ATTACHMENT A
TO
ATTACHMENT 4.19-D

ALASKA STATUTES

Binder 9

TITLE 46 TO TITLE 47
TABLES

1994 Cumulative Supplement

OCTOBER 1994

Effective Date of Statutes

See Alaska Constitution, art. II, § 18

Annotated through Sup. Ct. Op. No. 4105. For complete scope of annotations, see scope page in front of supplement to first binder. For detailed information on the use of the Alaska Statutes, see User's Guide published following the scope page.

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Chapter
80. Persons with Handicaps (§§ 47.80.030, 47.80.040, 47.80.070, 47.80.090, 47.80.110, 47.80.140, 47.80.150, 47.80.900)

Chapter 05. Administration of Welfare, Social Services and Institutions.

Section
17. Home care providers

Sec. 47.05.017. Home care providers. (a) State money may not be used for a home care provider unless records under AS 12.62.035(a) are requested for the provider within 10 business days after the provider is hired to provide the care and are reviewed within five business days after they are received. The department shall require the grantee or contractor to do the records request and review required under this subsection for a home care provider employed by a person who has a grant or contract from the department to provide home care services.

(b) The department shall adopt regulations identifying actions that it will take, in addition to those otherwise required under AS 47.17 and AS 47.24, when a report of harm is made under AS 47.17 or AS 47.24 that might relate to harm caused by actions or inactions of a public home care provider. The regulations must

(1) address circumstances under which the department will, or will require a contractor or grantee to, reassign, suspend, or terminate a person alleged to have perpetrated harm; and

(2) include appropriate procedural safeguards to protect the due process rights of public home care providers who may be reassigned, suspended, or terminated under the circumstances described in (1) of this subsection.

(c) In this section, "public home care provider" means a person who is paid by the state, or by an entity that has contracted with the state or received a grant from state funds, to provide homemaker services, chore services, personal care services, home health care services, or similar services in or around a client's private residence or to provide respite care in either the client's residence or the caregiver's residence or facility. (§ 2 ch 45 SLA 1994)

Cross references. — For date by which regulations must be adopted and required to report to the legislature, see § 9, ch. 45, SLA 1994 in the Temporary and Special Acts.

Effective dates. — Section 10, ch. 45, SLA 1994 makes this section effective May 24, 1994, in accordance with AS 01.10.070(c).

Sec. 47.05.030. Misuse of public assistance lists and records.

NOTES TO DECISIONS

Quoted in Hertz v. Hertz, 847 P.2d 71 (Alaska 1993).

Sec. 47.05.060. Purpose and policy relating to children.

NOTES TO DECISIONS

Protection of children is the paramount purpose.

Child in Need of Aid proceedings are designed to protect children from injury or mistreatment and to help safeguard their physical, mental and emotional well-being. In re A.S.W., 834 P.2d 801 (Alaska 1992).

Quoted in L.O. v. State, 816 P.2d 1352 (Alaska Ct. App. 1991).

Chapter 07. Medical Assistance for Needy Persons.

Section
20. Eligible persons
25. Assignment of medical support rights
30. Medical services to be provided
35. Priority of medical assistance
40. State plan for provision of medical assistance
42. Recipient cost-sharing
55. Recovery of medical assistance from estates
72. [Repealed]
900. Definitions

Sec. 47.07.020. Eligible persons. (a) All residents of the state for whom the Social Security Act requires Medicaid coverage are eligible to receive medical assistance under 42 U.S.C. 1396 — 1396p (Title XIX, Social Security Act).

