

**7 AAC 130 - Home and Community-Based Waiver Services;
Nursing Facility and ICF/IID Level of Care**

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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

Authority: AS 47.05.010

AS 47.07.030

AS 47.07.040

AS 47.07.045

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

Authority: AS 47.05.010

AS 47.07.030

AS 47.07.040

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/MR, 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/MR;

(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

Authority: AS 47.05.010

AS 47.07.030

AS 47.07.040

AS 47.07.045

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.

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

Authority: AS 47.05.010

AS 47.07.030

AS 47.07.040

AS 47.07.045

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) and indicates that

(1) the applicant is

(A) diagnosed with a terminal illness and with a life expectancy of six months or less;

(B) expected to be discharged from a general acute care hospital not later than seven days after the date of application; or

(C) referred by the state agency responsible for adult protective services or the protective custody of children; or

(2) the applicant's primary caregiver

(A) died 30 or fewer days before the date of application; or

(B) is absent due to the caregiver's hospitalization or emergency travel.

(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

Authority: [AS 47.05.010](#)

[AS 47.07.030](#)

[AS 47.07.040](#)

[AS 47.07.045](#)

7 AAC 130.210. Recipient disenrollment

Repealed.

History: Eff. 2/1/2010, Register 193; repealed 7/1/2013, Register 206

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/MR 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

Authority: [AS 47.05.010](#)

[AS 47.07.030](#)

[AS 47.07.040](#)

[AS 47.07.045](#)

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 AAC [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) If a reassessment indicates that the recipient meets the level-of-care requirement in 7 AAC [130.215](#), the care coordinator shall prepare a new plan of care that

(1) incorporates the findings of the reassessment; and

(2) meets the requirements of 7 AAC [130.217](#).

(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 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).

(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

Authority: [AS 47.05.010](#)

[AS 47.07.030](#)

[AS 47.07.040](#)

[AS 47.07.045](#)

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/MR;

(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/MR;

(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

Authority: [AS 47.05.010](#)

AS 47.07.030

AS 47.07.040

AS 47.07.045

7 AAC 130.217. Plan of care development and amendment

(a) 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 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 AAC 130.215, if the plan of care follows an assessment;

(B) 30 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 AAC 130.215, if the plan of care follows a reassessment.

(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 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) The department will approve or deny an amendment to a plan of care in accordance with (c) of this section.

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

Authority: AS 47.05.010

AS 47.07.030

AS 47.07.040

AS 47.07.045

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/MR; 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 [130.213\(e\)](#) and 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 in the time required by the department's written notice under 7 AAC [130.217\(a\)](#) (5)(B);

(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 qualify;

(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.

(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

Authority: [AS 47.05.010](#)

[AS 47.07.030](#)

AS 47.07.040

AS 47.07.045

7 AAC 130.220. Provider certification

(a) 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 must

(1) submit an application using the department's *Home and Community-Based Waiver Services Certification Application*, adopted by reference in 7 AAC 160.900;

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

(3) be in compliance with applicable provisions of this chapter for each service that the provider chooses to offer.

(b) The department will certify a provider under this section as one or more of the following provider types, and will designate the specific home and community-based waiver services for which that provider is certified:

(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) meals 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](#).

(c) Except as provided under (e) of this section, 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) The department will deny 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 any 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 indicates the provider operates in a manner that creates a risk to the health, safety, or welfare of a recipient; or

(6) 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.

(f) The department will monitor a home and community-based waiver services provider's compliance with the requirements of this chapter.

(g) If the department finds that a provider is not in compliance with the requirements of this chapter, the department may

(1) issue the department's findings in a written report;

(2) establish a provider remediation plan, designed to bring the provider into compliance, that includes the

(A) method by which the provider will verify compliance; and

(B) date that compliance is required; and

(3) monitor a provider's progress toward meeting the requirements of the remediation plan; if the department finds that the provider has not met the requirements of the remediation plan in the period provided, the department may

(A) impose a provider sanction under 7 AAC [105.400](#) - 7 AAC [105.490](#); or

(B) decertify the provider.

(h) The department may decertify a home and community-based waiver services provider

(1) if the department determines, under this section, that the provider is no longer qualified for certification 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](#);

(3) if the provider fails to meet applicable requirements of this chapter; or

(4) if the department has evidence that demonstrates that the provider has not satisfied the requirements of a remediation plan under (g) of this section.

(i) A provider may appeal under 7 AAC [105.460](#) a decision by the department to

(1) deny the provider's application for recertification; or

(2) decertify the provider.

