# DEPARTMENT OF HEALTH & SOCIAL SERVICES

# PROPOSED CHANGES TO REGULATIONS

## STREAMLINING THE ASSESSMENT PROCESS FOR MEDICAID NURSING FACILITY LEVEL OF CARE DETERMINATIONS FOR WAIVER SERVICES.

### 7 AAC 130. MEDICAID COVERAGE; HOME AND COMMUNITY-BASED WAIVER SERVICES.

### 7 AAC 160. MEDICAID PROGRAM; GENERAL PROVISIONS.

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**PUBLIC REVIEW DRAFT**
**August 11, 2020**

**COMMENT PERIOD ENDS: September 30, 2020**

**Please see the public notice for details about how to comment on these proposed changes.**

**Notes to reader:**

1. Except as discussed in note 2, new text that amends an existing regulation is **bolded and underlined**.

2. If the lead-in line above the text of each section of the regulations states that a new section, subsection, paragraph, or subparagraph is being added, or that an existing section, subsection, paragraph, or subparagraph is being repealed and readopted (replaced), *the new or replaced text is not bolded or underlined*.

3. [ALL-CAPS TEXT WITHIN BRACKETS] indicates text that is to be deleted.

4. When the word "including" is used, Alaska Statutes provide that it means "including, but not limited to."

5. Only the text that is being changed within a section of the current regulations is included in this draft. Refer to the text of that whole section, published in the current Alaska Administrative Code, to determine how a proposed change relates within the context of the whole section and the whole chapter.

## Title 7 Health and Social Services.

## Chapter 130. Medicaid Coverage; Home and Community-Based Waiver Services.

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

7 AAC 30.207 is repealed and readopted to read:

(a) To apply for home and community-based waiver services under this chapter

(1) for the recipient categories of children with complex medical conditions, adults with physical and developmental disabilities, and older adults or adults with physical disabilities, an individual

(A) must participate in the person-centered intake process approved by the department; and

(B) if the person-centered intake process recommends and the individual chooses to apply for the services available under this chapter, the individual must submit to the department a completed application in a format provided by the department with relevant supporting documents;

(2) for the recipient category of individuals with intellectual and developmental disabilities, an individual must first submit to the department a completed Intellectual & Developmental Disabilities (DD) Registration and Review form, adopted by reference in 7 AAC 160.900, and follow the process outlined in 7 AAC 130.206 (b) and (d).

(b) The department will

(1) for the recipient categories in (a)(1) of this section, send the applicant and the applicant's care coordinator notice in writing of any missing information or documentation needed to make the application complete not later than 14 business days after receipt of an application. 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; and

(2) for the recipient category in (a)(2) of this section, if the individual chooses to apply for the services available under this chapter, follow the application process outlined in 7 AAC 130.206(b) and (d).

(c) Not later than 30 business days after the department determines that an application under (a)(1) of this section is complete or the documents required under 7 AAC 130.206 (d) have been submitted, the department will

(1) conduct an assessment under 7 AAC 130.213;

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

(3) notify the applicant and care coordinator of the level-of-care determination, except that the department may extend the notification timeframe for an additional 30 business days if the department, under 7 AAC 130.213(f), forwards an assessment for review by an

independent qualified health care professional in accordance with AS 47.07.045(b) and 7 AAC 130.219(e)(4).

(Eff. 10/1/2018, Register 227; am____/____/____, Register____)

**Authority:** AS 47.05.010 AS 47.07.030 AS 47.07.040

7 AAC 130.209 is amended to read:

7 AAC 130.209. Expedited application, assessment, level-of-care determination, and **support** [PLAN OF] care.

7 AAC 130.209(a) is amended to read:

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

**…**

(Eff. 7/1/2013, Register 206; am 7/1/2015, Register 214; am 11/5/2017, Register 224; am____/____/____, Register____)

**Authority:** AS 47.05.010 AS 47.07.040 AS 47.07.045
AS 47.07.030

7 AAC 130.211(c) is amended to read:

(c) Following notification of a decision by the department that an applicant would not need services as specified in (a) of this section, the applicant may submit, and the department will pay for and review, another application within the time period in (a) of this section, only if a

material change in the applicant's condition occurred after submission of a prior application. [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.]

(Eff. 7/1/2013, Register 206; am 11/5/2017, Register 224; am 10/1/2018, Register 227; am____/____/____, Register____)

**Authority:** AS 47.05.010 AS 47.07.040 AS 47.07.045
AS 47.07.030

7 AAC 130.213 is repealed and readopted to read:

**7 AAC 130.213. Assessment.**

(a) If an application 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 assess 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 the department determines 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 support plan in accordance with 7 AAC 130.217 and 7 AAC 130.218.

(c) To request an evaluation to determine whether a recipient has a 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) For recipients enrolled in the recipient categories specified in 7 AAC 130.205(d)(1), (2), and (4), the department will

(1) evaluate the 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 by conducting:

(A) an assessment for

(i) a recipient's second year of enrollment; and

(ii) subsequent years of enrollment, every third year if there has been no change in the recipient's condition; or

(B) an interim file review for each year an assessment does not occur; if the review indicates that there has been a material change in the recipient's condition, the department will conduct an assessment; and

(2) after each assessment or interim level of care review, the department will notify the recipient, the recipient's representative, and the recipient's care coordinator of the department's determination.