(b) In addition to the persons specified in (a) of this section, the following optional groups of persons for whom the state may claim federal financial participation are eligible for medical assistance:

(1) persons eligible for but not receiving assistance under any plan of the state approved under 42 U.S.C. 601 — 615 (Title IV-A, Social Security Act, Aid to Families with Dependent Children) or 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act, Supplemental Security Income);

(2) persons in a general hospital, skilled nursing facility, or intermediate care facility, who, if they left the facility, would be eligible for assistance under one of the federal programs specified in (1) of this subsection;

(3) persons under age 21 who are under supervision of the department, for whom maintenance is being paid in whole or in part from public funds, and who are in foster homes or private child-care institutions;

(4) aged, blind, or disabled persons, who, because they do not meet income and resources requirements, do not receive supplemental security income under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act), and who do not receive a mandatory state supplement, but who are eligible, or would be eligible if they were not in a skilled nursing facility or intermediate care facility to receive an optional state supplementary payment;

(5) persons under age 21 who are in an institution designated as an intermediate care facility for the mentally retarded and who are financially eligible as determined by the standards of the federal aid to families with dependent children program;

(6) persons in a medical or intermediate care facility whose income while in the facility does not exceed 300 percent of the supplemental security income benefit rate under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act) but who would not be eligible for an optional state supplementary payment if they left the hospital or other facility;

(7) persons under age 21 who are receiving active treatment in a psychiatric hospital and who are financially eligible as determined by the standards of 42 U.S.C. 601 — 615 (Title IV-A, Social Security Act, Aid to Families with Dependent Children);

(8) persons under age 21 and not covered under (a) of this section, who would be eligible for benefits under the federal aid to families with dependent children program, except that they have the care and support of both their natural and adoptive parents;

(9) pregnant women not covered under (a) of this section and who meet the income and resource requirements of the federal aid to families with dependent children program;

(10) persons under age 21 not covered under (a) of this section who the department has determined cannot be placed for adoption without medical assistance because of a special need for medical or rehabilitative care and who the department has determined are hard-to-place children eligible for subsidy under AS 25.23.190 — 25.23.220;

(11) **[See delayed amendment note]** persons who can be considered under 42 U.S.C. 1396a(e)(3) (Title XIX, Social Security Act, Medical Assistance) to be individuals with respect to whom a supplemental security income is being paid under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act) because they meet all of the following criteria:

(A) they are 18 years of age or younger and qualify as disabled individuals under 42 U.S.C. 1382c(a) (Title XVI, Social Security Act);

(B) the department has determined that

(i) they require a level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded;

(ii) it is appropriate to provide their care outside of an institution; and

(iii) the estimated amount that would be spent for medical assistance for their individual care outside an institution is not greater than the estimated amount that would otherwise be expended individually for medical assistance within an appropriate institution;

(C) if they were in a medical institution, they would be eligible for medical assistance under other provisions of this chapter; and

(D) home and community-based services under a waiver approved by the federal government are either not available to them under this chapter or would be inappropriate for them.

(c) Receipt of medical assistance under this chapter is considered to be an additional benefit to these individuals and does not affect other assistance payments, federal or state, for which the recipient is eligible.

(d) Additional groups may not be added unless approved by the legislature.

(e) Notwithstanding (b)(4) of this section, a person is not eligible for Medicaid benefits until a final determination is made on the eligibility of that person for benefits under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act).

(f) A person may not be denied eligibility for medical assistance under this chapter on the basis of a diversion of income, whether by assignment or after receipt of the income, into a Medicaid-qualifying trust that, according to a determination made by the department,

(1) has provisions that require that the state will receive all of the trust assets remaining at the death of the individual, subject to a maximum amount that equals the total medical assistance paid on behalf of the individual; and

(2) otherwise meets the requirements of 42 U.S.C. 1396p(d)(4).

(g) A person's eligibility for medical assistance under this chapter may not be denied or delayed on the basis of a transfer of assets for less than fair market value if the person establishes to the satisfaction of the department that the denial or delay would work an undue hardship on the person as determined on the basis of criteria in applicable federal regulations. (§ 1 ch 182 SLA 1972; am § 1 ch 105 SLA 1974; am § 1 ch 117 SLA 1975; am § 1 ch 221 SLA 1976; am § 1 ch 11 SLA 1978; am § 1 ch 132 SLA 1982; am § 13 ch 138 SLA 1982; am § 3 ch 105 SLA 1986; am § 1 ch 119 SLA 1988; am § 38 ch 168 SLA 1990; am § 1 ch 76 SLA 1993; am § 17 ch 102 SLA 1994)

Delayed amendment of subsection (b). — Under Section 4, ch. 76, SLA 1993, paragraph (b)(11) takes effect on the 180th day after the effective date of Medicaid plan amendments approved by the federal government under which the state would implement a waiver for home and community-based services under 42 U.S.C. 1396n for persons who are Medicaid eligible and who would otherwise require a level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded in the absence of home and community-based services.

