Article 28
Home and Community-Based Waiver Services Program

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7 AAC 43.990. Definitions

Relocated 12/19/93.

Editor's note: As of Register 128, January 1994, the text of 7 AAC 43.990 was relocated by the regulations attorney to 7 AAC 43.1990.

7 AAC 43.1000. Purpose The purpose of 7 AAC 43.1000 - 7 AAC 43.1110 is to offer a choice between home and community-based waiver services and institutional care to aged, blind, physically or developmentally disabled, or mentally retarded persons who meet the eligibility criteria in 7 AAC 43.1010.

History: Eff. 12/19/93, Register 128; am 5/15/2004, Register 170 Authority: AS 47.05.010 AS 47.07.030

7 AAC 43.1002. Notification of option for home and community-based waiver services The department will notify an applicant who meets the eligibility requirements of 7 AAC 43.1010 that the applicant may choose between home and community-based waiver services and institutional care. The applicant's choice of service must be documented on a form approved by the department.

History: Eff. 5/15/2004, Register 170 Authority: AS 47.05.010 AS 47.07.030

7 AAC 43.1010. Recipient enrollment and eligibility (a) For the department to make payment under Medicaid for home and community-based waiver services provided to an individual, the

(1) individual must be

(A) eligible for coverage under 7 AAC 43.020 and (d) of this section; and

(B) enrolled in accordance with (e) of this section; and

(2) services must be provided in accordance with the applicable requirements of 7 AAC 43.1000 - 7 AAC 43.1110.

(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 or individuals with related conditions (ICF/MR); or

(2) if the individual's need for home and community-based services, supports, devices, or supplies may be provided for entirely under 7 AAC 43.100 - 7 AAC 43.942.

(c) A recipient enrolled in the home and community-based waiver services program is eligible to receive other Medicaid services for which the recipient is otherwise eligible.

(d) For the department to determine an applicant eligible to receive home and community-based waiver services, the applicant must

(1) fall into one of the following recipient categories:

(A) children with complex medical conditions; the department will determine an applicant to be a child with a complex medical condition if the applicant

(i) is under 22 years of age;

(ii) would receive long-term care in a facility for more than 30 days per year if the applicant did not receive home and community-based waiver services;

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

(iv) experiences periods of acute exacerbation or life-threatening conditions;

(v) needs extraordinary supervision and observation; and

(vi) either needs frequent or life-saving administration of specialized treatment or is dependent on mechanical support devices;

(B) adults with physical disabilities; in this subparagraph, "adult" means an individual at least 21 years of age and less than 65 years of age;

(C) individuals with mental retardation and developmental disabilities;

(D) older adults; in this subparagraph, "older adult" means an individual 65 years of age or older; and

(2) require a level of care provided in a nursing facility or ICF/MR; the department will base a determination of eligibility under this paragraph on the level-of-care assessment under 7 AAC 43.1030(b), and will determine eligibility under

(A) 7 AAC 43.180 - 7 AAC 43.190, if the applicant falls within the recipient category of

(i) children with complex medical conditions;

(ii) adults with physical disabilities; or

(iii) older adults; or

(B) 7 AAC 43.300, if the applicant falls within the recipient category of individuals with mental retardation and developmental disabilities;

(e) An applicant determined eligible under (a)(1)(A) of this section will be enrolled for home and community-based waiver services 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.

(f) Except as provided in 7 AAC 43.1041, home and community-based waiver services to be provided to a recipient are reimbursable under 7 AAC 43.1000 - 7 AAC 43.1110 only after the department

(1) approves, under 7 AAC 43.1030, the plan of care for the recipient; and

(2) determines that a home and community-based services provider is available that

(A) is enrolled with the department in accordance with 7 AAC 43.1090; and

(B) has the capacity to meet the service levels approved under (1) of this subsection as part of the plan of care.

(g) The earliest date that an individual may receive home and community-based waiver services is the first date when all of the requirements in (d) of this section have been met. Except as provided in 7 AAC 43.1041, the department will not make payment for services that are reimbursable under (f) of this section unless the recipient is enrolled under (e) of this section.

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

History: Eff. 12/19/93, Register 128; am 5/15/2004, Register 170 Authority: AS 47.05.010 AS 47.07.030

7 AAC 43.1020. Recipient disenrollment (a) The department will disenroll a recipient for one or more of the following reasons:

(1) the recipient is no longer eligible for Medicaid coverage under 7 AAC 43.020;

(2) the recipient no longer meets the eligibility requirements of 7 AAC 43.1010(d);

(3) the recipient or the recipient's representative chooses to end use of home and community-based waiver services;

(4) the department terminates its participation in the waiver program under 42 U.S.C. 1396n(c);

(5) the recipient fails to take an action or submit documentation as required in 7 AAC 43.1030;

(6) the recipient's care coordinator, on the behalf of the recipient, fails to take an action or submit documentation as required in 7 AAC 43.1030, if the department has provided the recipient with written notice

(A) identifying the action the care coordinator did not take or the documentation the care coordinator did not provide;

(B) indicating that the recipient has 30 days to take the action or submit the documentation required;

(C) informing the recipient that the recipient may choose a new care coordinator; and

(D) indicating whether the department is not willing to assume the duties of care coordination under 7 AAC 43.1030(i);

(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 43.1030(c), or of placing caregivers at risk of physical injury; for purposes of this paragraph, a documented history exists if service providers

(A) report that they cannot obtain cooperation with service delivery or eliminate the risk of physical injury to caregivers through reasonable accommodation to a person's disability; and

(B) maintain records to support that report; those records must be available to the department for inspection; the department will review those records before making a decision on disenrollment under this paragraph.

