipient categories:

(A) children with complex medical conditions;

(B) individuals with mental retardation or developmental disabilities;

(2) family-directed respite care services must be provided through a home and community-based waiver services provider that is certified and enrolled under 7 AAC 130.220 to provide respite care services; prior authorization will not be given unless the department has on file a current letter of agreement, in which the home and community-based waiver services provider acknowledges responsibility to

(A) comply 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

(B) ensure 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

(i) applicable to employment of that individual, including applicable provisions of 26 U.S.C. (Internal Revenue Code); or

(ii) to protect the health and safety of the recipient;

(3) out-of-home daily respite care services may not be provided as family-directed respite care services;

(4) family-directed respite care services may not be provided to relieve providers of family habilitation home services under 7 AAC 130.265(b) (1);

(5) primary unpaid caregivers of a recipient receiving family-directed respite care services may not provide the service for other recipients of family-directed respite care services;

(6) a primary unpaid caregiver

(A) may identify and train individuals who meet the minimum requirements listed in the "Respite Services Provider Standards" text on page 26 of the department's *Home and Community-Based Waiver Services Certification Application Packet*, adopted by reference in 7 AAC 160.900;

(B) may complete and sign timesheets for individuals providing family-directed respite care services; and

(C) shall provide, to the home and community-based waiver services provider that has received prior authorization for the family-directed respite care services, written assurance that the primary unpaid caregiver

understands the additional risk that the primary unpaid caregiver assumes in the provision of family-directed respite care services;

(7) individuals providing family-directed respite care services shall be paid directly by the home and community-based waiver services provider that received prior authorization for those services.

(f) In this section,

(1) "daily respite care services" means respite care services no less than 12 and no more than 24 hours in duration;

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

(A) the family of the recipient retains; and

(B) a home and community-based waiver services provider pays;

(3) "out-of-home daily respite care services" means daily respite care services provided in

(A) a nursing facility;

(B) a general acute care hospital;

(C) an intermediate care facility for the mentally retarded or persons with related conditions (ICF/MR);

(D) an assisted living home licensed under AS 47.32; or

(E) a foster home licensed under AS 47.32.

History: Eff. 2/1/2010, Register 193

Authority: AS 47.05.010

AS 47.07.030

AS 47.07.040

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

(A) in one of the following recipient categories:

(i) adults with physical disabilities;

(ii) individuals with mental retardation or developmental disabilities; however, the department will pay only if a recipient in that recipient category is 21 years of age or older;

(iii) older adults; and

(B) who meets the eligibility requirements that apply to a Medicaid recipient under 21 years of age under 7 AAC 110.525(a) ;

(2) are approved under 7 AAC 130.230 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 they

(1) provide individual and continuous care by individuals licensed under AS 08.68 other than certified nurse aides; and

(2) are tailored to the specific needs of a particular individual.

(c) The department will not pay under this section for temporary or intermittent services, and will not pay under this section for services that fail to satisfy the requirements and limitations of 7 AAC 110.520 - 7 AAC 110.539, except that the cost cap limitations in 7 AAC 145.250 do not apply.

(d) To provide services under this section, an employee subject to 7 AAC 110.520(b) must be enrolled separately under that subsection.

History: Eff. 2/1/2010, Register 193

Authority: AS 47.05.010

AS 47.07.030

AS 47.07.040

7 AAC 130.290. Transportation services

(a) The department will pay for transportation services that

(1) are approved under 7 AAC 130.230 as part of the recipient's plan of care; and

(2) receive prior authorization.

(b) The department will consider services to be transportation services if they enable a recipient, and any necessary escort that receives prior authorization under (a)(2) of this section, to gain access to home and community-based waiver services or other community services and resources.

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

(1) medical transportation services payable under 7 AAC 120.400 - 7 AAC 120.490; or

(2) transportation paid under 7 AAC 130.265.

(d) In this section, "escort" means an individual who accompanies a recipient to or from a service using a transportation provider enrolled under 7 AAC 130.220.