Cross references. — For legislative purposes in enacting (f) of this section, see

§ 1, ch. 102, SLA 1994 in the Temporary and Special Acts.

Effect of amendments. — The 1993 amendment added paragraphs (b)(10) and (b)(11).

The 1994 amendment, effective September 7, 1994, added subsections (f) and (g).

Sec. 47.07.025. Assignment of medical support rights. (a) An applicant for or recipient of assistance under this chapter is considered to have assigned to the state, through the department and the child support enforcement agency, all rights to accrued and continuing medical support that the applicant and other persons for whom assistance is sought may have from all sources. The assignment takes effect upon a determination that the applicant is eligible for assistance under this chapter. Except with respect to the amount of any unpaid medical support obligation accrued under the assignment, the assignment under this section terminates when the applicant ceases to receive assistance under this chapter.

(b) Through the child support enforcement agency or on its own behalf, the department may garnish the wages, salary, or other employment income of a person who

(1) is required by a medical support order under AS 25.27.063 to provide coverage of the costs of medical care to a child who is eligible for medical assistance under this chapter;

(2) has received payment from a third party for the costs of the services; and

(3) has not used the payments to reimburse, as appropriate, the other parent or custodian of the child, the provider of the services, or the department.

(c) Garnishment under (b) of this section is limited to the amount necessary to reimburse the department for expenditures for the child under this chapter. Claims for current support or support arrearages take priority over claims under this section. (§ 18 ch 102 SLA 1994)

Cross references. — For legislative purposes in enacting this section, see § 1, ch. 102, SLA 1994 in the Temporary and Special Acts.

Effective dates. — Section 18, ch. 102, SLA 1994, which enacted this section, took effect on September 7, 1994.

Sec. 47.07.030. Medical services to be provided. (a) The department shall offer all mandatory services required under 42 U.S.C. 1396 — 1396p (Title XIX of the Social Security Act).

(b) In addition to the mandatory services specified in (a) of this section, the department may offer only the following optional services: case management and nutrition services for pregnant women; personal care services in a recipient's home; emergency hospital services; long-term care noninstitutional services; medical supplies and equipment; advanced nurse practitioner services; clinic services; rehabilitative services for substance abusers and emotionally disturbed or chronically mentally ill adults; targeted case management services for

substance abusers, chronically mentally ill adults, and severely emotionally disturbed persons under the age of 21; inpatient psychiatric facility services for individuals age 65 or older and individuals under age 21; psychologists' services; clinical social workers' services; midwife services; prescribed drugs; physical therapy; occupational therapy; chiropractic services; low-dose mammography screening, as defined in AS 21.42.375(e); hospice care; treatment of speech, hearing, and language disorders; adult dental services; prosthetic devices and eyeglasses; optometrists' services; intermediate care facility services, including intermediate care facility services for the mentally retarded; skilled nursing facility services for individuals under age 21; and reasonable transportation to and from the point of medical care.

(c) Notwithstanding (b) of this section, the department may offer a service for which the department has received a waiver from the federal government if the department was authorized, directed, or requested to apply for the waiver by law or by a concurrent or joint resolution of the legislature. The department shall annually submit to the legislature its recommendations about where a service offered under this subsection should be placed on the priority list in AS 47.07.035.