(e) For recipients enrolled in the recipient category specified in 7 AAC 130.205(d)(3), if the new application indicates a need for continuing services, the department will

(1) either

(A) reassess the recipient to determine if the recipient continues to meet the eligibility requirements of 7 AAC 130.205(d)(3) and the level-of-care requirement under 7 AAC 130.215(3); the department will schedule a reassessment on the basis of the age of the recipient or earlier if the department determines it necessary, as follows:

(i) annually for recipients at least three years of age and under seven years of age;

(ii) every three years for recipients at least seven years of age and under 22 years of age;

(iii) as necessary for recipients 22 years of age or older; or

(B) for each year an assessment is not conducted, conduct a file review and confer with the care coordinator for the recipient, to confirm that the recipient continues to meet the level-of-care requirement; if the review indicates that there has been a material change in the recipient's condition, the department will conduct an assessment; in this subparagraph, "material change in the recipient's condition," with respect to a recipient, has the meaning given "material change in the applicant's condition" in 7 AAC 130.211(c); and

(2) after a reassessment or review under this subsection, notify the recipient, the recipient's representative, and the recipient's care coordinator of the department's determination.

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

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

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

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

(h) The department may schedule and conduct assessments by teleassessment for applicants or recipients who submit to the department, before scheduling the following:

(1) an application in accordance with 7 AAC 130.207;

(2) in a format provided by the department, information about the residential setting of the applicant or recipient.

(Eff. 7/1/2013, Register 206; am 7/1/2015, Register 214; am 11/5/2017, Register 224; am____/____/____, Register____)

**Authority:** AS 47.05.010 AS 47.07.040 AS 47.07.045
AS 47.07.030

7 AAC 130.215(1) is amended to read:

**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, **or an interim level of care review,** whether

**…**

7 AAC 130.215(2) is amended to read:

(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, **or an interim level of care review,** whether the applicant has both a physical disability and a developmental disability, and whether

**…**

7 AAC 130.215(4) is amended to read:

(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, **or an interim level of care review,** whether

**…**

(Eff. 7/1/2013, Register 206; am____/____/____, Register____)

**Authority:** AS 47.05.010 AS 47.07.040 AS 47.07.045
AS 47.07.030

The title of section 7 AAC 130.217 is amended to read:

**7 AAC 130.217. <u>Support</u> plan [OF CARE] development and amendment.**

7 AAC 130.217(a) is amended to read:

(a) Not less than once every 12 months, the care coordinator shall submit a **<u>support</u>** plan [OF CARE], based on the current needs of the recipient, the most recent assessment or **<u>interim level of care review</u>** [REASSESSMENT] conducted under 7 AAC 130.213, and the level-of-care determination made in accordance with 7 AAC 130.215. After an assessment or **<u>interim level of care review</u>** [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

(Eff. 7/1/2013, Register 206; am 7/1/2015, Register 214; 11/5/2017, Register 224; am 10/1/2018, Register 227; am____/____/____, Register____)

**Authority:** AS 47.05.010 AS 47.07.040 AS 47.07.045
AS 47.07.030

**7 AAC 130.218. Person-centered practice.**

7 AAC 130.218(c) is amended to read:

(c) The providers, selected in accordance with (d) of this section, must collaborate with the recipient, and with the individuals chosen by the recipient to participate in the planning process, to develop for the recipient a written, person-centered **<u>support</u>** plan [OF CARE]. The **<u>support</u>** plan [OF CARE] must

**…**

7 AAC 130.218(c)(4)(C)(ii) is amended to read:

(C) for each service

**…**

(ii) an analysis of whether the service and amount of that service is consistent with the assessment or **interim level of care review** [REASSESSMENT] conducted under 7 AAC 130.213, the level-of-care-determination made in accordance with 7 AAC 130.215, and any treatment plans developed for the recipient;

(Eff. 11/5/2017, Register 224; am____/____/____, Register____)

**Authority:** AS 47.05.010 AS 47.07.040 AS 47.07.045
AS 47.07.030

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

7 AAC 130.219(c)(3) is amended to read:

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

**…**

(3) been assessed **or received an interim level of care review** under 7 AAC 130.213;

7 AAC 130.219(c)(5) is amended to read:

(5) received an approved **support** plan [OF CARE] under 7 AAC 130.217 and 7 AAC 130.218.