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

Authority: [AS 47.05.010](#)

[AS 47.07.030](#)

AS 47.07.040

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

Authority: AS 47.05.010

AS 47.07.030

AS 47.07.040

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, "critical incident" means
 - (1) a missing recipient;
 - (2) recipient behavior that resulted in harm to the recipient or others;

(3) misuse of restrictive interventions; in this paragraph, "restrictive intervention" has the meaning given in 7 AAC [130.229\(g\)](#) ;

(4) a use of restrictive intervention that resulted in the need for medical intervention; in this paragraph, "restrictive intervention" has the meaning given in 7 AAC [130.229\(g\)](#) ;

(5) death of a recipient;

(6) an injury to a recipient that resulted in the need for medical intervention;

(7) a medication error that resulted in the need for medical intervention; in this paragraph, "medication error" has the meaning given in 7 AAC [130.227\(j\)](#) ;

(8) an event that involved the recipient and a response from a peace officer.

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

Authority: [AS 47.05.010](#)

[AS 47.07.030](#)

[AS 47.07.040](#)

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. Medication administration

(a) Except as provided in (i) of this section, a provider of the following home and community-based waiver services shall offer medication administration as an integral part of those 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 medication administration 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 medication administration for that recipient is available at the time when the recipient requires medication; and

(5) the individual that provides medication administration 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 medication administration 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) medication administration while the recipient is in the care of and receiving services from the provider;

(2) training in medication administration under (f) of this section;

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

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

(5) monitoring and evaluation of medication administration; and

(6) requirements for reporting medication errors.

(e) Before a provider may provide medication administration under this section, the provider must

(1) have a written delegation for medication administration 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.

(f) Each individual that provides medication administration 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 has been approved by the department;

(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 medication administration 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 medication administration.
- (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 written notice to the provider of an individual designated to be responsible for medication administration for the recipient, and the provider arranges with that individual to administer the medication at the time medication is required by the recipient.
- (j) In this section,
- (1) "administration of medication" means the direct application of an oral, nasal, ophthalmic, otic, topical, vaginal, or rectal medication by a provider to or into the body of a recipient, 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) "medication administration"

(A) means the delivery of medication by a provider to a recipient that is unable to administer medication independently;

(B) includes

- (i) assistance with the recipient's self-administration of medication; and
 - (ii) administration of medication to a recipient by another individual;
- (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

Authority: [AS 47.05.010](#)

[AS 47.07.030](#)

[AS 47.07.040](#)

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;
 - (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.

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

Authority: AS 47.05.010

AS 47.07.030

AS 47.07.040

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

Authority: [AS 47.05.010](#)

[AS 47.07.030](#)

[AS 47.07.040](#)

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 not later than 60 days before the closure, sale, or change in ownership.

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

Authority: AS 47.05.010

AS 47.07.030

AS 47.07.040

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

Authority: [AS 47.05.010](#)

[AS 47.07.030](#)

[AS 47.07.040](#)

7 AAC 130.238. Certification of care coordinators

(a) An employee of a home and community-based waiver services provider may not provide care coordination services unless the department certifies the individual under this section and the individual is enrolled in the Medicaid program under 7 AAC 105.210. The certification requirements of this section are separate from and in addition to the provider certification requirements under 7 AAC 130.220.

(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 AAC 160.900; 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)(1)(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 recertification or re-enrollment; or

(2) decertify the care coordinator.

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

Authority: [AS 47.05.010](#)

[AS 47.07.030](#)

[AS 47.07.040](#)

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 in a manner and with a frequency appropriate to the needs of the recipient, but at a minimum makes two contacts with the recipient per month, one of which must be in person, unless the department waives the visits 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) For purposes of (d) of this section, a recipient lives in a remote community or location if the site 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 services are available in one of them.

(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.

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

Authority: [AS 47.05.010](#)

[AS 47.07.030](#)

[AS 47.07.040](#)

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.

(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;

(D) 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 not authorize chore services if

(1) any relative or caregiver of the recipient living in the recipient's home, any community or volunteer agency, or any third-party payer is capable of or responsible for the provision of those services;

(2) 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

(3) the provider that is certified under 7 AAC [130.220](#) to provide chore services 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

Authority: [AS 47.05.010](#)

[AS 47.07.030](#)

[AS 47.07.040](#)

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 six hours per day, not including transportation to and from the setting; 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/MR.