(d) The department may use a case management system under which certain eligible individuals are required to seek approval from the case manager before receiving some services under this chapter and under which certain services may be denied eligibility under this chapter if the case manager does not approve provision of the service. A case manager may approve coverage of an optional service listed in AS 47.07.035, notwithstanding that coverage of that service may have been eliminated under AS 47.07.035. (§ 1 ch 182 SLA 1972; am § 1 ch 35 SLA 1973; am § 2 ch 105 SLA 1974; am § 1 ch 12 SLA 1976; am § 2 ch 221 SLA 1976; am § 1 ch 82 SLA 1978; am § 25 ch 40 SLA 1981; am § 2 ch 132 SLA 1982; am § 1 ch 20 SLA 1986; am § 4 ch 105 SLA 1986; am § 2 ch 119 SLA 1988; am § 3 ch 45 SLA 1989; am § 3 ch 69 SLA 1991; am § 1 ch 70 SLA 1991; am § 1 ch 38 SLA 1992; am § 1 ch 110 SLA 1992; am § 2 ch 51 SLA 1993; am § 1 ch 75 SLA 1993; am § 2 ch 76 SLA 1993; am § 19 ch 102 SLA 1994)

Effect of amendments. — The first 1991 amendment, effective September 19, 1991, inserted "low-dose mammography screening, as defined in AS 21.42.375(e)" near the middle of subsection (b).

The second 1991 amendment, effective September 19, 1991, inserted "psychologists' services; clinical social workers' services" near the middle of subsection (b).

The first 1992 amendment, effective July 1, 1992, in subsection (b), inserted "rehabilitative services for substance abusers and emotionally disturbed or chronically mentally ill adults; targeted case management services for substance abusers, chronically mentally ill adults, and severely emotionally disturbed persons under the age of 21;".

The second 1992 amendment, effective September 20, 1992, inserted "advanced nurse practitioner services;" in subsection (b).

The first 1993 amendment, effective July 1, 1993, inserted "midwife services" near the middle of subsection (b).

The second 1993 amendment, effective

January 1, 1994, inserted "hospice care" near the end of subsection (b).

The third 1993 amendment, effective June 26, 1993, added subsection (c).

The 1994 amendment, effective September 7, 1994, added subsection (d).

Sec. 47.07.035. Priority of medical assistance. If the department finds that the cost of medical assistance for all persons eligible under this chapter will exceed the amount allocated in the state budget for that assistance for the fiscal year, the department shall eliminate coverage for optional medical services and optionally eligible groups of individuals in the following order:

(1) midwife services;
(2) clinical social workers' services;
(3) psychologists' services;
(4) chiropractic services;
(5) advanced nurse practitioner services;
(6) adult dental services;
(7) emergency hospital services;
(8) treatment of speech, hearing, and language disorders;
(9) optometrists' services and eyeglasses;
(10) occupational therapy;
(11) mammography screening;
(12) prosthetic devices;
(13) medical supplies and equipment;
(14) targeted case management services;
(15) rehabilitative services for substance abusers and emotionally disturbed or chronically mentally ill adults;
(16) clinic services;
(17) physical therapy;
(18) personal care services in a recipient's home;
(19) prescribed drugs;
(20) hospice care;
(21) long-term care noninstitutional services;
(22) inpatient psychiatric facility services;
(23) intermediate care facility services for the mentally retarded;
(24) intermediate care facility services;
(25) **[See delayed amendment note]** individuals described in AS 47.07.020(b)(11);
(26) individuals under age 21 who are not eligible for benefits under the federal aid to families with dependent children program because they are not deprived of one or more of their natural or adoptive parents;
(27) skilled nursing facility services for persons under age 21;
(28) aged, blind, and disabled individuals who, because they do not meet the income requirements, do not receive supplemental security income under Title XVI of the Social Security Act, but who are eligible, or would be eligible if they were not in a skilled nursing facility or

