

# DEPARTMENT OF HEALTH AND SOCIAL SERVICES



## *PROPOSED REGULATIONS*

### **MEDICAID HOME AND COMMUNITY-BASED WAIVER SERVICES 7 AAC 130**

**Public Review Draft**

**June 29, 2012**

**COMMENT PERIOD ENDS: August 3, 2012**

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

**NOTES TO READER:**

Except as noted below, when an existing regulations is being amended the proposed new text is **bolded and underlined**.

If the lead-in line above the regulations introduces the text as a *new* section, subsection, paragraph, or subparagraph, OR that an existing section, subsection, paragraph, or subparagraph is being “repealed and readopted” (replaced), *the new or replacement text is not bolded or underlined*.

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

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

7 AAC 130.200 is repealed and readopted to read:

**7 AAC 130.200. Purpose.** The purpose of 7 AAC 130.200 - 7 AAC 130.319 is to offer to individuals that meet the eligibility criteria in 7 AAC 130.205 the opportunity to choose to receive institutional care or home and community-based waiver services. (Eff. 2/1/2010, Register 193; am \_\_\_/\_\_\_/\_\_\_, Register \_\_\_)

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

7 AAC 130.205 is repealed and readopted to read:

**7 AAC 130.205. Eligibility for home and community-based services.**

(a) Except as provided in 7 AAC 130.200 - 7 AAC 130.319, the department will pay for home and community-based waiver services, provided in accordance with the applicable requirements of 7 AAC 130.200 - 7 AAC 130.319, 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 130.209.

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

(1) while the individual is an inpatient of a nursing facility, acute care hospital, or intermediate care facility for the mentally retarded (ICF/MR), except for screening under 7 AAC 130.211 and assessment under 7 AAC 130.212; 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 7 AAC 130.200 – 7 AAC 130.319.

(c) A recipient enrolled in the home and community-based waiver services

program is eligible to receive 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 fall into 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) require long-term care in a nursing facility for more than 30 days per year if the applicant does not receive home and community-based waiver services;

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

(D) experience 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 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 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 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

(A) be 65 years of age or older; or

(B) be 21 years of age or older and have a physical disability; and

(C) require a level of care provided in a nursing facility.

(Eff. 2/1/2010, Register 193; am \_\_\_/\_\_\_/\_\_\_, Register \_\_\_)

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

7 AAC 130 is amended by adding new sections to read:

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

(a) To apply for home and community-based waiver services under 7 AAC 130.200 – 7 AAC 130.310, an individual must submit a complete application for home and community-based waiver services to the department.

(b) The department will notify the applicant and care coordinator in writing of any missing information or documentation needed to make the application complete; the

notice will be sent no later than 14 business days after the date the application was received by the department. If the application is not complete 15 business days after the date of the notice of an incomplete application, the application will be denied.

(c) No later than 30 business days after the department determines that the application is complete, the department will

- (1) conduct an assessment under 7 AAC 130.212;
- (2) make a level of care determination under 7 AAC 130.212; and
- (3) notify the applicant and care coordinator of the level-of-care

determination. (Eff. \_\_\_/\_\_\_/\_\_\_, Register \_\_\_)

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

**7 AAC 130.208. Expedited application, assessment, level of care determination and plan of care.** (a) The department will conduct an expedited review of a complete application that indicates

- (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 an acute care hospital in seven days or less from 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 in the 30 days immediately preceding the date of application; or
  - (B) is absent due to the caregiver's hospitalization or emergency travel.

(b) The department will notify the applicant and care coordinator in writing of any missing information or documentation needed to make the application complete no later than five business days after the date the application was received by the department. If the application is not complete five business days after the date of the notice of an incomplete application, the application will be denied. The applicant may submit another complete application that will be processed in accordance with 7 AAC 130.207.

(c) No later than 10 business days after the department determines that the application is complete, the department will

- (1) conduct an assessment under 7 AAC 130.212;
- (2) make a level of care determination under 7 AAC 130.212; and
- (3) notify the applicant and care coordinator of the level of care

determination.

(d) No 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 130.213.

(e) The department will notify the recipient and the recipient's care coordinator

of the department's approval or disapproval of specific services no later than 10 days after the department receives the complete plan of care. (Eff. \_\_\_/\_\_\_/\_\_\_, Register \_\_\_)

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

**7 AAC 130.209. Enrollment in home and community-based services.** (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 that meets the eligibility requirements of 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 that is enrolled and eligible 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 130.216; and

(B) provides the home and community-based service for which the recipient is eligible.

(c) 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 (d)(1) of this section have been met, and the department makes a determination under (d)(2) of this section.

(d) Except for care coordination services under 7 AAC 130.240, the department will not make payment for home and community-based services that are payable under 7 AAC 130.200 – 7 AAC 130.319 unless

(1) the recipient is enrolled under this section; and

(2) the department determines that a home and community-based waiver services provider named in the plan of care

(A) is available to provide services to the recipient;

(B) is enrolled with the department in accordance with

7 AAC 105.210; and

(C) has the capacity to meet the service level approved under 7 AAC 130.213 as part of the plan of care.

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

(f) In this section, "complete application" means all the forms, identified by the department as constituting an application for home and community-based waiver services, that have been completed by the applicant and submitted to the department for

review. (Eff. \_\_\_/\_\_\_/\_\_\_, Register \_\_\_)

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

7 AAC 130.210 is repealed and readopted to read:

**7 AAC 130.210. Recipient disenrollment.** (a) 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 130.205(e) 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;

(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 130.214, 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) *Determination of Material Improvement for CCMC Waivers*, adopted by reference in 7 AAC 160.900, if the recipient is in the category of children with complex medical conditions;

(ii) *Determination of Material Improvement for IDD Waiver Services Recipients Under Age Three*, adopted by reference in 7 AAC 160.900, if the recipient is under age three and in the category of individuals with intellectual and developmental disabilities;

(iii) *Determination of Material Improvement for IDD Waiver Service Recipients Three and Older*, adopted by reference in 7 AAC 160.900, if the recipient is age three or older and in the category of individuals with intellectual and developmental disabilities;

(iv) *Determination of Material Improvement for ALI/APDD Waivers*, adopted by reference in 7 AAC 160.900, if the recipient is in the category of older adults or adults with physical disabilities or in the 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;

(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 130.213, or of placing caregivers or other recipients at risk of physical injury, and there are no other providers that 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 cannot obtain cooperation with service delivery or mitigate the risk of physical injury to a caregiver or other recipient 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.