History: Eff. 2/1/2010, Register 193

Authority: AS 47.05.010

AS 47.07.030

AS 47.07.040

7 AAC 130.295. Meals services

(a) The department will pay for meals services that

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

(2) are approved under 7 AAC 130.230 as part of the recipient's plan of care; and

(3) receive prior authorization.

(b) The department will pay under this section for meals services subject to the following limitations:

(1) meals must be provided in the recipient's home, or in a congregate setting other than an assisted living home licensed under AS 47.32;

(2) meals must be provided as described in 42 U.S.C. 3030g.

History: Eff. 2/1/2010, Register 193

Authority: AS 47.05.010

AS 47.07.030

AS 47.07.040

7 AAC 130.300. Environmental modification services

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

(1) are approved under 7 AAC 130.230 as part of the recipient's plan of care; and

(2) receive prior authorization.

(b) The department will consider services to be environmental modification services if they make physical adaptations to the recipient's home, as identified in the recipient's plan of care, and are necessary to ensure the health, welfare, and safety of the recipient.

(c) To pursue payment from the department under this section, a home and community-based waiver services provider must comply with the following requirements:

(1) before an environmental modification service is approved as part of the recipient's plan of care, the home and community-based waiver services provider that is to deliver the service must demonstrate to the department that the requirements of AS 08.18 for contractor registration and bonding have been met;

(2) upon completion of an environmental modification service, the home and community-based waiver services provider shall verify compliance with applicable provisions of 13 AAC 50, 13 AAC 55, and applicable municipal building codes;

(3) the home and community-based waiver services provider with prior authorization for the environmental modification service must complete the service or subcontract with a contractor registered and bonded under AS 08.18;

(4) for environmental modification services expected to exceed $1,000, cost estimates from three home and community-based waiver services providers must be solicited and, if obtained, appended to the plan of care;

(5) the cost of all environmental modification services for a recipient, including the cost of labor and the cost of building materials, parts, supplies, permits, demolition, and other goods that are necessary to accomplish the modifications in the recipient's home and that remain with the recipient, may not exceed a total of $10,000 in a continuous 36-month period, beginning with the month the recipient is enrolled under 7 AAC 130.205(e) , and may not exceed a total of $10,000 in each subsequent continuous 36-month period that the recipient remains enrolled; however, within any of those periods, the total for environmental modification services may exceed $10,000 if the excess expenditure

(A) is for the repair or replacement of a previous environmental modification, does not exceed $500 per year of the remaining 36-month period, and is approved by the department before the expenditure is made; or

(B) results solely from the cost of freight to deliver materials and supplies to a rural community; in this subparagraph, "rural community" means a municipality or unincorporated community that is a social unit, that has a residential population of no less than 25 and no more than

(i) 10,000, and that is not connected by road or rail to Anchorage or Fairbanks; for purposes of this sub-subparagraph, a connection by road or rail does not include a connection by the Alaska marine highway system or by an international highway; or

(ii) 1,600, and that is connected by road or rail to Anchorage or Fairbanks and at least 50 miles outside of Anchorage or 25 miles outside of Fairbanks; for purposes of this sub-subparagraph, a connection by road or rail does not include a connection by the Alaska marine highway system or by an international highway;

(6) in addition to paying for the actual environmental modification services, the department will pay the home and community-based waiver services provider an administrative fee under 7 AAC 145.520(e) , if the provider

(A) is certified and enrolled under 7 AAC 130.220(b) (1)(J); and

(B) acts as an organized health care delivery system under 42 C.F.R. 447.10 for the purpose of overseeing the purchase of an environmental modification for a recipient;

(7) once the home and community-based waiver services provider that received the prior authorization has been paid in full, the environmental modification will be considered complete and the provider shall be financially responsible for any additional work necessary to complete the modification.