intermediate care facility, to receive an optional state supplementary payment;
(29) individuals in a hospital, skilled nursing facility, or intermediate care facility whose income while in the facility does not exceed 300 percent of the supplemental security income benefit rate under Title XVI of the Social Security Act, but who, because of income, are not eligible for the optional state supplementary payment;
(30) individuals under age 21 under supervision of the department for whom maintenance is being paid in whole or in part from public money and who are in foster homes or private child-care institutions.
(31) individuals under age 21 who the department has determined cannot be placed for adoption without medical assistance because of a special need for medical or rehabilitative care and who the department has determined are hard-to-place children eligible for subsidy under AS 25.23.190 — 25.23.220. (§ 3 ch 132 SLA 1982; am § 2 ch 20 SLA 1986; am § 5 ch 105 SLA 1986; am § 3 ch 119 SLA 1988; am § 4 ch 45 SLA 1989; am § 38 ch 168 SLA 1990; am § 4 ch 69 SLA 1991; am § 2 ch 70 SLA 1991; am § 2 ch 38 SLA 1992; am § 2 ch 110 SLA 1992; am § 3 ch 51 SLA 1993; am § 2 ch 75 SLA 1993; am § 3 ch 76 SLA 1993)

Delayed amendment of paragraph (25). — Under Section 4, ch. 76, SLA 1993, paragraph (23) (now (25)) takes effect on the 180th day after the effective date of Medicaid plan amendments approved by the federal government under which the state would implement a waiver for home and community-based services under 42 U.S.C. 1396n for persons who are Medicaid eligible and who would otherwise require a level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded in the absence of home and community-based services.

Revisor's notes. — Paragraphs (14) and (15) enacted as (12) and (13) and renumbered in 1992. Renumbered again by the first 1993 amendment. Paragraph (20) was enacted as (19), paragraph (25) was enacted as (23), and paragraph (31) was enacted as (29). Renumbered in 1993.

Effect of amendments. — The first 1991 amendment, effective September 19, 1991, added paragraph (9) (now (11)) and redesignated the succeeding paragraphs accordingly.

The second 1991 amendment, effective September 19, 1991, added paragraphs (1) and (2) (now (2) and (3)) and redesignated the subsequent paragraphs accordingly.

The first 1992 amendment, effective July 1, 1992, added paragraphs (12) and (13) (now (13) and (14)) and redesignated former paragraphs (12) to (24) as paragraphs (14) to (26) (now (15) — (19), (20) — (24), and (26) — (30)).

The second 1992 amendment, effective September 20, 1992, added paragraph (4) (now (5)) and redesignated the subsequent paragraphs accordingly.

The first 1993 amendment, effective July 1, 1993, added present paragraph (1) and redesignated the subsequent paragraphs accordingly.

The second 1993 amendment, effective January 1, 1994, added present paragraph (20) and renumbered the subsequent paragraphs accordingly.

The third 1993 amendment added present paragraph (25), redesignated the subsequent paragraphs accordingly, and added paragraph (31).

Sec. 47.07.040. State plan for provision of medical assistance. The department shall prepare a state plan in accordance with the provisions of 42 U.S.C. 1396 — 1396p (Title XIX, Social Security Act, Medical Assistance) and submit it for approval to the United States Department of Health and Human Services. The plan shall designate that the Department of Health and Social Services is the single state agency to administer this plan. The department shall act for the state in any negotiations relative to the submission and approval of the plan. The department may make those arrangements or regulatory changes, not inconsistent with law, as may be required under federal law to obtain and retain approval of the United States Department of Health and Human Services to secure for the state the optimum federal payment under the provisions of 42 U.S.C. 1396 — 1396p (Title XIX, Social Security Act, Medical Assistance). (§ 1 ch 182 SLA 1972; am § 6 ch 105 SLA 1986; am E.O. No. 72 § 3 (1989); am § 32 ch 126 SLA 1994)

Effect of amendments. — The 1994 amendment, effective July 1, 1994, deleted the former last sentence, relating to the annual departmental report concerning the status of the state plan for the provision of medical assistance and recommended changes in the coverage of eligible persons and services.

Sec. 47.07.042. Recipient cost-sharing. (a) Except as provided in (b) and (c) of this section, the state plan developed under AS 47.07.040 shall impose deductible, coinsurance, and copayment requirements or similar charges on persons eligible for assistance under this chapter to the maximum extent allowed under federal law and regulations. The plan must provide that health care providers shall collect the allowable charge. The department shall reduce payments to each provider by the amount of the allowable charge. A provider may not deny services because a recipient is unable to share costs, but an inability to share costs imposed under this section does not relieve the recipient of liability for the costs.