(b) A recipient that is disenrolled from the home and community-based waiver services program for reasons described in (a) of this section may appeal that decision under 7 AAC 49. (Eff. 2/1/2010, Register 193; am \_\_\_/\_\_\_/\_\_\_, Register \_\_\_)

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

7 AAC 130 is amended by adding new sections to read:

**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 7 AAC 130.200 – 7 AAC 130.319. 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 the screening is conducted by a care coordinator, the care coordinator shall inform the recipient regarding the care coordinator's relationship as an employee of any provider certified under 7 AAC 130.216 and of any relationship described in 7 AAC 130.240(f).

(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 may 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 such significance the department is likely to reach a different decision regarding the applicant's need for home and community-based waiver services.

(Eff. \_\_\_/\_\_\_/\_\_\_, Register \_\_\_)

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

**7 AAC 130.212. Assessment and level of care determination.** (a) If warranted by the screening under 7 AAC 130.211 and if there is supportive diagnostic documentation, the department or the department's designee will conduct an assessment

of the applicant's physical, emotional, and cognitive functioning to determine, in accordance with 7 AAC 130.206, the

- (1) recipient category for which the applicant is eligible; and
- (2) level of care the applicant requires.

(b) The department will determine a recipient's level of care as follows, and will provide notice to the recipient and the recipient's care coordinator of the department's determination:

(1) for children with complex medical conditions, the department will determine whether the applicant requires a skilled nursing facility level of care under 7 AAC 140.515 or intermediate care facility level of care under 7 AAC 140.510; the level of care determination must incorporate the results of the department's *Nursing Facility Level of Care Assessment Form for Children*, adopted by reference in 7 AAC 160.900;

(2) for adults with physical and developmental disabilities, the department will determine whether the applicant requires a skilled nursing facility level of care under 7 AAC 140.515 or an intermediate care facility level of care under 7 AAC 140.510 and whether the applicant has both a physical disability and a developmental disability; the level of care determination must incorporate the results of the department's *Consumer Assessment Tool*, adopted by reference in 7 AAC 160.900

(3) for individuals with intellectual and developmental disabilities, the department will make a level of care determination under 7 AAC 140.600(c) - (d); for individuals three years of age or older, the level of care determination must incorporate the results of the *Inventory for Client and Agency Planning (ICAP)*, adopted by reference in 7 AAC 160.900, that is administered under 7 AAC 140.600(c) - (d); for individuals less than three years of age, the level of care determination must incorporate the results of an evaluation that is age appropriate, standardized and norm referenced, and includes a comparison of skills attainment to that of the individual's peers; or

(4) for older adults or adults with physical disabilities, the department will determine whether the applicant requires a skilled nursing facility level of care under 7 AAC 140.515 or intermediate care facility level of care under 7 AAC 140.510; the level of care determination must incorporate the results of the department's *Consumer Assessment Tool (CAT)*, adopted by reference in 7 AAC 160.900.

(c) 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 (a) of this section, the department will secure and pay for those services. (Eff. \_\_\_/\_\_\_/\_\_\_, Register \_\_\_)

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

**7 AAC 130.213. Plan of care development.** (a) After receiving the department's notice that the recipient meets the level of care requirement under 7 AAC 130.212, 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 130.216 and of any relationship described in

7 AAC 130.240(f);

(B) the full range of 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 with a planning team that

(A) at a minimum, includes

(i) the recipient;

(ii) the recipient's representative; and

(iii) a representative of each certified provider that is expected to provide services to the recipient; 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 certified providers 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 service,

(i) the certified provider 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 conducted and the level of care determination made in accordance with 7 AAC 130.212; and

(ii) any treatment plans developed for the recipient;

(4) support the plan of care developed under this subsection with appropriate and contemporaneous documentation that

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

(B) justifies the recipient's need for home and community-based waiver services;

(5) secure the signature of

(A) the recipient or recipient's representative indicating that the recipient or recipient's representative agrees to the plan of care;

(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

(6) no later than 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 130.212, 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.

(b) The department will approve a plan of care if the department determines that

(1) each service listed on the plan of care

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

(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 7 AAC 130.200 – 7 AAC 130.319; and

(2) if nursing oversight and care management services are to be provided, a nursing plan in accordance with 7 AAC 130.235 is included.

(c) The department will notify the recipient and the recipient's care coordinator of the department's approval or disapproval of specific services no later than 30 days after the department receives the complete plan of care. (Eff. \_\_/\_\_/\_\_, Register \_\_)

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

**7 AAC 130.214. Recipient reassessment.** (a) The department will reassess a recipient's need for home and community-based waiver services at least annually to determine if the recipient continues to meet the eligibility requirements of 7 AAC 130.205, and will notify the recipient and the recipient's care coordinator of the determination.

(b) No later than 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 under this section, the care coordinator shall

(1) prepare a new plan of care that

(A) incorporates the findings of the reassessment; and

(B) meets the requirements of 7 AAC 130.213; and

(2) submit the new 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.

(c) 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 130.212, the department will forward the reassessment for review by an independent qualified health care professional in accordance with 7 AAC 130.210(a)(4).

(d) If the department determines that translation services for a non-English speaking applicant or interpretation services for a deaf applicant are necessary for a reassessment under (a) of this section, the department will secure and pay for those services. (Eff. \_\_\_/\_\_\_/\_\_\_, Register \_\_\_)

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

**7 AAC 130.215. Plan of care amendment.** (a) A recipient's care coordinator shall

(1) prepare an amendment to the recipient's plan of care

(A) if 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) because the recipient needs an increase or decrease in the number of service units approved under 7 AAC 130.213 or in a prior amendment to the plan of care;

(2) convene a comprehensive planning team under 7 AAC 130.213 to participate in preparing the amendment to the plan of care;

(3) secure the signature of

(A) the recipient or recipient's representative indicating that the recipient or recipient's representative agrees to the plan of care amendment;

(B) each provider representative indicating the provider agrees to render the services as specified in the plan of care amendment; and

(C) each individual on the planning team to verify participation in the development of the recipient's plan of care amendment; 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 amendment, must be documented and attached to the plan of care amendment submitted to the department for consideration and approval; and

(4) submit the plan of care amendment to the department no later than 10 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.