(b) A recipient who is disenrolled from the home and community-based waiver services program, as documented by the department for reasons described in (a) of this section may appeal that decision under 7 AAC 49.

History: Eff. 12/19/93, Register 128; am 5/15/2004, Register 170 Authority: AS 47.05.010 AS 47.07.030

7 AAC 43.1030. Screening, assessment, plan of care, and level of care determination (a) An applicant for home and community-based waiver services must obtain an initial, informal screening, for use by the department to determine whether an assessment is warranted under (b) of this section. The department will offer the applicant a choice of care coordination agency providers. The applicant must obtain the screening from one of those providers. A care coordinator shall perform the screening.

(b) If warranted by the screening under (a) of this section and supportive diagnostic documentation, and to determine if the applicant meets the level of care required under 7 AAC 43.1010(d)(2), the department will authorize the care coordinator to prepare a complete assessment of the applicant's physical, emotional, and cognitive functioning and need for care and services. If the assessment is to determine if the applicant falls within the recipient category for

(1) individuals with mental retardation and developmental disabilities, the

(A) department will make a level of care determination under 7 AAC 43.300(c) - (d); and

(B) level of care determination must incorporate the results of the *Inventory for Client and Agency Planning (ICAP),* as revised as of 1986 and adopted by reference, that is administered under 7 AAC 43.300(c) - (d); or

(2) adults with physical disabilities or older adults, the

(A) department will make a determination to determine whether the applicant requires skilled care under 7 AAC 43.180 or intermediate care under 7 AAC 43.185; and

(B) level of care determination under (A) of this paragraph must incorporate the results of the department's *Consumer Assessment Tool (CAT),* revised as of 2003 and adopted by reference.

(c) After the level of care is established, the care coordinator shall

(1) prepare, in writing, a plan of care addressing the comprehensive needs of the recipient, the availability of enrolled providers, types of services that have been agreed to by specific enrolled providers, family and community supports, and the number of units, frequency, projected duration, and projected cost of each home and community-based waiver service;

(2) include in the plan of care an analysis of whether the type, amount, duration, and scope of services in the plan of care is consistent with the findings of the assessment in (b) of this section and with any other treatment plan for the recipient;

(3) make a recommendation whether the services in the plan of care meet the identified needs of the recipient;

(4) support the plan of care with appropriate and contemporaneous documentation that

(A) relates to each medical condition that places the recipient into a recipient category listed in 7 AAC 43.1010(d)(1); and

(B) describes, supports, or justifies the recipient's request and need for home and community-based waiver services; and

(5) present the plan of care to the department for consideration and approval, and for consideration and approval of the home and community-based waiver services requested in the plan of care.

(d) If a plan of care is for a recipient who falls within the recipient category for children with complex medical conditions or for individuals with mental retardation and developmental disabilities,

(1) the care coordinator shall convene a comprehensive planning team to participate in preparing the plan of care;

(2) the comprehensive planning team must consist of the

(A) recipient;

(B) recipient's;

(i) family members, including parents, guardians, siblings, and others similarly involved in providing general oversight of the recipient; or

(ii) legal guardian, if any;

(C) care coordinator; and

(D) enrolled providers that are expected to provide services;

(3) each individual who participates on the comprehensive planning team shall verify that participation by signature on the recipient's plan of care; and

(4) any disagreement among participants about outcomes or service levels, or any suggestion by a participant for an outcome or service level that differs from what is in the plan of care, must be documented and attached to the plan of care when that plan of care is submitted to the department for consideration and approval.

(e) Before the submission of a plan of care to the department for consideration and approval, the recipient or recipient's representative must indicate by signature that individual's agreement with the plan of care.

(f) The department will approve a plan of care if the department determines that each service listed on the plan of care

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

(2) is supported by the documentation required in (c)(4) of this section; and

(3) cannot be paid for under 7 AAC 43.005.

(g) A recipient's need for home and community-based waiver services must be reviewed annually in accordance with 7 AAC 43.1010, a new assessment must be prepared in accordance with (b) of this section, and the recipient's plan of care must be changed accordingly, unless the department determines that an earlier review is necessary due to changing and significant events in the health and welfare of the recipient. The care coordinator shall submit in writing, for the department's consideration and approval, any change to a recipient's plan of care, shall document the need for changes to the plan of care, and shall relate those changes to findings in the current assessment. If a comprehensive planning team is required under (d) of this section, the team must participate in preparing, in accordance with that subsection, any subsequent changes to the plan of care. If the department determines that adequate documentation is not provided, the department may cap service levels at prior year levels, or reduce service levels to reflect the recipient's historical usage. Before the submission of any change to a plan of care to the department for consideration and approval, the recipient or the recipient's representative must indicate by signature that individual's agreement with that change. The department will approve changes to a plan of care if the department determines that

(1) the amount, scope, and duration of services to be provided will reasonably achieve the purposes of the plan of care, and are sufficient to prevent institutionalization;

(2) each service to be provided is supported by documentation as required by (c)(4) of this section; and

(3) the services to be provided cannot be paid for under 7 AAC 43.005.

(h) The plan of care required in (c) of this section must be completed within 60 days after completion of an initial assessment required in (b) of this section, or within 30 days after the completion of a new assessment required in (g) of this section, unless the care coordinator submits written documentation of unusual circumstances that would prevent timely completion of the plan of care.

(i) Notwithstanding (a), (b), (c), or (g) of this section, the department may perform the screening, assessment, or plan of care development for an applicant or recipient itself.

(j) Screenings, assessments, and plans of care under this section must be completed on a form or in a format approved by the department.