7 AAC 130.219(e)(2) is amended to read:

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

(2) the department is unable to determine eligibility for home and community-based waiver services because the documentation required under 7 AAC 130.217 and 7 AAC 130.218 [AS PART OF A REASSESSMENT] to determine the recipient's continuing eligibility for services was not submitted by the recipient, the recipient's representative, or the recipient's care coordinator at least 30 days before expiration of the current plan year;

7 AAC 130.219(e)(4) is amended to read:

(4) the recipient is no longer eligible for services because the recipient's **assessment or interim level of care review** [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

7 AAC 130.219(e)(4)(A)

(A) the annual assessment **or interim level of care review** and determination have been reviewed in accordance with AS 47.07.045(b)(2) using the department's

(Eff. 7/1/2013, Register 206; am 7/1/2015, Register 214; am 11/5/2017, Register 224; am____/____/____, Register____)

**Authority:** AS 47.05.010 AS 47.07.040 AS 47.07.045

AS 47.07.030

**7 AAC 130.319. Definitions.**

7 AAC 130. 319 is repealed and readopted to read:

In this chapter, unless the context requires otherwise,

(1) “applicant” refers to a person that has started the process required to be evaluated for an initial level of care assessment;

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

(3) “assessment” means the process by which the department, using an assessment tool specified by recipient category in 7 AAC 130.215, determines if an applicant meets a level of care necessary to qualify for home and community-based waiver services;

(4) "business day" means a day other than Saturday, Sunday, or a legal holiday under AS 44.12.010;

(5) "care coordination" means those services provided in accordance with 7 AAC 130.240 by a care coordinator;

(6) "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;

(7) "care coordinator" means an individual that the department has enrolled under 7 AAC 105.210 and certified under 7 AAC 130.238;

(8) "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 non-institutional 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;

(9) "home and community-based waiver services provider" has the meaning given in 7 AAC 160.990(b);

(10) "immediate family" means the spouse of the recipient, and the parent of a minor child that is the recipient;

(11) “individual” means a person who has engaged in the pre-application process for waiver services;

(12) “interim level of care review” means an evaluation of a recipient’s most recent documents related to receiving home and community-based waiver services, including the contents of the most recent application, the results of the recipient’s most recent assessment, medical records, and other relevant documents or observations, in order to determine if an applicant meets a level of care necessary to continue to qualify for home and community-based waiver services;

(13) “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;

(14) "natural supports" means

(A) individuals that, voluntarily and without payment, provide care and supports that enhance quality of life and foster community access and integration for the recipient; and

(B) the care and supports that are

(i) provided voluntarily and without pay for a recipient; and

(ii) similar to and supplemented by home and community-based waiver services;

(15) “person-centered intake” has the meaning given in 7 AAC 127.990(10);

(16) "primary caregiver" means an individual

(A) that lives in the same licensed residence as a recipient and provides care for a recipient; and

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

(17) "primary unpaid caregiver" means an individual that

(A) lives

(i) with a recipient in the same unlicensed residence; or

(ii) in a different residence and assists a recipient in the recipient's unlicensed residence;

(B) provides the oversight, care, and support needed by the recipient to prevent risk of institutionalization of that recipient, by assisting with the recipient's basic personal activities or with activities related to independent living; and

(C) does not receive payment for providing any other services for the recipient;

(18) "private residence" means a home that a recipient owns or rents, or a home where the recipient resides with other family members or friends;

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

(20) "recipient's representative" has the meaning given in 7 AAC 160.990(b);

(21) "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;

(22) "support plan" means a plan of care;

(23) “teleassessment” means the use of audio, visual, or data communication methods that are compliant with Title III of the Americans’ with Disabilities Act 28 CFR 36 to complete an assessment as defined in 7 AAC 130.319(3).

(Eff. 2/1/2010, Register 193; am 11/3/2012, Register 204; am 7/1/2013, Register 206; am 7/1/2015, Register 214; am 11/5/2017, Register 224; am 10/1/2018, Register 227; am____/____/____, Register____)

**Authority:** AS 47.05.010 AS 47.07.030 AS 47.07.040

## Chapter 160. Medicaid Program; General Provisions.

### 7 AAC 160.900. Requirements adopted by reference.

7 AAC 160.900(d)(31) is repealed:

(31) repealed ____/____/____;

(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; am 5/11/2012, Register 202; am 10/16/2012, Register 204; am 11/3/2012, Register 204; am 12/1/2012, Register 204; am 12/2/2012, Register 204; am 1/1/2013, Register 204; am 1/16/2013, Register 205; am 7/1/2013, Register 206; add'l am 7/1/2013, Register 206; am 11/3/2013, Register 208; am 1/1/2014, Register 208; am 2/2/2014, Register 209; am 3/19/2014, Register 209; am 3/22/2014, Register 209; am 5/18/2014, Register 210; am 2/26/2015, Register 213; am 3/15/2015, Register 213; am 7/1/2015, Register 214; am 5/1/2016, Register 218; am 6/16/2016, Register 218; am 6/16/2016, Register 218; am 7/22/2017, Register 223; am 11/5/2017, Register 224; am 3/1/2018, Register 225; am 10/1/2018, Register 227; am 1/1/2019, Register 228; am 3/24/2019, Register 229; am 6/2/2019, Register 230; am 6/13/2019, Register 230; am 7/1/2019, Register 231; am 10/25/2019, Register 232; am 11/10/2019, Register 232; am____/____/____, Register____)

**Authority:** AS 47.05.010 AS 47.07.030 AS 47.07.040
AS 47.05.012