(b) The department will approve or deny an amendment to a plan of care in accordance with 7 AAC 130.213. (Eff. \_\_\_/\_\_\_/\_\_\_, Register \_\_\_)

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

**7 AAC 130.216. Provider certification.** (a) To be certified by the department,

a provider must

- (1) submit an application on a form provided by the department;
- (2) meet the applicable certification criteria, including provider qualifications and program standards, set out in the department's *Conditions of Participation*, adopted by reference in 7 AAC 160.900; and
- (3) enroll in the Medicaid program under 7 AAC 105.210.

(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, all individuals employed by that agency to provide care coordination services must be certified separately and individually under this section;

(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 services; or
- (2) two years for a currently certified provider that is renewing that provider's certification.

(d) No later than 90 days before the expiration of a provider's certification, the department will send the provider notice of the requirement to renew that certification. The provider must submit a new application for certification and all required documentation no later than 60 days before the expiration date of the 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 no 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 determines that the owner or the administrator of an agency does not operate honestly, responsibly, and in accordance with applicable laws and regulations 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 service provider's compliance with the requirements of 7 AAC 130.200 – 7 AAC 130.319, including the *Conditions of Participation*, adopted by reference in 7 AAC 160.900.

(g) If the department finds that a provider is not in compliance with the requirements of 7 AAC 130.200 – 7 AAC 130.319, the department may

(1) issue the department's finding 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;

(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 timeframe given, 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 provider of a home and community-based waiver service under 7 AAC 130.200 – 7 AAC 130.319

(1) if the department determines that the provider is no longer qualified for certification as required under this section 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 in the department's *Conditions of Participation*, adopted by reference in 7 AAC 160.900; 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 re-enrollment; or

(2) decertify the provider. (Eff. \_\_\_/\_\_\_/\_\_\_, Register \_\_\_)

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

**7 AAC 130.217. Recipient safeguards.** A provider of home and community-based waiver services, certified under 7 AAC 130.216, shall be

(1) responsible for protecting a recipient's health, safety, and welfare while rendering a service under 7 AAC 130.200 - 7 AAC 130.319; and

(2) subject to, and shall provide training for all employees regarding the reporting requirements of this section and the mandatory reporting requirements of AS 47.17.020 for children and AS 47.24.010 for vulnerable adults. (Eff. \_\_\_/\_\_\_/\_\_\_, Register \_\_\_)

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

**7 AAC 130.218. Critical incident reporting.** (a) A provider shall report to the department on a form provided by the department, a critical incident involving a recipient no later than 24 hours after observing or learning of the critical incident.

(b) A provider shall develop and implement a system to manage and report critical incidents that include the following:

(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 all provider staff are 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;

(4) use of restrictive interventions that resulted in the need for medical intervention;

(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;

(8) an event that involved the recipient and a response from a law enforcement officer. (Eff. \_\_\_/\_\_\_/\_\_\_, Register \_\_\_)

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

**7 AAC 130.219. Medication administration.** (a) A provider of the following home and community-based waiver services shall provide medication administration as an integral part of the following home and community-based waiver 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, except for

services provided in a foster home or assisted living home licensed under AS 47.32;

- (4) supported-employment services under 7 AAC 130.270;
- (5) intensive active treatment services under 7 AAC 130.275; and
- (6) respite care services under 7 AAC 130.280.

(b) The requirements of (a) of this section do not apply to a recipient that administers the recipient's own medication without assistance.

(c) A provider of the services listed in (a) of this section shall be responsible for medication administration when

(1) a medication, prescribed by a health care professional listed in (e) of this section, is time sensitive and may not be delayed or is 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 130.213 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 medication is required by the recipient; and

(5) the individual that provides medication administration has completed the training requirements of (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 one of the following delegating authorities:

(A) the recipient or recipient's representative; or

(B) an individual with a valid license under AS 08 to practice as a nurse, advanced nurse practitioner, physician, physician assistant, or dentist;

(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 each medication;

(E) individual to notify in the event of an adverse reaction to a medication;

(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 should be notified before the medication is administered.

(f) Each individual that provides medication administration must have on file, with the department or the provider, written verification of attendance and successful completion of the following training appropriate to 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 an administration of medication training course that includes the content outlined in the Alaska Board of Nursing *Medication Administration Course Requirements*, adopted by reference in 7 AAC 160.900, and that has been approved by the department.

(g) An individual providing medication administration under this section must document the following information in the recipient's record for all medication taken by the recipient while the recipient is in the care of the individual:

(1) name of the medication;

(2) dosage administered;

(3) time of administration;

(4) name of the individual that assisted the recipient with the recipient's self-administration of medication or administered medication to the recipient;

(5) the written delegation under (e) 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 the following:

(1) a plan for documenting and tracking medication errors;

(2) a requirement for reporting, as a critical incident under (b) of this section, 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 130.216 or upon request.

(i) 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 autoinjector 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

- (A) prescribed for a recipient by an individual 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; and
- (B) intended to be taken by the recipient at a scheduled time or as needed;

(4) "medication administration" means the delivery of medication by a provider to a recipient that is unable to administer medication independently; the term encompasses both assistance with the recipient's self-administration of medication and 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) 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. (Eff. \_\_/\_\_/\_\_, Register \_\_)

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

7 AAC 130.220 is repealed:

**7 AAC 130.220. Provider certification and enrollment.** Repealed. (Eff. 2/1/2010, Register 193; repealed \_\_/\_\_/\_\_, Register \_\_)

7 AAC 130 is amended by adding new sections to read:

**7 AAC 130.221. Use of restrictive intervention.** (a) A provider may use restrictive intervention

(1) in the following circumstances only:

(A) as a response when a recipient presents an imminent danger to the recipient's safety or the safety of others;

(B) as an element of a behavior support plan;

(2) when other types of interventions have been tried, and documented to be ineffective;

(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) A provider may elect to exclude the use of

(1) specific types of restrictive interventions, but must define which are permitted and which are excluded in the provider's policies and procedures; or

(2) all types of restrictive interventions, but must establish a protocol to follow in the event a recipient presents an imminent danger to the recipient's safety or the safety of others.