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

(1) modifications that increase the square footage of an existing residence, are part of a larger renovation to an existing residence, or are included in construction of a new residence;

(2) general utility adaptations, modifications, or improvements to the existing residence; for purposes of this paragraph, general utility adaptations

(A) include routine maintenance or improvements, including flooring and floor coverings, bathroom furnishings, carpeting, roof repair, central air conditioning, heating system or sewer system replacement, appliances, cabinets, and shelves; and

(B) do not include improvements made to substantially reduce the risk of serious injury or illness to the recipient if another practical modification is not available to reduce that risk;

(3) adaptations, modifications, or improvements to the exterior of the dwelling, including outbuildings, yards, driveways, and fences, except for adaptations, modifications, or improvements to doors, exterior stairs, and porches necessary for egress for the recipient;

(4) duplicate accessibility modifications to the same residence;

(5) elevator installation, repair, or maintenance; or

(6) installation of privately purchased specialized medical equipment that would not be paid under 7 AAC 130.305.

(e) The department will pay for an environmental modification service under this section only upon completion of the environmental modification and upon compliance with (g) of this section, except that the department will issue prior authorization for 25 percent or less of the accepted cost estimate for materials required for an environmental modification service plus 25 percent or less of the cost for any specialized medical equipment, material, and supplies not locally available, if the department determines that those materials and the specialized medical equipment, material, and supplies are essential to the environmental modification service. The home and community-based waiver services provider shall repay the department for any charges paid on this prior authorization if the environmental modification is completed more than 90 days after the first date of billing.

(f) Home and community-based waiver services providers shall purchase and install all required material, supplies, and equipment required for the environmental modification service, except for those supplies and equipment provided as specialized medical equipment and supplies under 7 AAC 130.305.

(g) The department will make final payment under this section for an environmental modification service only upon submission by the

(1) home and community-based waiver services provider to the department of a photograph of the completed environmental modification and a copy of a written final inspection by the municipality concurring that the project is complete and meets applicable codes; or

(2) recipient or recipient's representative to the department of written verification that the project is complete and a photograph of the completed environmental modification, if the recipient's home is not within a municipality that conducts inspections.

(h) The state is not responsible for removal of any modification if the recipient ceases to reside at a residence.

(i) Environmental modifications will not be authorized for waiver recipients who reside in an assisted living home or foster home licensed under AS 47.32, unless the recipient residing in the assisted living home or foster home is receiving family habilitation home services under 7 AAC 130.265(b) (1).

History: Eff. 2/1/2010, Register 193

Authority: AS 47.05.010

AS 47.07.030

AS 47.07.040

7 AAC 130.305. Specialized medical equipment and supplies

(a) The department will pay for specialized medical equipment and supplies

(1) that are approved under 7 AAC 130.230 as part of the recipient's plan of care;

(2) that receive prior authorization; and

(3) for which the department receives written supportive contemporaneous documentation from a licensed physician, occupational therapist, physical therapist, speech therapist or pathologist, or physiatrist that the specific item requested is appropriate for the recipient, consistent with the plan of care, and necessary to avoid placing the recipient at risk of institutionalization.

(b) The department will consider items to be specialized medical equipment and supplies if they are

(1) devices, controls, or appliances that enable a recipient to increase the recipient's ability to perform activities of daily living or to perceive, control, or communicate with the environment in which the recipient lives, or are ancillary supplies and equipment necessary for the proper functioning of those items; and

(2) identified in the department's *Specialized Medical Equipment Fee Schedule*, adopted by reference in 7 AAC 160.900.

(c) The department will pay under this section subject to the following limitations:

(1) the unit cost of equipment must be determined by including the cost of

(A) training in the equipment's proper use; and

(B) routine fitting of and maintenance on the equipment necessary to meet applicable standards of manufacture, design, and installation;

(2) the cost of repair, modification, or adaptation of equipment may be paid as separate units of service, if the department determines that payment as separate units of service is cost-effective;

(3) the department will not pay as a home and community-based waiver service the cost of any medical equipment or supplies that is payable under 7 AAC 120.200 - 7 AAC 120.299;

(4) specialized medical equipment and supplies must be rented if the equipment is a personal emergency response system or if the department determines that renting the equipment is more cost-effective than purchasing it;

(5) once purchased, specialized medical equipment and supplies become the property of the recipient;

(6) specialized medical equipment may include a portable hydrotherapy tub device, but does not include items listed in (d)(1) of this section;

(7) the department will not give prior authorization to replace specialized medical equipment before the end of that item's expected useful life, unless the department determines that replacing rather than repairing that item is more cost-effective.