History: Eff. 12/19/93, Register 128; am 5/15/2004, Register 170; am 5/19/2004, Register 170 Authority: AS 47.05.010 AS 47.07.030

Editor's note: *The Inventory for Client and Agency Planning (ICAP),* and the *Consumer Assessment Tool* adopted by reference in 7 AAC 43.1030, are available for inspection at the Department of Health and Social Services, Division of Senior and Disabilities Services, Court Plaza Building, 240 Main Street, Suite 602, Juneau, Alaska.

7 AAC 43.1035. Nursing oversight (a) The department will require nursing oversight in the form and frequency required under (b) of this section if

(1) in the course of receiving a home and community-based waiver service, a recipient is to perform self-care of a medical nature or receive care of a medical nature from an individual, regardless of whether the individual is a home and community-based services provider or employed by that provider;

(2) the individual to perform care under (1) of this subsection is not licensed under AS 08 in a health care profession in which the competent delivery of that form of care is a prerequisite for licensure; and

(3) the recipient is within the recipient category for

(A) children with complex medical conditions; or

(B) individuals with mental retardation and developmental disabilities, but would be eligible under the recipient category for children with complex medical conditions if the individual were under 22 years of age.

(b) Nursing oversight must

(1) be provided by a registered nurse licensed under AS 08.68 who is

(A) a care coordinator enrolled under 7 AAC 43.1041(a), and employed by a care coordination agency provider;

(B) employed by a home and community-based services provider, and who provides nursing oversight as a component of another Medicaid service; or

(C) employed by a private health care provider, and who submits verification of nursing oversight through written reports of scope and frequency that are approved under 7 AAC 43.1030 as part of the recipient's plan of care; and

(2) include contacts between the registered nurse, the recipient, and any individual described in (a)(1) - (2) of this section, during which the registered nurse shall confirm that the care is being delivered in a manner that protects the health and safety of the recipient; the department will determine the number and frequency of required contacts, not to exceed one contact per month, and as appropriate to the medical condition of the recipient and the complexity of the care to be delivered.

History: Eff. 5/15/2004, Register 170 Authority: AS 47.05.010 AS 47.07.030

7 AAC 43.1040. Requirements for all reimbursable waiver services (a) Home and community-based waiver services described in 7 AAC 43.1041 - 7 AAC 43.1055 are subject to the administrative provisions and requirements of Medicaid under 7 AAC 43.005 - 7 AAC 43.090.

(b) The department will not reimburse a member of the recipient's immediate family for services that the member provides to the recipient.

(c) The department will not reimburse a provider for services provided by guardians to wards unless a court has authorized the guardian to provide those services under AS 13.26.145 (c).

History: Eff. 12/19/93, Register 128; am 7/3/94, Register 130; am 7/1/95, Register 134; am 3/3/2001, Register 157; am 5/15/2004, Register 170 Authority: AS 47.05.010 AS 47.07.030

7 AAC 43.1041. Care coordination services (a) An employee of a care coordination agency rendering care coordination services must be separately enrolled under this subsection as a care coordinator with the department. Before an employee of a care coordination agency can provide care coordination services, the care coordination agency must

(1) be certified and enrolled with the department in accordance with 7 AAC 43.1090;

(2) certify, in writing, to the department that the employee

(A) meets the minimum requirements listed in the "Care Coordinator Provider Standards" text on pages 14 - 15 of the department's *Home and Community Based Waiver Services Certification Application Packet,* adopted by reference in 7 AAC 43.1090(a);

(B) is employed by the care coordination agency; and

(C) meets the agency's employment and certification standards to provide care coordination services; and

(3) provide documentation as listed for the employee in the "Required Attachments" text on page 15 of the department's *Home and Community Based Waiver Services Certification Application Packet,* adopted by reference in 7 AAC 43.1090(a);

(b) The department will reimburse for the following services:

(1) for an applicant, one screening per calendar year under 7 AAC 43.1030(a), except that the department will reimburse for a second screening if the applicant

was determined, based on the first screening, ineligible for home and community-based waiver services;

(2) for an applicant or recipient, one initial assessment under 7 AAC 43.1030(b) per calendar year;

(3) for a recipient, one development of a plan of care per calendar year, if that plan of care is accompanied by the form required under 7 AAC 43.1002 documenting the recipient's choice of home and community-based services; the plan of care must be developed in accordance with 7 AAC 43.1030, except that the department will reimburse for a plan of care

(A) for which agreement of the recipient or the recipient's representative was not obtained under 7 AAC 43.1030(e), if the department would have approved the plan of care had agreement been obtained; or

(B) that was developed in reliance on the form required under 7 AAC 43.1002, but that the department cannot approve because home and community-based waiver services were subsequently determined not to be available under 7 AAC 43.1010(b).

(c) The department will reimburse a care coordinator for ongoing care coordination services provided to each recipient, beginning with the first month that the recipient is enrolled under 7 AAC 43.1010(e) and has a plan of care approved under 7 AAC 43.1010(f)(1). Ongoing care coordination services include

(1) routine monitoring and support;

(2) review and revision of a plan of care under 7 AAC 43.1030(g);

(3) case terminations;

(4) two contacts each month with the recipient, one of which must be face-to-face; however, the department will waive the monthly face-to-face requirement if the plan of care documents, to the department's satisfaction, that the recipient lives in a rural community as defined in 7 AAC 43.1054(c)(5)(B); if the department waives the monthly face-to-face requirement, the care coordinator must document a minimum of one face-to-face visit per calendar quarter with each recipient whom the care coordinator serves, to monitor service delivery; notwithstanding a waiver under this paragraph, if the purpose of a contact is to develop the annual plan of care for the recipient, that contact must be face-to-face;

(5) evaluation of the need for specific home and community-based waiver services;

(6) coordination of multiple services and providers; and

(7) monitoring of the quality of care.