(c) A provider that plans to use restrictive intervention 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) training in the use of restrictive intervention;

(3) documentation of all events that involve the use of restrictive intervention;

(4) supervision of individuals that use restrictive intervention while recipients are in the care of or receiving services from the provider; and

(5) monitoring and evaluation of each use of restrictive intervention.

(d) An individual that uses restrictive intervention must have on file with the provider, written verification of training appropriate to the type of restrictive intervention that the provider has elected to use.

(e) An individual that uses restrictive intervention shall document the following information in the recipient's record:

(1) the date and time;

(2) a description of the behavior that lead to the use of restrictive intervention;

(3) a rationale for and a description of each type of restrictive intervention used;

(4) the recipient's response to each type of restrictive intervention used; and

(5) the names of all staff involved in the restrictive intervention.

(f) 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; and

(3) the outcome for the recipient and for the staff involved in the event.

(g) The provider shall develop and implement a system to manage and report the use of restrictive intervention that includes the following:

(1) a plan for documenting and tracking the use of restrictive intervention;  
(2) requirements for reporting critical incidents, the misuse of restrictive intervention, or 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 130.216, or upon request.

(h) In this section

(1) "behavior support plan" means a plan developed for a recipient that is designed to guide or alter behavior in a systematic way, that aims to prevent and decrease the frequency of behaviors referenced in the support plan through various approaches, and that provides for the implementation for restrictive intervention only when other approaches would not be effective;

(2) "restrictive intervention" means an action or procedure that limits an individual's movement or access to other individuals, locations, or activities.

(Eff. \_\_\_/\_\_\_/\_\_\_, Register \_\_\_)

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

7 AAC 130.225 is repealed:

**7 AAC 130.225. Provider disenrollment and decertification.** Repealed.

(Eff. 2/1/2010, Register 193; repealed \_\_\_/\_\_\_/\_\_\_, Register \_\_\_)

7 AAC 130 is amended by adding new sections to read:

**7 AAC 130.226. Services during temporary absence.** (a) The department will pay for home and community-based waiver services, rendered by a provider certified under 7 AAC 130.216 to a recipient, during a recipient's temporary absence from the recipient's community whether the recipient travels to another location within the state or to an out-of-state destination, if the services

(1) 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); or

(D) hourly respite services under 7 AAC 130.280;

(2) are approved under 7 AAC 130.213 as part of the recipient's plan of care; and

(3) receive prior authorization.

(b) The department may approve services for a recipient under this section if the following conditions are met:

(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 licensed physician;

(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 under 7 AAC 130.213; or

(C) a vacation;

(4) the absence will not exceed 30 days in any 365 day period;

(5) the recipient meets the requirements of 7 AAC 100.064 if travel is to be out-of-state; and

(6) the provider of services 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 in any 365 day period if

(1) a licensed physician justifies a longer temporary absence as a medical necessity under (b)(3)(A) of this section; or

(2) the department determines 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) services during the recipient's temporary absence if the need for those services is not established under (b)(1) of this section;

(2) transportation, room and board, or any other expenses for any individual providing services under this section; or

(3) any services provided in any location other than in the 50 states of the United States, the District of Columbia, Puerto Rico, U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. (Eff. \_\_/\_\_/\_\_, Register \_\_)

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

**7 AAC 130.227. Provider termination of services to a recipient.** (a) 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 no later than 30 days before the date of service termination.

(b) A provider that intends to close, sell, or change ownership of a home and community-based waiver services provider business shall send written notice of such intention to the department and to all affected recipients no later than 60 days before the closure, sale, or change in ownership. (Eff. \_\_\_/\_\_\_/\_\_\_, Register \_\_\_)

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

7 AAC 130.230 is repealed:

**7 AAC 130.230. Screening, assessment, level-of-care determination, and plan of care.** Repealed. (Eff. 2/1/2010, Register 193; repealed \_\_\_/\_\_\_/\_\_\_, Register \_\_\_)

7 AAC 130.235 is repealed and readopted to read:

**7 AAC 130.235. Nursing oversight and care management services.** (a) Nursing oversight and care management services are required 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, with the exception of the age requirement, the criteria for the recipient category for children with complex medical conditions under 7 AAC 130.205.

(b) The department will pay for nursing oversight and care management services that

(1) are approved under 7 AAC 130.213 as part of the recipient's plan of care;

(2) receive prior authorization;

(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) To qualify for payment for nursing oversight and care management services, a registered nurse shall

(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 safety;

(B) recipient's medical care needs; and

(C) training required for paid and unpaid caregivers;

(3) participate in planning the recipient's care in accordance with

7 AAC 130.213;

(4) provide oversight by evaluating whether services

(A) are delivered according to 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 that nursing duties were delegated to shall be in attendance.

(d) The department will not pay

(1) for more than four units of service for the nursing plan under (c)(2) of this section at the local rate for nursing oversight and care management services under 7 AAC 160.900(d)(10); or

(2) separately for services under this section that duplicate

(A) specialized private duty nursing services under 7 AAC 120.525 or 7 AAC 130.285;

(B) private-duty nursing services under 7 AAC 110.525; or

(C) intensive active treatment service under 7 AAC 130.275.

(Eff. 2/1/2010, Register 193; am \_\_\_/\_\_\_/\_\_\_, Register \_\_\_)

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

7 AAC 130.240 is repealed and readopted to read:

**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 130.213 as part of the recipient's plan of care.

(b) An employee of a certified care coordination agency provider must be certified as a care coordinator with the department in accordance with 7 AAC 105.210. Before an employee of a care coordination provider agency may provide care coordination services, the care coordination agency provider must

(1) be certified with the department in accordance with 7 AAC 130.216;

(2) 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 and certification standards to provide care coordination services.

(c) The department will pay for the following care coordination services for a recipient:

(1) one plan of care in any 365 day period, provided that the plan of care is accompanied by the form required under 7 AAC 130.209(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 130.213, except that the department will pay for a plan of care

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

(B) that was developed based on the choice of service form required under 7 AAC 130.209(b)(1), but cannot be approved by the department because home and community-based waiver services are not available under 7 AAC 130.205(b); and

(2) a monthly case management service rate, established in accordance with 7 AAC 145.520, provided 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 one in-person visit with the recipient per month, unless the department waives the visit under (e) of this section;

(B) notwithstanding the grant of a visit waiver under (e) of this section, meets the recipient in person to monitor service delivery at least once per calendar quarter and to develop the annual plan of care, which may be accomplished 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.