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

(1) hot tubs, spas, saunas, or permanently installed hydrotherapy devices;

(2) developmental toys;

(3) personal computers, other computer hardware, peripherals, computer software, personal data assistants (PDAs), or cellular telephones;

(4) outdoor playground equipment, scissors lifts, bicycles, other pedal-driven devices, or exercise equipment;

(5) lights or other devices used to treat seasonal affective disorder;

(6) vacuum cleaners or household appliances;

(7) devices that receive, record, or play audio or video in any medium, including televisions, compact disc players, MP3 players, videocassette players, and DVD players;

(8) micro cars; or

(9) adaptive clothing.

History: Eff. 2/1/2010, Register 193

Authority: AS 47.05.010

AS 47.07.030

AS 47.07.040

7 AAC 130.310. Restrictions on residential supported-living services payment

(a) Unless waived in writing by the department under (b) of this section, the department will not pay for residential supported-living services provided under 7 AAC 130.255 to a recipient if that recipient's approved plan of care was prepared by a care coordination agency provider that has a close familial or business relationship with the residential supported-living services provider.

(b) The limitation on payment of certain residential supported-living services providers under (a) of this section may be waived by the department for the benefit of the recipient, subject to any conditions that the department may impose, based on one of the following considerations:

(1) another care coordination agency provider is not reasonably available to serve the recipient;

(2) the person rendering the care coordination service is not subject to supervision or control by the owner, administrator, or staff of the residential supported-living services provider and does not have a close familial or business relationship with the residential supported-living services provider or its owner or administrator.

(c) In this section,

(1) "close business relationship" means

(A) having a 15 percent or greater ownership, partnership, or equity interest in the other provider or its owner; or

(B) having a 15 percent or greater ownership, partnership, or equity interest in any other business or commercial activity in which the other provider or its owner or administrator also has a 15 percent or greater ownership, partnership, or equity interest;

(2) "close familial relationship" includes the person's spouse; a parent, sibling, or child of the person; and the spouse of the person's parent, sibling, or child;

(3) "owner" means a person having a 15 percent or greater ownership, partnership, or equity interest.

History: Eff. 2/1/2010, Register 193

Authority: AS 47.05.010

AS 47.07.030

AS 47.07.040

7 AAC 130.319. Definitions

In 7 AAC 130.200 - 7 AAC 130.319,

(1) "care coordination" means those services necessary to promote overall maintenance of the recipient's physical survival, personal growth, and community participation; "care coordination" includes coordinating assessment and treatment services, facilitating access to appropriate and necessary services, assessing recipient skill level, providing treatment and crisis assistance planning, providing linkage between the recipient's needs and services, coordinating the training of the recipient in the use of basic community resources, monitoring the overall provision of service and the recipient's progress, providing social support, promoting treatment or community adjustment, providing advocacy to ensure that services are appropriate to the recipient's needs, and providing outreach services necessary to assist the recipient in obtaining benefits to which the recipient is entitled;

(2) "care coordination agency provider" means a provider that the department has enrolled under 7 AAC 130.220 to provide care coordination services under 7 AAC 130.240;

(3) "habilitation services" means services that help recipients acquire, retain, or improve skills related to activities of daily living and self-help, social, and adaptive skills necessary to enable the recipient to reside in a noninstitutional setting that is provided in a recipient's home, a shared-care environment, an assisted living home licensed under AS 47.32, or a foster home licensed under AS 47.32;

(4) "immediate family" includes the parents or minor siblings of a recipient under 18 years of age and the spouse of a recipient;

(5) "recipient category" means a category listed in 7 AAC 130.205(d) (1);

(6) "residential supported-living services provider" means a provider that the department has enrolled under 7 AAC 130.220 to provide residential supported-living services under 7 AAC 130.255.

History: Eff. 2/1/2010, Register 193

Authority: AS 47.05.010

AS 47.07.030

AS 47.07.040