(d) The department will reimburse a care coordinator for one new assessment under 7 AAC 43.1030(g) during the 12-month period following the month that the recipient is enrolled under 7 AAC 43.1010(e), and for no more than two new assessments during each subsequent 12-month period.

(e) The department will not reimburse for care coordination services provided by the recipient, a member of the recipient's immediate family, the recipient's guardian, a holder of power of attorney for the recipient, or the recipient's personal care assistant.

(f) Within seven days after a recipient's admission to or subsequent discharge from an acute care hospital, the recipient's care coordinator shall notify the department of the date

of the admission or discharge, to assist the department in determining the correct reimbursement amount payable to providers of home and community-based waiver services to that recipient.

(g) Notwithstanding (b) and (d) of this section, the department will reimburse for additional screenings, assessments, or plans of care that have received prior authorization.

History: Eff. 5/15/2004, Register 170; am 8/21/2005, Register 175 Authority: AS 47.05.010 AS 47.07.030

7 AAC 43.1042. Chore services (a) The department will reimburse for chore services that

(1) are approved under 7 AAC 43.1030 as part of the recipient's plan of care;

(2) receive prior authorization; and

(3) do not exceed

(A) 10 hours per week for recipients within the following recipient categories:

(i) adults with physical disabilities;

(ii) older adults; or

(B) five hours per week for recipients within the following recipient categories:

(i) children with complex medical conditions; however, if a recipient in that recipient category has a documented history of respiratory illness, the department will reimburse for chore services not to exceed 10 hours per week;

(ii) individuals with mental retardation and developmental disabilities.

(b) The department will consider the following services to be chore services:

(1) regular cleaning within the residence used by the recipient;

(2) performing heavy household chores, including

(A) washing floors, windows, and walls;

(B) tacking down loose rugs and tiles;

(C) moving heavy items of furniture; and

(D) snow shoveling in order to provide safe access and egress;

(3) food preparation and shopping for recipients in the following recipient categories:

(A) adults with physical disabilities;

(B) older adults;

(4) other services that the department determines necessary to maintain a clean, sanitary, and safe environment with respect to the residence used by the recipient.

(c) The department will not authorize chore services if

(1) the recipient or anyone else in the household is capable of performing or financially providing for them;

(2) any other relative or caregiver of the recipient, or any community or volunteer agency or third party payer is capable of or responsible for the provision of those services; or

(3) 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.

History: Eff. 5/15/2004, Register 170 Authority: AS 47.05.010 AS 47.07.030

7 AAC 43.1043. Adult day services (a) The department will reimburse for adult day services that

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

(A) adults with physical disabilities;

(B) older adults;

(2) are approved under 7 AAC 43.1030 as part of the recipient's plan of care;

(3) receive prior authorization; and

(4) are provided to a recipient who does not experience a developmental disability.

(b) The department will consider health, social, and related support services to be adult day services if

(1) they are provided in a protective setting, other than a nursing facility, during any part of a day, but less than 24 hours per day; and

(2) recipients attend those services on a planned basis during specified hours.

(c) The department will not reimburse for adult day services that duplicate

(1) services performed by personal care assistants under 7 AAC 43.750 - 7 AAC 43.795; or

(2) other home and community-based waiver services.

History: Eff. 5/15/2004, Register 170 Authority: AS 47.05.010 AS 47.07.030

7 AAC 43.1044. Residential supported living services (a) The department will reimburse for residential supported living services that

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

(A) adults with physical disabilities; however, the department will reimburse only if a recipient in that recipient category does not experience a developmental disability;

(B) older adults;

(2) are approved under 7 AAC 43.1030 as part of the recipient's plan of care;

(3) receive prior authorization; and

(4) are provided in an assisted living home licensed under AS 47.33.

(b) The department will consider services to be residential supported living services if they

(1) assist, in a residential setting, a recipient with the activities of daily living; and

(2) are designed for a recipient who can no longer live alone and who does not need 24-hour care provided by a nursing facility, but who would be placed in a nursing facility for lack of alternate placements.

(c) The department will not reimburse

(1) for residential supported living services that are provided the same day as the recipient receives

(A) personal care assistant services reimbursable under 7 AAC 43.750 - 7 AAC 43.795;

(B) chore services reimbursable under 7 AAC 43.1042;

(C) meals services reimbursable under 7 AAC 43.1053, unless the meals are provided in a congregate setting other than an assisted living home licensed under AS 47.33; or

(D) respite care services reimbursable under 7 AAC 43.1049; or

(2) under this section for

(A) payment of the recipient's room and board;

(B) the cost of facility maintenance, upkeep, or improvement, except for actual costs for modifications or adaptations to a facility required to assure the health and safety of residents or to meet the life safety requirements of 13 AAC 50, 13 AAC 55, or an applicable municipal code; or

(C) activities or supervision for which a source other than Medicaid makes payment; or

(3) for residential supported living services that are subject to the restrictions in 7 AAC 43.1080.

History: Eff. 5/15/2004, Register 170 Authority: AS 47.05.010 AS 47.07.030

7 AAC 43.1045. Day habilitation services (a) The department will reimburse for day habilitation services that

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

(A) children with complex medical conditions;

(B) adults with physical disabilities; however, the department will reimburse only if a recipient in that recipient category is also diagnosed as experiencing a developmental disability:

(C) individuals with mental retardation or developmental disabilities;

(2) are approved under 7 AAC 43.1030 as part of the recipient's plan of care; and

(3) receive prior authorization.