(d) The department will pay a care coordinator, beginning with the first month that the recipient is enrolled under 7 AAC 130.209 and has a plan of care approved under 7 AAC 130.213, for the following ongoing care coordination services provided in accordance with (c) 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 130.213;

(5) coordinating multiple services and providers; and

(6) assisting the recipient in case terminations.

(e) 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 amounts to or exceeds 50 percent of the payment for all care coordination services for all recipients that receive such 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) no local care coordinator is available; or, if present, no local care coordinator is willing or able to provide services to the recipient; and

(3) the health, safety, and welfare of the recipient will not be compromised by infrequent, in-person contacts.

(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 certified under 7 AAC 130.216.

(g) The department will

(1) 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; and

(2) 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.

(h) The care coordinator shall notify the department no more than seven days after

(1) the date of a recipient's admission to a general acute care hospital; and

(2) the date of a recipient's discharge from a general acute care hospital.

(i) Notwithstanding (c) of this section, the department will pay for additional assessments, or plans of care that have received prior authorization.

(j) In this section,

(1) "close business relationship" means

(A) having a five percent or greater ownership, partnership, or equity interest in another provider or its owner; or

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

(2) "close familial relationship" means a relationship with

(A) the individual's spouse, parent, sibling, or child; or

(B) spouse of the individual's parent, sibling, or child;

(3) "owner" means a person having a five percent or greater ownership, partnership, or equity interest. (Eff. 2/1/2010, Register 193; am \_\_\_/\_\_\_/\_\_\_, Register \_\_\_)

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

7 AAC 130.245 is repealed and readopted to read:

**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 130.213 as part of the recipient's plan of care;

(3) receive prior authorization; and

(4) do not exceed

(A) 520 hours per plan duration, based on a maximum of 10 hours per week, for recipients in the following recipient categories:

(i) adults with physical and developmental disabilities; and

(ii) older adults or adults with physical disabilities; or

(B) 260 hours per plan duration, based on a maximum of five hours per week, for recipients in the following recipient categories:

(i) children with complex medical conditions; however, if a recipient in this program has a documented history of respiratory illness, the department will pay for chore services not to exceed 520 hours per plan duration, based on a maximum of 10 hours per week; and

(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; and

(G) 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 recipients 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, 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 certified chore provider resides in the same residence as the recipient of chore services.

(d) If a recipient is eligible for chore service 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. (Eff. 2/1/2010, Register 193; am \_\_\_/\_\_\_/\_\_\_, Register \_\_\_)

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

7 AAC 130.250 is repealed and readopted to read:

**7 AAC 130.250. Adult day services.** (a) The department will pay for adult day services that

(1) are provided to recipients in the following 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 130.213 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 non-institutional community setting on a regular basis for three consecutive hours per half-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 services performed by

- (1) personal care assistants under 7 AAC 125.010 - 7 AAC 125.199; or
- (2) other home and community-based waiver services. (Eff. 2/1/2010, Register 193; am \_\_\_/\_\_\_/\_\_\_, Register \_\_\_)

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

7 AAC 130.255 is repealed and readopted to read:

**7 AAC 130.255. Residential supported-living services.** (a) The department will pay for residential supported-living services that

- (1) are provided to recipients in the following 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 Conditions of Participation*, adopted by reference in 7 AAC 160.900;
- (3) are approved under 7 AAC 130.213 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 with the activities of daily living and supportive services, including social and recreational activities in the assisted living home; and
- (3) are designed for a recipient that
  - (A) can no longer live alone, but does not need the degree of care

provided by a nursing facility; and

(B) without the services, would require placement in a nursing facility for lack of alternate placements.

(c) 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 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. (Eff. 2/1/2010, Register 193; am \_\_\_/\_\_\_/\_\_\_, Register \_\_\_)

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

7 AAC 130.260 is repealed and readopted to read:

**7 AAC 130.260. Day habilitation services.** (a) The department will pay for day habilitation services that

(1) are provided to a recipient in 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 130.213 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 non-residential setting, separate from the recipient's private residence or another residential setting, to a recipient individually or as a member of a group of two or more;

(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;

(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) Notwithstanding (b)(1) of this section, the department may waive the requirement for provision of day habilitation services in a non-residential 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. (Eff. 2/1/2010, Register 193; am \_\_\_/\_\_\_/\_\_\_, Register \_\_\_)

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

7 AAC 130.265 is repealed and readopted to read:

**7 AAC 130.265. Residential habilitation services.** (a) The department will pay for residential habilitation services that

- (1) are provided to recipients 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 130.213 as part of the recipient's plan of care;
- (4) receive prior authorization; and
- (5) meet the requirements specified in (c), (e), (g) or (i) of this section.

(b) The department will consider a service to be a residential habilitation service if the service

- (1) assists the recipient to reside in the most integrated setting appropriate to the recipient's needs;
- (2) meets scheduled and unpredictable recipient needs;
- (3) provides supervision, safety, and security;
- (4) assists the recipient with acquisition, retention, or improvement of age-appropriate skills related to living in the community;
- (5) is an individually tailored support, including
  - (A) adaptive skill development;

- (B) assistance with activities of daily living;
- (C) assistance with instrumental activities of daily living;
- (D) community inclusion;
- (E) transportation;
- (F) adult educational supports;
- (G) social and leisure skill development; and
- (H) personal care;

(6) is provided as a

- (A) family home habilitation service described in (c) of this section;
- (B) supported-living habilitation service described in (e) of this section;
- (C) group-home habilitation service described in (g) of this section; or
- (D) in-home support habilitation service described in (i) of this section.

(c) The department will consider 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 is not at risk because of the primary caregiver's other obligations;

(3) a caregiver in the residence, paid or unpaid, is not a member of the recipient's immediate family; and

(4) the services are provided to a recipient that spends more than 50 percent of the time in the family home habilitation services site.