(b) The state plan developed under AS 47.07.040 shall impose a copayment requirement for inpatient hospital services in an amount that is the lesser of

(1) $50 a day, up to a maximum of $200 per discharge; or

(2) the maximum allowed under federal law and regulations.

(c) If the department has clear and compelling reason to believe that application of the maximum allowable charges under (a) of this section to a specific service would not reduce state expenditures or would generate savings to the state that are insignificant in relation to the total cost containment possible, then the department may waive the charges otherwise required under (a) of this section as to that specific service. (§ 20 ch 102 SLA 1994)

Cross references. — For legislative purposes in enacting this section, see § 1, ch. 102, SLA 1994 in the Temporary and Special Acts.

Effective dates. — Section 20, ch. 102, SLA 1994, which enacted this section, took effect on September 7, 1994.

Editor's notes. — Section 22, ch. 102, SLA 1994 provides that the charges provided for under this section "apply to services performed on or after July 1, 1994."

Sec. 47.07.055. Recovery of medical assistance from estates. (a) The estate of an individual who received medical assistance payments is subject to a claim for recovery of the medical assistance after the individual's death that, except as provided in (b) of this section, may be secured by a lien filed against the individual's real property during the individual's lifetime if the

(1) individual was an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution;

(2) department required the individual, as a condition of receiving medical assistance under this chapter, to spend for medical expenses all but a minimal amount of that individual's income; and

(3) department determined during the individual's lifetime, after notice and opportunity for hearing, that the individual could not reasonably be expected to be discharged from the institution and to return home.

(b) A lien may not be filed under (a) of this section against an individual's home if the home is lawfully occupied by the individual's

(1) spouse;

(2) child under age 21;

(3) blind or disabled child as described in AS 47.25.615(3) or (5) or 42 U.S.C. 1382(c); or

(4) sibling, if the sibling has an equity interest in the home and was residing in the home for at least one year before the date of the individual's admission to the institution.

(c) The state may not recover the costs of medical assistance under a lien on a home under (a) of this section until after the death of the individual's surviving spouse, if any, and only at a time when neither of the following is lawfully residing in the home:

(1) a sibling of the individual who was residing in the individual's home for a period of at least one year immediately preceding the date of the individual's institutionalization and who has continuously resided in the home since the institutionalization began; or

(2) a son or daughter of the individual who

(A) resided in the home for at least two years immediately preceding the date of the individual's institutionalization;

(B) has continuously resided in the home since the institutionalization began; and

(C) establishes to the department's satisfaction that the son or daughter provided care to the individual that allowed the individual to reside in the home rather than in an institution.

(d) A lien and claim authorized under (a) of this section are extinguished if, during the individual's lifetime, the individual is discharged from the institution and returns home. However, a new lien and claim are authorized for subsequent expenses if the circumstances described in (a) of this section occur after the individual returns home.

(e) In addition to recovery of medical assistance upon sale of property subject to a lien authorized under (a) — (d) of this section, after an individual's death, the individual's estate is subject to a claim for reimbursement for medical assistance payments made on behalf of the individual under this chapter for the following services to the extent that those services were provided when the individual was 55 years of age or older:

(1) services received while an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institutions; and

(2) home and community-based services provided through a waiver received from the federal government that allows home and community-based services to be covered under this chapter for persons who are eligible for coverage under this chapter while in an institution but who are able to avoid institutionalization because of the provision of home and community-based services.

(f) Other than a recovery upon sale of a home, a claim under this section may be made only after the death of the individual's surviving spouse, if any, and only at a time when the individual has no surviving child under age 21 and no surviving child who is blind or totally and permanently disabled.

(g) For purposes of AS 13.16.470, the claims authorized under this section are debts with preference under the laws of the state. (§ 21 ch 102 SLA 1994)

Cross references. — For legislative purposes in enacting this section, see § 1, ch. 102, SLA 1994 in the Temporary and Special Acts.

Effective dates. — Section 21, ch. 102, SLA 1994, which enacted this section, took effect on September 7, 1994.