(b) The department will consider habilitation services to be day habilitation services if they

(1) take place in a nonresidential setting, separate from the home, assisted living home licensed under AS 47.33, or foster home licensed under AS 47.35 in which the recipient resides; for purposes of this paragraph, day habilitation services include transportation of the recipient between the home, assisted living home, or foster home where the recipient resides and the site where the services are provided; and

(2) do not replace, enhance, or supplement educational services for which the recipient is eligible under 4 AAC 52.

History: Eff. 5/15/2004, Register 170 Authority: AS 47.05.010 AS 47.07.030

7 AAC 43.1046. Residential habilitation services (a) The department will reimburse for residential habilitation services that

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

(A) children with complex medical conditions;
(B) adults with physical disabilities; however, the department will reimburse only if a recipient in that recipient category is also diagnosed as experiencing a developmental disability;
(C) individuals with mental retardation or developmental disabilities;
(2) are approved under 7 AAC 43.1030 as part of the recipient's plan of care; and
(3) receive prior authorization.

(b) Reimbursement for residential habilitation services will be limited to the following habilitation services, and is subject to the following limitations:

(1) family habilitation home services; the department will consider habilitation services to be family habilitation home services if they are provided to a recipient who spends more than 50 percent of the time in an assisted living home licensed under AS 47.33 or a foster home licensed under AS 47.35, and if the home has a paid primary caregiver in residence who is not a member of the recipient's immediate family; reimbursement under this paragraph is subject to the following limitations:
(A) the total number of individuals receiving care in the home, regardless of whether they receive home and community-based waiver services, may not exceed
(i) two, for a recipient in the recipient category of children with complex medical conditions; however, the total number may be exceeded to allow the placement of siblings with the same primary caregiver in residence;
(ii) three, for a recipient in the recipient category of adults with physical disabilities; or
(iii) three, for a recipient in the recipient category of individuals with mental retardation or developmental disabilities; however, the total number may be exceeded to allow the placement of siblings with the same primary caregiver in residence;
(B) the department will not make separate payment for
(i) chore services under 7 AAC 43.1042;
(ii) transportation services under 7 AAC 43.1052; or
(iii) meals services under 7 AAC 43.1053;
(2) shared care services; the department will consider habilitation services to be shared care services if they are provided to a recipient who spends more than 50 percent of the time in the home of an unpaid primary caregiver and the remainder in an assisted living home licensed under AS 47.33 or a foster home licensed under AS 47.35;
(3) supported living services; the department will consider habilitation services to be supported living services if they are provided to a recipient 18 years of age or older and in the recipient's private residence, subject to the following limitations:
(A) the department will not reimburse for more than 18 hours per day of supported living services, unless the department determines that the recipient is unable to benefit from other home and community-based waiver services;

(B) other persons also may furnish direct care services after providing written assurance to the department that those services do not supplant services provided by informal community supports; for purposes of this subparagraph, "direct care services" includes

(i) personal care assistants under 7 AAC 43.750 - 7 AAC 43.795;

(ii) chore services under 7 AAC 43.1042;

(iii) transportation services under 7 AAC 43.1052; and

(iv) meals services under 7 AAC 43.1053;

(4) group home habilitation services; the department will consider habilitation services to be group home habilitation services if they are provided to a recipient 18 years of age or older living full-time in an assisted living home licensed under AS 47.33;

(5) in-home support services; the department will consider habilitation services to be in-home support services if they are provided in the recipient's private residence where an unpaid primary caregiver resides; if a recipient receives in-home support services, the department will not make separate payment for

(A) personal care assistants under 7 AAC 43.750 - 7 AAC 43.795;

(B) chore services under 7 AAC 43.1042;

(C) transportation services under 7 AAC 43.1052; or

(D) meals services under 7 AAC 43.1053.

History: Eff. 5/15/2004, Register 170; am 8/21/2005, Register 175 Authority: AS 47.05.010 AS 47.07.030

7 AAC 43.1047. Supported employment services (a) The department will reimburse 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 disabilities; however, the department will reimburse only if a recipient in that recipient category is also diagnosed as experiencing a developmental disability;

(C) individuals with mental retardation or developmental disabilities;

(2) are approved under 7 AAC 43.1030 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 to be received do not duplicate or supplant educational services for which a recipient is eligible under 4 AAC 52; and

(3) receive prior authorization.

(b) The department will consider services to be supported employment services if

(1) they are provided at a work site in which individuals without disabilities are employed;

(2) they include only the adaptations, supervision, and training required by individuals receiving home and community-based waiver services as a result of their disabilities; and

(3) the recipient is unlikely to obtain competitive employment at or above the minimum wage and, because of the recipient's disability, needs intensive ongoing support, including supervision and training, to perform in a work setting.

(c) The department will not reimburse for

(1) services otherwise available under a program paid for with money provided under 20 U.S.C. 1401 - 1487 (Individuals with Disabilities Education Act) or 29 U.S.C. 730 (Rehabilitation Act);

(2) supervisory activities rendered as a normal part of the business; or

(3) accommodations routinely provided to employees.

History: Eff. 5/15/2004, Register 170 Authority: AS 47.05.010 AS 47.07.030

7 AAC 43.1048. Intensive active treatment services (a) The department will reimburse 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 disabilities; however, the department will reimburse only if a recipient in that recipient category is also diagnosed as experiencing a developmental disability;

(C) individuals with mental retardation or developmental disabilities;

(2) that are approved under 7 AAC 43.1030 as part of the recipient's plan of care;

(3) that receive prior authorization; and

(4) for which the professional providing or supervising the services submits supporting documentation to the department that the recipient needs immediate intervention to decelerate a condition or behavior regression that, if left untreated, would place the recipient at risk of institutionalization.

