DEPARTMENT OF HEALTH AND SOCIAL SERVICES

CHANGES TO REGULATIONS

Medicaid Coverage and Payment.

Home and Community-Based Waiver Services, Rates, and Personal Care Services

♦

FILED REGULATIONS

Effective April 1, 2012

The regulations reproduced here are provided by the Alaska Department of Health and Social Services as a public courtesy. While every effort has been made to assure the accuracy of the reproduced version, the department cannot guarantee its absolute accuracy. A paper copy of the regulations originally filed by the Lieutenant Governor is available from the department. For the official published version of the regulations, please refer to the Alaska Administrative Code, Register 201, April 2012.

7 AAC 130 is amended by adding a new section to read:

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(h)(4) 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 130.230; 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 130.230 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 130.230 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 130.230 specific to the home and community-based waiver services plan of care;

(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 130.230 specific to the home and community-based waiver services plan of care; 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. (Eff. 4/1/2012, Register 201)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

7 AAC 145.520(m) is amended to read:

(m) A qualified recipient receiving residential supported-living services under 7 AAC 130.255 that are assigned procedure code T2031 in the *Healthcare Common Procedure Coding System (HCPCS)*, adopted by reference in 7 AAC 160.900, or group-home habilitation services under 7 AAC 130.265 that are assigned procedure code T2016 in the *Healthcare Common Procedure Coding System*, is eligible for**,** [AN ACUITY RATE OF $320 PER APPROVED DAY] in addition to the qualified recipient's daily rate provided for under (f) and (h) of this section**, an acuity rate at the daily rate established in the department's *Chart of Personal Care and Waiver Services Rates*, adopted by reference in 7 AAC 160.900 and adjusted as set out in (g) of this section**. For purposes of this subsection, a qualified recipient is a recipient **for whom the department has given prior authorization under 7 AAC 130.267 for additional services** [WHOSE PLAN OF CARE DEVELOPED AND APPROVED UNDER 7 AAC 130.230 DOCUMENTS AND REQUIRES THAT THE RECIPIENT RECEIVE DEDICATED ONE-ON-ONE STAFFING 24 HOURS PER DAY].

(Eff. 2/1/2010, Register 193; am 3/1/2011, Register 197; am 4/1/2012, Register 201)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.045

7 AAC 160.900(d)(10) is amended to read:

(10) the *Chart of Personal Care Attendant and Waiver Services Rates* [*2011*], dated **February 1, 2012** [JANUARY 21, 2011], for providers of personal care services under 7 AAC 125.010 - 7 AAC 125.199 and home and community-based waiver services under 7 AAC 130.200 - 7 AAC 130.319;

7 AAC 160.900(d)(18) is amended to read:

(18) the *Specialized Medical Equipment Fee Schedule* [*2011*], dated **February 1, 2012** [JANUARY 21, 2011], for home and community-based waiver services;

7 AAC 160.900(d)(25) is amended to read:

(25) the *Cost Survey* and *Cost Survey* [*2011*] *Instructions*, dated **February 1, 2012** [JANUARY 21, 2011], for providers of personal care services under 7 AAC 125.010 - 7 AAC 125.199 and home and community-based waiver services under 7 AAC 130.200 - 7 AAC 130.319;

(Eff. 2/1/2010, Register 193; am 8/25/2010, Register 195; am 12/1/2010, Register 196; am 1/1/2011, Register 196; am 1/15/2011, Register 197; am 2/9/2011, Register 197; am 3/1/2011, Register 197; am 10/1/2011, Register 199; am 12/1/2011, Register 200; am 1/26/2012, Register 201; am 3/8/2012, Register 201; am 4/1/2012, Register 201; add'l am 4/1/2012, Register 201)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040
AS 47.05.012