Sec. 47.07.070. Payment to health facilities.

NOTES TO DECISIONS

"Fair rate" of compensation. — The state statutory standard of a "fair rate" does not require the state to compensate a provider fully for increases in workers' compensation insurance. State and federal law mandate only that the overall rate paid to a facility be fair in relation to the costs incurred by the facility, not that each component of a facility's costs be compensated at a fair rate. State, Dep't of Health & Social Serv. v. Hope Cottages, Inc., 863 P.2d 246 (Alaska 1993).

Federal reimbursement requirements. — Federal Medicaid law, specifically the Boren Amendment to 42 U.S.C. § 1396a, does not require actual reimbursement of a providers costs. State, Dep't of Health & Social Serv. v. Hope Cottages, Inc., 863 P.2d 246 (Alaska 1993).

Reimbursement on modified cost basis. — Under the regulatory scheme in Alaska, a Medicaid facility is reimbursed based on a modified "cost plus" basis—actual operating costs incurred two fiscal years ago plus an inflation factor anticipating capital improvement costs. State, Dep't of Health & Social Serv. v. Hope Cottages, Inc., 863 P.2d 246 (Alaska 1993).

Sec. 47.07.072. Report by the department [Repealed, § 35 ch 126 SLA 1994.]

Sec. 47.07.900. Definitions. In this chapter

(1) "adult dental services" means minimum treatment for the immediate relief of pain and acute infection provided by a licensed dentist;

(2) "advanced nurse practitioner services" means services furnished by a person who is certified as an advanced nurse practitioner under AS 08.68.410 that are within the scope of the person's certified authority, whether or not the person is under the supervision of, or associated with, a physician or other health care provider;

(3) "chiropractic services" includes only services that are provided by a chiropractor licensed under AS 08.20 that consist of treatment by means of manual manipulation of the spine and x-rays necessary for treatment;

(4) "clinic services" means services provided by state-approved outpatient community mental health clinics that receive grants under AS 47.30.520 — 47.30.620, state-operated community mental health clinics, outpatient surgical care centers, and physician clinics;

(5) "clinical social workers' services" means clinical social work services provided by a person licensed as a clinical social worker under AS 08.95;

(6) "commission" means the Medicaid Rate Advisory Commission;

(7) "department" means the Department of Health and Social Services;

(8) "emergency hospital services" means services that

(A) are necessary to prevent the death or serious impairment of the health of the individual; and

(B) because of the threat to the life or health of the individual, necessitate the use of the most accessible hospital available that is equipped to furnish the services, even if the hospital does not currently meet

(i) the conditions for participation under Medicare; or

(ii) the definitions of inpatient or outpatient hospital services under 42 C.F.R. 440.10 and 440.20;

(9) "emotionally disturbed or chronically mentally ill adults" and "severely emotionally disturbed persons under age 21" include only persons who receive mental health services from an entity that has a contract to provide community mental health services under AS 47.30.520 — 47.30.620;

(10) "eyeglasses" are lenses, including frames when necessary, and other aids to vision prescribed by a physician skilled in diseases of the eye, or by an optometrist, whichever the patient may select, to aid or improve vision;

(11) "health facility" includes a hospital, skilled nursing facility, intermediate care facility, intermediate care facility for the mentally retarded, rehabilitation facility, inpatient psychiatric facility, home health agency, rural health clinic, and outpatient surgical clinic;

(12) "hospice care" means services to a terminally ill individual of the type and under the circumstances described in 42 U.S.C. 1396d(o), as amended, and applicable federal regulations;

(13) "midwife services" means services within the practice of midwifery, as defined in AS 08.65.190, that are performed by a certified direct-entry midwife and miscellaneous fees, other than facility fees, for birth kits, oxygen, and other ancillary expenses necessary for a birth attended by a certified direct-entry midwife;

(14) "nurse midwife" means a registered professional nurse who is certified as an advanced nurse practitioner under AS 08.68.410(1) and authorized to practice as a nurse midwife under regulations adopted in accordance with AS 08.68.410(8);