(b) The department will consider services to be intensive active treatment services if

(1) the department determines them to provide specific treatment or therapy, in the form of time-limited interventions to address a family problem or a personal, social, behavioral, mental, or substance abuse disorder in order to maintain or improve effective functioning of the recipient;

(2) each intervention requires the precision and knowledge possessed only by specifically trained professionals in specific disciplines, whose services are not covered under Medicaid or as habilitation services under 7 AAC 43.1045 - 7 AAC 43.1046; and

(3) the treatment or therapy is designed and provided by a professional licensed under AS 08 with expertise specific to the diagnosed condition, or by a paraprofessional licensed under AS 08 if necessary and supervised by that professional.

History: Eff. 5/15/2004, Register 170 Authority: AS 47.05.010 AS 47.07.030

7 AAC 43.1049. Respite care services (a) The department will reimburse for respite care services that

(1) are approved under 7 AAC 43.1030 as part of the recipient's plan of care;

(2) receive prior authorization; and

(3) do not exceed the maximum number of hours and days in (c) of this section.

(b) The department will consider services to be respite care services if they provide alternative caregivers, regardless of whether the services are provided in the recipient's home or at another location, to relieve

(1) primary unpaid caregivers, including family members and court-appointed guardians;

(2) providers of family habilitation home services under 7 AAC 43.1046(b)(1), except as provided in (e)(4) of this section; or

(3) foster parents licensed under AS 47.35.

(c) The department will not reimburse for respite care services that exceed the following duration limits:

(1) 520 hours of hourly respite care services per year, unless the lack of additional care or support would result in risk of institutionalization because

(A) the recipient has inadequate supports from unpaid caregivers; or

(B) appropriate out-of-home daily respite care services are unavailable;

(2) 14 days of daily respite care services per year.

(d) The department will reimburse under this section for respite care services subject to the following limitations:

(1) the department will reimburse for room and board expenses incurred during the provision of respite care services only if the room and board are provided in

(A) a nursing facility;

(B) an acute care hospital;

(C) an intermediate care facility for the mentally retarded or persons with related conditions (ICF/MR);

(D) an assisted living home licensed under AS 47.33, and that home is not the recipient's residence; or

(E) a foster home licensed under AS 47.35, and that home is not the recipient's residence;

(2) the department will not reimburse more than $250 per day for respite care services, whether provided singly or in combination, other than out-of-home daily respite care services;

(3) the department will not reimburse for out-of-home daily respite care services at a rate in excess of the rate established for Medicaid providers under this chapter; or

(4) the department will not reimburse for respite care services to

(A) allow a primary caregiver to work;

(B) relieve other paid providers of Medicaid services, except providers of family habilitation home services under 7 AAC 43.1046(b)(1); or

(C) provide oversight for additional minor children in the home; for purposes of this subparagraph, "additional minor children" means unemancipated individuals under 18 years of age other than recipients;

(5) the department will reimburse for respite care services provided at the same time as personal care assistants under 7 AAC 43.750 - 7 AAC 43.795 or habilitation services provided under 7 AAC 43.1045 - 7 AAC 43.1046 only if the lack of additional care or support would result in risk of institutionalization because

(A) the recipient has inadequate supports from unpaid caregivers; or

(B) appropriate out-of-home daily respite care services are unavailable;

(6) the department will not reimburse for hourly respite care services provided to recipients receiving residential supported living services under 7 AAC 43.1044.

(e) The department will reimburse under this section for family-directed respite care services subject to the following additional limitations:

(1) family-directed respite care services will be reimbursed only for a recipient in one of the following recipient categories:

(A) children with complex medical conditions;

(B) individuals with mental retardation or developmental disabilities;

(2) family-directed respite care services must be provided through a home and community-based services provider that is certified and enrolled under 7 AAC 43.1090 to provide respite care services; prior authorization will not be given unless the department has on file a current letter of agreement, in which the home and community-based services provider acknowledges responsibility to

(A) comply with the requirements of AS 47.05.017 with respect to an individual retained and directed by a family to provide respite care services under this subsection; and

(B) ensure that the retention and direction of an individual by a family to provide respite care services under this subsection is in accordance with municipal, state, and federal law

(i) applicable to employment of that individual, including applicable provisions of 26 U.S.C. (Internal Revenue Code); or

(ii) to protect the health and safety of the recipient;

(3) out-of-home daily respite care services may not be provided as family-directed respite care services;

(4) family-directed respite care services may not be provided to relieve providers of family habilitation home services under 7 AAC 43.1046(b)(1);

(5) primary unpaid caregivers of a recipient receiving family-directed respite care services may not provide the service for other recipients of family-directed respite care services;

(6) a primary unpaid caregiver

(A) may identify and train individuals who meet the minimum requirements listed in the "Respite Provider Standards" text on page 27 of the department's *Home and Community Based Waiver Services Certification Application Packet,* adopted by reference in 7 AAC 43.1090(a);

(B) may complete and sign timesheets for individuals providing family-directed respite care services; and

(C) shall provide, to the home and community-based services provider that has received prior authorization for the family-directed respite care services, written assurance that the primary unpaid caregiver understands the additional risk that the primary unpaid caregiver assumes in the provision of family-directed respite care services;

(7) individuals providing family-directed respite care services shall be reimbursed directly by the home and community-based services provider that received prior authorization for those services.

(f) In this section,

(1) "daily respite care services" means respite care services between 12 and 24 hours in duration;

(2) "family-directed respite care services" means respite care services provided by an individual whom

(A) the family of the recipient retains; and

(B) a home and community-based services provider reimburses;

(3) "out-of-home daily respite care services" means daily respite care services provided in

(A) a nursing facility;

(B) an acute care hospital;

(C) an intermediate care facility for the mentally retarded or persons with related conditions (ICF/MR);

(D) an assisted living home licensed under AS 47.33; or

(E) a foster home licensed under AS 47.35.