(d) The department will pay for family home habilitation services under (c) 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

(A) two recipients in the children with complex medical conditions recipient category; however, the total number may be exceeded to allow placement of siblings in the same residence as the recipients;

(B) three recipients in the adults with physical and developmental disabilities recipient category; however, the total number may be exceeded to allow placement of siblings in the same residence as the recipients; or

(C) three recipients in the individuals with intellectual and developmental disabilities recipient category; however, the total number may be exceeded to allow placement of siblings in the same residence as the recipients;

(2) the department will not make separate payment for the following services:

- (A) chore services under 7 AAC 130.245;
- (B) family-directed respite 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, or by a member of the family of the resident primary caregiver.

(e) The department will consider 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.

(f) The department will pay for supported living services under (e) of this section subject to the following limitations:

(1) the department will not pay for more than 18 hours per day of supported-living services, unless the department determines that the recipient is unable to benefit from

- (A) other home and community-based waiver services; or
- (B) services provided by family members or community supports;

(2) other individuals may render direct care services after providing written assurance to the department 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) meals services under 7 AAC 130.295;

(g) The department will consider 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 home licensed as an assisted living home for two or more residents under AS 47.32 that provides 24-hour care;

(h) The department will pay for group-home habilitation services under (g) of this section subject to the following limitations:

(1) the department will not pay for more than 15 hours per week of day habilitation services under 7 AAC 130.260 for a recipient, unless the department determines that the recipient is unable to benefit from any other home and community-based waiver service;

(2) services rendered by the provider under (b)(4) and (b)(5) of this section, whether in the group home or in the community, may not be billed separately as day habilitation services under 7 AAC 130.260; and

(3) the department will not make separate payment for the following services:

- (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) meals services under 7 AAC 130.295; or

(E) services provided by another resident of the group home, or by a member of the family of the resident primary caregiver.

(i) The department will consider 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.

(j) The department will pay for in-home support habilitation services under (i) of this section, except that 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) meals services under 7 AAC 130.295; or

(5) services provided by another resident of the home, by a member of the family of the recipient, or by the primary unpaid caregiver.

(k) 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 (Eff. 2/1/2010, Register 193; am \_\_\_/\_\_\_/\_\_\_, Register \_\_\_)

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

7 AAC 130.270 is repealed and readopted to read:

**7 AAC 130.270. Supported-employment services.** (a) The department will pay for supported-employment services that

(1) are provided to a recipient in one of the following recipient categories:

(A) children with complex medical conditions;

(B) adults with physical and developmental disabilities;

(C) individuals with intellectual and developmental disabilities;

(2) are provided to a recipient individually or as a member of a group of two or more;

(3) are approved under 7 AAC 130.213 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

(4) 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

(A) where individuals without disabilities are employed; or

(B) where 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) more than three months of services under (b)(1) of this section;
  - (4) accommodations routinely provided by the employer to employees; or
  - (5) 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). (Eff. 2/1/2010, Register 193; am \_\_\_/\_\_\_/\_\_\_, Register \_\_\_)

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

7 AAC 130.275 is repealed and readopted to read:

**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 130.213 as part of the recipient's plan of care;
- (3) that receive prior authorization;
- (4) that do not duplicate other Medicaid services; and
- (5) 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 service 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, whose services are not otherwise covered under Medicaid or as day habilitation services under 7 AAC 130.260 or residential habilitation services under 7 AAC 130.265; and

(4) provide 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 on-going, 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 other health-related providers or of caregivers. (Eff. 2/1/2010, Register 193; am 3/1/2011, Register 197; am \_\_\_/\_\_\_/\_\_\_, Register \_\_\_)

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

7 AAC 130.280 is repealed and readopted to read:

**7 AAC 130.280. Respite care services.** (a) The department will pay for respite care services that

(1) are approved under 7 AAC 130.213 as part of the recipient's plan of care;

(2) are provided in accordance with the department's *Respite Services Conditions of Participation*, adopted by reference in 7 AAC 160.900;

(3) receive prior authorization; and

(4) do not exceed the following limits:

(A) 14 days of daily respite care services per plan duration; and

(B) 520 hours of hourly respite care services per plan duration, unless the recipient would be at risk of institutionalization without additional respite services.

(b) The department will consider services to be respite care services if the services are provided in the recipient's home or at another location to relieve

(1) unpaid primary caregivers that provide

(A) at least 40 hours of care per to recipients in the following categories:

(i) children with complex medical conditions;

(ii) adults with physical and developmental disabilities;

and

(iii) individuals with intellectual and developmental disabilities; or

(B) at least 20 hours of care per week to recipients in the recipient category of older adults or adults with physical disabilities; however, the department will not pay for respite care services for unpaid primary caregivers if

(i) the recipient can provide for the recipient's own care for a portion of the day adequate for the primary caregiver's respite, or if other caregivers are available to provide care while the primary caregiver is not providing care; or

(ii) the recipient is not dependent on the care of the primary unpaid caregiver in order to live in the recipient's residence, and would not be at risk for placement in a more restrictive setting without that care;

(2) providers of family home habilitation services under 7 AAC 130.265(c), except that those providers are not eligible for family-directed respite services under (d) of this section; or

(3) foster parents licensed under AS 47.32.

(c) The department will pay for the following services or expenses incurred at the same time respite care services under this section are provided:

(1) room and board expenses if respite care services are provided in

(A) a nursing facility;

(B) a general acute care hospital;

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

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

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

(2) day habilitation services under 7 AAC 130.260 or residential habilitation services under 7 ACC 130.265, if the recipient would be at risk of institutionalization without additional services because

(A) the department has determined that the supports provided by unpaid caregivers do not meet the needs of the recipient, or

(B) out of home daily or hourly respite care services appropriate for the recipient are not available.