(15) "personal care services in a recipient's home" means services prescribed by a physician in accordance with the recipient's plan of treatment and provided by an individual who is

(A) qualified to provide the services;

(B) supervised by a registered nurse; and

(C) not a member of the recipient's family;

(16) "psychologists' services" means services within the practice of psychology provided by a person licensed as a psychologist or psychological associate under AS 08.86;

(17) "rehabilitative services" means services for substance abusers and emotionally disturbed or chronically mentally ill adults provided by

(A) a drug or alcohol treatment center that is funded with a grant under AS 47.30.475; or

(B) an outpatient community mental health clinic that has a contract to provide community mental health services under AS 47.30.520 — 47.30.620;

(18) "substance abuser" means a person who

(A) is an alcoholic, as defined in AS 47.37.270;

(B) participates in inhalant abuse, as defined in AS 47.37.270; or

(C) misuses illegal or prescription drugs;

(19) "targeted case management services" means case management services for substance abusers, chronically mentally ill adults, and severely emotionally disturbed persons under age 21 that are provided by

(A) a drug or alcohol treatment center that is funded with a grant under AS 47.30.475; or

(B) an outpatient community mental health clinic that has a contract to provide community mental health services under AS 47.30.520 — 47.30.620. (§ 1 ch 182 SLA 1972; am § 2 ch 12 SLA 1976; am § 3 ch 221 SLA 1976; am § 26 ch 40 SLA 1981; am § 4 ch 132 SLA 1982; am §§ 5, 10 ch 95 SLA 1983; am § 3 ch 20 SLA 1986; am §§ 9, 10 ch 105 SLA 1986; am E.O. No. 72 § 12 (1989); am § 3 ch 70 SLA 1991; am § 3 ch 38 SLA 1992; am § 3 ch 110 SLA 1992; am § 4 ch 51 SLA 1993; am § 3 ch 75 SLA 1993)

Revisor's notes. — Formerly AS 47.07.080. Renumbered in 1983, at which time it was reorganized to alphabetize the defined terms. Reorganized in 1986, 1991, 1992, and 1993 to maintain alphabetical order.

Effect of amendments. — The 1991 amendment, effective September 19, 1991, added paragraphs (4) (now (5)) and (12) (now (16)).

The first 1992 amendment, effective July 1, 1992, added paragraphs (9) and (15)-(17) (now (17) — (19)).

The second 1992 amendment, effective September 20, 1992, added paragraph (2).

The first 1993 amendment, effective July 1, 1993, added paragraph (13).

The second 1993 amendment, effective January 1, 1994, added paragraph (12).

Chapter 10. Delinquent Minors and Children in Need of Aid.

Article
1. Children's Proceedings (§§ 47.10.010, 47.10.020, 47.10.060 — 47.10.072, 47.10.080, 47.10.081, 47.10.084, 47.10.090 — 47.10.093, 47.10.097, 47.10.120 — 47.10.142)
2. Juvenile Institutions (§§ 47.10.150 — 47.10.190)
3. Care of Children (§§ 47.10.230, 47.10.270, 47.10.290)
4. Programs for Runaway Minors (§§ 47.10.300, 47.10.310, 47.10.330, 47.10.350)
4A. Shelters for Runaway Minors (§§ 47.10.392 — 47.10.399)
5. Citizens' Review Panel for Permanency Planning (§ 47.10.410)
6. General Provisions (§ 47.10.990)

NOTES TO DECISIONS

Cited in Allam v. State, 830 P.2d 435 (Alaska Ct. App. 1992).

Article 1. Children's Proceedings.

Section
10. Jurisdiction
20. Investigation and petition
60. Waiver of jurisdiction
70. Hearings
72. [Repealed]
80. Judgments and orders
81. Predisposition hearing reports
84. Legal custody, guardianship, and residual parental rights and responsibilities
90. Court records
92. Parental right to disclose information
93. Disclosure of agency records
97. Fingerprinting of minors
120. Support of minor
130. Detention
140. Temporary detention and detention hearing
141. Runaway and missing minors
142. Emergency custody and temporary placement hearing