History: Eff. 5/15/2004, Register 170 Authority: AS 47.05.010 AS 47.07.030

7 AAC 43.1050. Amounts of reimbursement for home and community-based waiver services Repealed. **History: Eff. 12/19/93 Register 128; am 7/1/95, Register 134; repealed 5/15/2004, Register 170**

7 AAC 43.1051. Specialized private duty nursing services (a) The department will reimburse for specialized private duty nursing services that

(1) are provided to a recipient

(A) in one of the following recipient categories:

(i) adults with physical disabilities;

(ii) individuals with mental retardation or developmental disabilities; however, the department will reimburse only if a recipient in that recipient category is 21 years of age or older;

(iii) older adults; and

(B) who meets the eligibility requirements that apply to a Medicaid recipient under 21 years of age under 7 AAC 43.456(a) , (b)(2), and (b)(4);

(2) are approved under 7 AAC 43.1030 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 they

(1) provide individual and continuous care by individuals licensed under AS 08.68 other than certified nurse aides; and

(2) are tailored to the specific needs of a particular individual.

(c) The department will not reimburse under this section for temporary or intermittent services, and will not reimburse under this section for services that fail to satisfy the

requirements and limitations of 7 AAC 43.456(c) - (g), except that the cost cap limitations in 7 AAC 43.456(f) do not apply.
(d) To provide services under this section, an employee subject to 7 AAC 43.456(d) must be enrolled separately under that subsection.
History: Eff. 5/15/2004, Register 170 Authority: AS 47.05.010 AS 47.07.030

7 AAC 43.1052. Transportation services (a) The department will reimburse for transportation services that

(1) are approved under 7 AAC 43.1030 as part of the recipient's plan of care; and
(2) receive prior authorization.

(b) The department will consider services to be transportation services if they enable a recipient, and any necessary escort that receives prior authorization under (a)(2) of this section, to gain access to home and community-based waiver services or other community services and resources.
(c) The department will not reimburse under this section for

(1) medical transportation services reimbursable under 7 AAC 43.500 - 7 AAC 43.530; or
(2) transportation reimbursed under 7 AAC 43.1046.

History: Eff. 5/15/2004, Register 170 Authority: AS 47.05.010 AS 47.07.030

7 AAC 43.1053. Meals services (a) The department will reimburse for meals services that

(1) are provided to a recipient 18 years of age or older;
(2) are approved under 7 AAC 43.1030 as part of the recipient's plan of care; and
(3) receive prior authorization.

(b) The department will reimburse under this section for meals services subject to the following limitations:

(1) meals must be provided in the recipient's home, or in a congregate setting other than an assisted living home licensed under AS 47.33;
(2) meals must be provided in accordance with 42 U.S.C. 3030e(1).

History: Eff. 5/15/2004, Register 170 Authority: AS 47.05.010 AS 47.07.030

7 AAC 43.1054. Environmental modification services (a) The department will reimburse for environmental modification services that

(1) are approved under 7 AAC 43.1030 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 they make physical adaptations to the recipient's home, as identified in the recipient's plan of care, and are necessary to ensure the health, welfare, and safety of the recipient.
(c) To pursue reimbursement from the department under this section, a home and community-based services provider must comply with the following requirements:

(1) before an environmental modification service is approved as part of the recipient's plan of care, the home and community-based services provider that is to deliver the service must demonstrate to the department that the requirements of AS 08.18 for contractor registration and bonding have been met;

(2) upon completion of an environmental modification service, the home and community-based services provider shall verify compliance with applicable provisions of 13 AAC 50, 13 AAC 55, and applicable municipal building codes;
(3) the home and community-based services provider with prior authorization for the environmental modification service must complete the service or subcontract with a contractor registered and bonded under AS 08.18;
(4) for environmental modification services expected to exceed $1,000, cost estimates from three home and community-based services providers must be solicited and, if obtained, appended to the plan of care;
(5) the cost of all environmental modification services for a recipient, including the cost of labor and the cost of building materials, parts, supplies, permits, demolition, and other goods that are necessary to accomplish the modifications in the recipient's home and that remain with the recipient, may not exceed a total of $10,000 in a continuous 36-month period, beginning with the month the recipient is enrolled under 7 AAC 43.1010(e), and may not exceed a total of $10,000 in each subsequent continuous 36-month period that the recipient remains enrolled; however, within any of those periods, the total for environmental modification services may exceed $10,000 if the excess expenditure

(A) is for the repair or replacement of a previous environmental modification, does not exceed $500 per year of the remaining 36-month period, and is approved by the department before the expenditure is made; or

(B) results solely from the cost of freight to deliver materials and supplies to a rural community; in this subparagraph, "rural community" means a municipality or unincorporated community that is a social unit, that has a residential population of no less than 25 and no more than

(i) 10,000, and that is not connected by road or rail to Anchorage or Fairbanks; for purposes of this sub-subparagraph, a connection by road or rail does not include a connection by the Alaska marine highway system or by an international highway; or

(ii) 1,600, and that is connected by road or rail to Anchorage or Fairbanks and at least 50 miles outside of Anchorage or 25 miles outside of Fairbanks; for purposes of this sub-subparagraph, a connection by road or rail does not include a connection by the Alaska marine highway system or by an international highway;

(6) in addition to reimbursing for the actual environmental modification services, the department will reimburse the home and community-based services provider an administrative fee under 7 AAC 43.1058(e), if the provider

A) is certified and enrolled under 7 AAC 43.1090(b)(1)(J); and

(B) acts as an organized health care delivery system under 42 C.F.R. 447.10 for the purpose of overseeing the purchase of an environmental modification for a recipient;

(7) once the home and community-based services provider that received the prior authorization has been paid in full, the environmental modification will be

considered complete and the provider shall be financially responsible for any additional work necessary to complete the modification.