(d) The department will pay for family-directed respite care services if the services are

(1) provided to recipients in one of the following recipient categories:

- (A) children with complex medical conditions; and
  - (B) individuals with intellectual and developmental disabilities;
  - (2) managed by a home and community-based waiver services provider
- that
- (A) is certified to provide respite care services under 7 AAC 130.216;
  - (B) has on file a letter of agreement acknowledging responsibility under this subsection
    - (i) for complying with the requirements of AS 47.05.017;
    - (ii) for ensuring that the family's retention and direction of an individual to provide respite care services under this subsection is in accordance with municipal, state, and federal law relating to employment, including applicable provisions of 26 U.S.C. (Internal Revenue Code); and
    - (iii) for protecting the health, safety and welfare of the recipient; and
  - (C) pays the individuals that provide family-directed respite care services; and
  - (3) directed by an unpaid primary caregiver that
    - (A) identifies and trains the individual that will provide family-directed respite care services;
    - (B) completes and signs timesheets for individuals providing family-directed respite care services;
    - (C) provides, 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 unpaid primary caregiver understands the risk that the unpaid primary caregiver assumes for family-directed respite care services; and
    - (D) does not identify, train, or sign timesheets for individuals that provide family-directed respite care services for other recipients.
  - (e) The department will not pay for
    - (1) out-of-home daily respite care services as family-directed respite care services; or
    - (2) respite care services or family-directed respite care services
      - (A) to relieve paid caregivers;
      - (B) to provide oversight for any individual that is not a home and community-based waiver services recipient;
      - (C) to provide hourly respite care services to recipients receiving residential supported living services under 7 AAC 130.255;
      - (D) provided at the same time the recipient is receiving personal care services under 7 AAC 125.010 - 7 AAC 125.199.
  - (f) In this section,
    - (1) "daily respite care services" means continuous respite care services for 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 that is

- (A) retained by the family of the recipient; and
- (B) paid by a home and community-based waiver services

provider;

(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;
- (D) an assisted living home licensed under AS 47.32; or
- (E) a foster home licensed under AS 47.32. (Eff. 2/1/2010,

Register 193; am \_\_\_/\_\_\_/\_\_\_, Register \_\_\_)

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

7 AAC 130.285 is repealed and readopted to read:

**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 enrolled 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 130.213 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, other than a certified nurse aide, licensed under AS 08.68;

(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 110.539; or

(2) an individual that is an employee of the provider certified under 7 AAC 120.216, and that is subject to the requirements of 7 AAC 110.520(b), is not enrolled individually and separately. (Eff. 2/1/2010, Register 193; am \_\_\_/\_\_\_/\_\_\_, Register \_\_\_)

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

7 AAC 130.290 is repealed and readopted to read:

**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 130.213 as part of the recipient's plan of care;

(3) receive prior authorization; and

(4) are provided in a vehicle that is owned or commercially leased by an agency certified for home and community-based services under 7 AAC 130.216.

(b) The department will consider services to be transportation services if the services enable a recipient and a necessary escort, that receives prior authorization under (a)(3) of this section, to travel round-trip between the recipient's residence and a destination where home and community-based waiver services are provided in the recipient's community or to other community services and resources that are identified in the recipient's plan of care.

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

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

(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.

(d) In this section, "escort" means an individual that accompanies a recipient to or from a location where a home and community-based waiver service is provided to the recipient or to or from other community services and resources while using a transportation provider certified under 7 AAC 130.216. (Eff. 2/1/2010, Register 193; am \_\_\_/\_\_\_/\_\_\_, Register \_\_\_)

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

7 AAC 130.295 is repealed and readopted to read:

**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 130.213 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.

(c) The department will pay for a maximum of two meals per day for a recipient under this section. (Eff. 2/1/2010, Register 193; am \_\_\_/\_\_\_/\_\_\_, Register \_\_\_)

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

7 AAC 130.300 is repealed and readopted to read:

**7 AAC 130.300. Environmental modification services.** (a) The department will pay for environmental modification services that

(1) are approved under 7 AAC 130.213 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 recipient's residence and 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;

(2) are rendered by a provider certified under 7 AAC 130.216 that is, or may subcontract with,

(A) a construction contractor registered and bonded under AS 08.18; or

(B) a tribal housing authority; and

(3) include the purchase and installation of all materials, supplies, and equipment required for the environmental modification approved under (c) of this section.

(c) The department

(1) will pay no more than a total of \$18,500 for all environmental modifications for a recipient in the three year period beginning July 1, 2012 and ending June 30, 2015, regardless of the approval, beginning, or completion date of the recipient's first environmental modification during that period; thereafter, the department will pay no more than a total of \$18,500 for all environmental modifications for a recipient in any three year period beginning July 1 of one year and ending June 30 of the third year;

(2) may pay for an environmental modification in excess of the limit established in this subsection if the expenditure

(A) 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;

(B) results solely from the cost of freight to deliver materials and supplies to a remote community or location; or

(C) results from costs of shipping items that are needed for the

environmental modification, but are not available in the recipient's community;  
and

(3) may authorize an environmental modification for

(A) rental property that is the recipient's residence if the owner of the property consents to the physical adaptations proposed for the property; and

(B) the residence of each parent or guardian that has joint custody of a recipient, and the recipient lives in each residence for any period of time; and

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

(d) In addition to payment for the environmental modification, the department will pay an administrative fee under 7 AAC 145.520(c) to an environmental modification services provider that is acting in an administrative capacity if that provider

(1) is certified under 7 AAC 130.216;

(2) is an organized health care delivery system under 42 C.F.R. 447.10;

(3) oversees the purchase of an environmental modification for a recipient; and

(4) upon completion of the environmental modification, verifies that the environmental modification is in compliance with the requirements of 13 AAC 50 and 13 AAC 55, and any applicable municipal building codes.

(e) Any funds approved by the department but unused when the environmental modification is completed will not be credited to, or available for another use by, the recipient or the environmental modification services provider.

(f) 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.

(g) The department will not be responsible for removal of an environmental modification should the recipient cease to reside at a residence in which physical adaptations have been made under this section.