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

Authority: [AS 47.05.010](#)

[AS 47.07.030](#)

[AS 47.07.040](#)

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

Authority: AS 47.05.010

AS 47.07.030

AS 47.07.040

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

Authority: [AS 47.05.010](#)

[AS 47.07.030](#)

[AS 47.07.040](#)

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;
 - (B) provides 24-hour care; and
 - (C) has a primary caregiver living in the residence;
 - (2) the health, safety, and welfare of a recipient receiving care in a family home habilitation services site are not at risk because of the primary caregiver's other obligations; and
 - (3) a caregiver in the residence, paid or unpaid, is not a member of the recipient's immediate family.
- (c) The department will pay for family home habilitation services under (b) of this section subject to the following limitations:
- (1) the number of individuals, including natural, adopted, or foster children and dependent adults receiving care at a family home habilitation services site, regardless of whether an individual is receiving any form of financial support from a public or private source, may not exceed the following unless the department approves a larger number of individuals to allow placement of siblings in the same residence as the recipients:
 - (A) two recipients in the children with complex medical conditions recipient category;
 - (B) three recipients in the adults with physical and developmental disabilities recipient category;
 - (C) three recipients in the individuals with intellectual and developmental disabilities recipient category;
 - (2) if a recipient is eligible for family home habilitation services, 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) meals services under 7 AAC [130.295](#); or

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

(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, except that if a recipient is eligible for in-home support habilitation services, the department will not make separate payment for

(1) personal care services under 7 AAC [125.010](#) - 7 AAC [125.199](#);

(2) chore services under 7 AAC [130.245](#);

(3) transportation services under 7 AAC [130.290](#);

(4) meal services under 7 AAC [130.295](#); or

(5) 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

Authority: [AS 47.05.010](#)

[AS 47.07.030](#)

[AS 47.07.040](#)

7 AAC 130.267. Acuity payments for qualified recipients

(a) The department will approve an acuity payment for additional services

(1) for a recipient who is

(A) eligible for and receiving

(i) residential supported-living services under 7 AAC [130.255](#) that are assigned the procedure code described in 7 AAC [145.520\(m\)](#); or

(ii) group-home habilitation services under 7 AAC [130.265\(f\)](#) that are assigned the procedure code described in 7 AAC [145.520\(m\)](#); and

(B) a qualified recipient under (b) of this section;

(2) for which a request for prior authorization is submitted in accordance with (c) - (e) of this section; and

(3) that receive prior authorization.

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

(1) needs services that exceed what is currently 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-on-one support from workers whose time is dedicated solely to providing services under (a)(1)(A) 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 prior authorization for additional services under this section, the care coordinator responsible under 7 AAC [130.217](#) for the recipient's plan of care must submit

(1) a description of how, based upon the recipient's physical condition or behavior, the recipient meets the requirements of (b) of this section;

(2) a description of the recipient's physical condition or behavior that has resulted in the recipient's need for the additional services under (b)(2) of this section;

(3) a description of each intervention that was tried or is in use to address the recipient's physical condition or behavior, and a description of whether each intervention was successful or unsuccessful;

(4) a description of how an acuity payment under this section would be used to manage the recipient's physical or behavioral needs;

(5) a description of how the additional services under this section are consistent with services approved under 7 AAC [130.217](#) as part of the recipient's plan of care; and

(6) 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 prior authorization must include, in addition to the information required under (c)(1) - (5) 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 home and community-based waiver services plan of care under 7 AAC [130.217](#);

(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 medication administration or 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)(1) - (5) 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 home and community-based waiver services plan of care under 7 AAC [130.217](#); 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 give prior authorization under this section for more than 12 consecutive months. The department may terminate authorization at any time if the department verifies that the recipient's physical condition or behavior no longer requires additional services under this section.

(g) 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 any time, at least one worker is awake to provide those services.

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

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 in accordance with the department's *Supported Employment Conditions of Participation*;

(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 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; or
- (6) 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

Authority: [AS 47.05.010](#)

[AS 47.07.030](#)

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 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

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 [130.217](#) 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 home habilitation services under 7 AAC [130.265\(b\)](#), 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 home habilitation services under 7 AAC 130.265(b) ; 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 home habilitation services under 7 AAC 130.265(b) ;

(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 Care Services Conditions of Participation*, 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; am 7/1/2013, Register 206

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 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 AAC 110.520(b) .

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

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 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

(4) are provided in a vehicle that is owned or commercially leased by an agency that is a home and community-based waiver services provider.

(b) 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 round trip between the recipient's residence and another location where

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

(2) other services and resources are available.

(c) For purposes of (b) of this section, a round trip may include intermediate stops. However, those intermediate stops may not be billed separately as trips under (b) of this section.