(h) The department will not pay for the following services under this section:

(1) environmental modifications that

(A) increase the square footage of an existing residence;

(B) are part of a larger renovation to an existing residence; or

(C) are included in construction of a new residence;

(2) any modification to a residential facility that is owned or leased by a provider of home and community-based waiver services;

(3) general utility adaptations, modifications, or improvements to the existing residence unless necessary to reduce the risk of serious injury or illness to the recipient when other practical modification is not available; for purposes of this paragraph, general utility adaptations, modifications, or improvements includes

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

(5) duplicate accessibility modifications to the same residence;

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

(7) installed back-up generator systems;

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

(9) modifications that supplant equipment or items, already provided through any other means, that are primarily for the convenience of the recipient or caregiver. (Eff. 2/1/2010, Register 193; am \_\_\_/\_\_\_/\_\_\_, Register \_\_\_)

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

7 AAC 130.305 is repealed and readopted to read:

**7 AAC 130.305. Specialized medical equipment.** (a) The department will pay for specialized medical equipment that

(1) is supported by written documentation

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

(i) a physician, including an osteopath;

(ii) a physician assistant;

(iii) an advanced nurse practitioner;

(iv) an occupational therapist; or

(v) a physical therapist;

(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 130.213 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

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

(2) is 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 cost of repair, modification, or adaptation of equipment and any

associated shipping costs may be paid as separate units of service;

(3) 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;

(4) 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;

(5) once purchased, specialized medical equipment becomes the property of the recipient;

(6) the department will not give prior authorization to replace specialized medical equipment before 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. (Eff. 2/1/2010, Register 193; am 3/1/2011, Register 197; am \_\_\_/\_\_\_/\_\_\_, Register \_\_\_)

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

7 AAC 130.310 is repealed:

**7 AAC 130.310. Restriction on residential supported-living services payment.** Repealed. (Eff. 2/1/2010, Register 193; repealed \_\_\_/\_\_\_/\_\_\_, Register \_\_\_)

7 AAC 130.319 is repealed and readopted to read:

**7 AAC 130.319. Definitions.** In 7 AAC 130.200 - 7 AAC 130.319,

(1) "activities of daily living" means basic personal activities, including bathing, dressing, transferring, such as from a bed to a chair, toileting, mobilization, and eating;

(2) "care coordination" means those services provided in accordance with 7 AAC 130.240 by an individual that the department has enrolled under 7 AAC 130.240(b);

(3) "care coordination agency provider" means a provider that the department has certified under 7 AAC 130.216 to provide care coordination services under 7 AAC 130.240;

(4) "developmental disabilities" means the severe, chronic disabilities that meet the criteria identified in the definition of "person with a developmental disability" in AS 47.80.900;

(5) "habilitation services" means services that

(A) help a recipient to acquire, retain, or improve skills related to activities of daily living 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;

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

(7) "instrumental activities of daily living" means activities related to independent living, including meal preparation, money management, shopping, housework, and communication;

(8) "intellectual and developmental disabilities" means

(A) mental retardation as defined in 7 AAC 140.600(c)(1); and

(B) developmental disabilities as defined in this section;

(9) "primary caregiver" means an individual that lives in the same unlicensed residence as a recipient and provides care for a recipient, or an individual that lives in a different residence and provides care in the recipient's residence; a primary caregiver assists with or provides the care described as activities of daily living and instrumental activities of daily living;

(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) "remote community or location" means a community or location that is not connected to the state highway system, including the Alaska Marine Highway system; however, a community or location is not considered to be remote if it is on a road system that connects two or more communities or locations, but does not connect to the state highway system, and the materials, supplies, or services needed are available in one of the communities or locations;

(13) "residential supported-living services provider" means a provider that the department has certified under 7 AAC 130.216 to provide residential supported-living services under 7 AAC 130.255. (Eff. 2/1/2010, Register 193; am \_\_/\_\_/\_\_, Register \_\_)

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

7 AAC 145.520(e) is amended to read:

(e) For environmental modification services provided under 7 AAC 130.300, the department will pay 100 percent of billed charges to a home and community-based [WAIVER] services provider **that oversees the purchase and installation of an environmental modification project for a recipient**. In addition, the department will pay the provider an administrative fee of two percent of billed charges or **\$100**, [\$50]whichever is greater, if the provider **is**

(1) [IS] certified [AND ENROLLED] under **7 AAC 130.214(b)(1)(K)** [7 AAC 130.220(b)(1)(J)]; and

(2) [ACTS AS] an organized health care delivery system under **42 C.F.R. 447** [42 C.F.R. 447.10 FOR THE PURPOSE OF OVERSEEING THE PURCHASE OF AN ENVIRONMENTAL MODIFICATION FOR A RECIPIENT]. (Eff. 2/1/2010, Register 193; am 3/1/2011, Register 197; am 4/1/2012, Register 201; am \_\_/\_\_/\_\_, Register \_\_)

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

7 AAC 160.900(a) is amended by adding a new paragraph to read:

(25) the Alaska Board of Nursing's *Medication Administration Course Requirements*, revised as of December, 2009;

7 AAC 160.900(d) is amended by adding new paragraphs to read:

(d) The following department documents are adopted by reference:

(30) *Nursing Facility Level of Care Assessment Form for Children*, dated 3/7/2011;

(31) *Conditions of Participation*, dated June 15, 2012;

(32) *Determination of Material Improvement for ALI/APDD Waivers*, dated 10/28/2011

(33) *Determination of Material Improvement for IDD Waiver Services Recipients Under Age Three*, dated 10/28/2011

(34) *Determination of Material Improvement for IDD Waiver Services Recipients Three and Older*, dated 10/28/2011

(35) *Determination of Material Improvement for CCMC Waiver*, dated 10/27/2011.

(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 \_\_\_/\_\_\_/\_\_\_, Register \_\_\_)

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

The editor's note following 7 AAC 160.900 is changed by adding new paragraphs to read:

**Editor's note:**

...

The *Nursing Facility Level of Care Assessment Form for Children*, *Conditions of Participation*, *Determination of Material Improvement for ALI/APDD Waivers*, *Determination of Material Improvement for IDD Waiver Services Recipients Under Age Three*, *Determination of Material Improvement for IDD Waiver Services Recipients Three and Older*, and *Determination of Material Improvement for CCMC Waiver*, adopted by reference in 7 AAC 160.900, may be obtained by contacting the Department of Health and Social Services, Division of Senior and Disabilities Services, P.O. Box 110680, Juneau, Alaska, 99811-0680 and are posted on the Department of Health and Social Services, Division of Senior and Disabilities Services Internet site at <http://www.hss.state.ak.us/dsds/>

The Alaska Board of Nursing *Medication Administration Course Requirements*, adopted by reference in 7 AAC 160.900, may be obtained by contacting the Department of Health and Social Services, Division of Senior and Disabilities Services, P.O. Box

110680, Juneau, Alaska, 99811-0680 and are posted on the Department of Commerce, Community, and Economic Development, Division of Corporations, Business, and Professional Licensing, Board of Nursing Internet site at <http://www.commerce.state.ak.us/occ/pnur.htm/>