(d) 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;
or

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

(3) transportation to destinations that are not located in the recipient's community unless approved by the department in the recipient's plan of care.

(e) In this section,

(1) "escort" means an individual that

(A) accompanies a recipient on round trip travel described in (b) and (c) 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 member of the provider's staff;

(2) "round trip" means transportation from the recipient's residence to the farthest point of travel and return from that point to the recipient's residence.

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

Authority: [AS 47.05.010](#)

[AS 47.07.030](#)

[AS 47.07.040](#)

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

Authority: [AS 47.05.010](#)

[AS 47.07.030](#)

7 AAC 130.300. Environmental modification services

- (a) The department will pay for environmental modification services that
 - (1) are approved under 7 AAC 130.217 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 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.

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

(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.

(e) The department will consider the environmental modification to be complete when the department makes final payment to the provider that received prior authorization.

(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.

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

Authority: AS 47.05.010

AS 47.07.030

AS 47.07.040

7 AAC 130.305. Specialized medical equipment

(a) The department will pay for specialized medical equipment that

(1) is supported by a prescription or other written documentation required by the department's *Specialized Medical Equipment Fee Schedule*, adopted by reference in 7 AAC 160.900,

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

(i) a physician, including an osteopath;

(ii) a physician assistant;

(iii) an advanced nurse practitioner;

(iv) an occupational therapist; or

(v) a physical therapist; and

(B) stating that the specific item requested is appropriate for the recipient and consistent with the plan of care;

(2) is supported by a written cost estimate;

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

(4) receives prior authorization.

(b) The department will consider an item to be specialized medical equipment if that item is

(1) a device, control, or appliance that increases the recipient's ability to perform activities of daily living described in 7 AAC 125.030(b) or to perceive, control, or communicate with the environment in which the recipient lives, or is equipment necessary for the proper functioning of that item; 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:

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

(3) specialized medical equipment and supplies shall 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;

(4) once purchased, specialized medical equipment become the property of the recipient;

(5) the department will not give prior authorization to replace specialized medical equipment before the expiration of the time period identified in the department's *Specialized Medical Equipment Fee Schedule*, adopted by reference in 7 AAC 160.900, unless the department determines that replacement is more cost-effective than repairing that equipment.

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

Authority: AS 47.05.010

AS 47.07.030

AS 47.07.040

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

Repealed.

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

7 AAC 130.319. Definitions

In this chapter, unless the context requires otherwise,

(1) "applicant's representative" means a person who serves, for an applicant, the functions of a recipient's representative;

- (2) "business day" means a day other than Saturday, Sunday, or a legal holiday under AS 44.12.010 ;
- (3) "care coordination" means those services provided in accordance with 7 AAC 130.240 by a care coordinator;
- (4) "care coordination agency provider" means a provider that the department has certified under 7 AAC 130.220 to provide care coordination services under 7 AAC 130.240;
- (5) "care coordinator" means an individual that the department has enrolled under 7 AAC 105.210 and certified under 7 AAC 130.238;
- (6) "habilitation services" means services that
- (A) help a recipient to acquire, retain, or improve skills related to activities of daily living as described in 7 AAC 125.030(b) and the self-help, social, and adaptive skills necessary to enable the recipient to reside in a noninstitutional setting; and
- (B) are provided in a recipient's private residence, an assisted living home licensed under AS 47.32, or a foster home licensed under AS 47.32;
- (7) "home and community-based waiver services provider" has the meaning given in 7 AAC 160.990(b) ;
- (8) "immediate family" includes the parents or minor siblings of a recipient under 18 years of age, and the spouse of a recipient;
- (9) "primary caregiver" means an individual
- (A) that lives in
- (i) the same unlicensed residence as a recipient and provides care for a recipient; or
- (ii) a different residence and provides care for a recipient in the recipient's unlicensed residence; and
- (B) assists with or provides the care described as activities of daily living in 7 AAC 125.030(b) and instrumental activities of daily living in 7 AAC 125.030(c) ;
- (10) "private residence" means a home that a recipient owns or rents, or a home where the recipient resides with other family members or friends;
- (11) "recipient category" means a category listed in 7 AAC 130.205(d) ;
- (12) "recipient's representative" has the meaning given in 7 AAC 160.990(b) ;

(13) "residential supported-living services provider" means a provider that the department has certified under 7 AAC [130.220](#) to provide residential supported-living services under 7 AAC [130.255](#).

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

Authority: [AS 47.05.010](#)

[AS 47.07.030](#)

[AS 47.07.040](#)