(d) The department will not reimburse under this section for

(1) modifications that increase the square footage of an existing residence, are part of a larger renovation to an existing residence, or are included in construction of a new residence;

(2) general utility adaptations, modifications, or improvements to the existing residence; for purposes of this paragraph, general utility adaptations

(A) include routine maintenance or improvements, including flooring and floor coverings; bathroom furnishings, carpeting, roof repair, central air conditioning, heating system or sewer system replacement, appliances, cabinets, and shelves; and

(B) do not include improvements made to substantially reduce the risk of serious injury or illness to the recipient if another practical modification is not available to reduce that risk;

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

(4) duplicate accessibility modifications to the same residence;

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

(6) installation of privately purchased specialized medical equipment that would not be reimbursed under 7 AAC 43.1055.

(e) The department will reimburse for an environmental modification service under this section only upon completion of the environmental modification and upon compliance with (g) of this section, except that the department will issue prior authorization for 25 percent or less of the accepted cost estimate for materials required for an environmental modification service plus 25 percent or less of the cost for any specialized medical equipment, material, and supplies not locally available, if the department determines that those materials and the specialized medical equipment, material, and supplies are essential to the environmental modification service. The home and community-based services provider shall repay the department for any charges paid on this prior authorization if the environmental modification is not completed within 90 days after the first date of billing.

(f) Home and community-based services providers shall purchase and install all required material, supplies and equipment required for the environmental modification service, except for those supplies and equipment provided as specialized medical equipment and supplies under 7 AAC 43.1055.

(g) The department will make final payment under this section for an environmental modification service only upon submission by the

(1) home and community-based services provider to the department of a photograph of the completed environmental modification and a copy of a written final inspection by the municipality concurring that the project is complete and meets applicable codes; or

(2) recipient or recipient's representative to the department of written verification that the project is complete and a photograph of the completed environmental modification, if the recipient's home is not within a municipality that conducts inspections.

(h) The state is not responsible for removal of any modification if the recipient ceases to reside at a residence.

(i) Environmental modifications will not be authorized for waiver recipients who reside in an assisted living home licensed under AS 47.33 or a foster home licensed under AS 47.35, unless the recipient residing in the assisted living home or foster home is receiving family habilitation home services under 7 AAC 43.1046(b)(1).

History: Eff. 5/15/2004, Register 170 Authority: AS 47.05.010 AS 47.07.030

7 AAC 43.1055. Specialized medical equipment and supplies (a) The department will reimburse for specialized medical equipment and supplies

(1) that are approved under 7 AAC 43.1030 as part of the recipient's plan of care;

(2) that receive prior authorization; and

(3) for which the department receives written supportive contemporaneous documentation from a licensed physician, occupational therapist, physical therapist, speech therapist or pathologist, or physiatrist that the specific item requested is appropriate for the recipient, consistent with the plan of care, and necessary to avoid placing the recipient at risk of institutionalization.

(b) The department will consider items to be specialized medical equipment and supplies if they are

(1) devices, controls, or appliances that enable a recipient to increase 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 are ancillary supplies and equipment necessary for the proper functioning of those items; and

(2) identified in

(A) Table I-4 of the durable medical equipment (DME) and supplies section of the *Alaska Medicaid Provider Billing Manual;* the September 1999 revision of Table I-4 of the durable medical equipment (DME) and supplies section of the *Alaska Medicaid Provider Billing Manual* is adopted by reference; or

(B) the department's Letter *DME FY02-004,* dated March 13, 2002 and adopted by reference.

(c) The department will reimburse under this section subject to the following limitations:

(1) the unit cost of equipment must be 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 may be paid as separate units of service, if the department determines that payment as separate units of service is cost-effective;

(3) the department will not reimburse as a home and community-based waiver service the cost of any medical equipment or supplies that is reimbursable under 7 AAC 43.925;

(4) specialized medical equipment and supplies must 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 and supplies become the property of the recipient;

(6) specialized medical equipment may include a portable hydrotherapy tub device, but does not include items listed in (d)(1) of this section;

(7) the department will not give prior authorization to replace specialized medical equipment before the end of that item's expected useful life, unless the department determines that replacing rather than repairing that item is more cost effective.

(d) The department will not reimburse under this section for

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

(2) developmental toys;

(3) personal computers, other computer hardware, peripherals, computer software, personal data assistants (PDAs), or cellular telephones;

(4) outdoor playground equipment, scissors lifts, bicycles, other pedal-driven devices, or exercise equipment;

(5) lights or other devices used to treat seasonal affective disorder;

(6) vacuum cleaners or household appliances;

(7) devices that receive, record, or play audio or video in any medium, including televisions, compact disc players, MP3 players, videocassette players, and DVD players;

(8) micro cars; or

(9) adaptive clothing.

History: Eff. 5/15/2004, Register 170; am 9/29/2005, Register 175 Authority: AS 47.05.010 AS 47.07.030

Editor's note: The specialized medical equipment and supplies part of the durable medical equipment and supplies section of the *Alaska Medicaid Provider Billing Manual and Letter DME FY02-004,* adopted by reference in 7 AAC 43.1055, may be obtained by contacting the Department of Health and Social Services, Division of Health Care Services, 4501 Business Park Boulevard, Suite 24, Anchorage, Alaska 99503-7167.

7 AAC 43.1058. Amounts of reimbursement for home and community-based waiver services (a) The department will reimburse a provider of home and community-based waiver services that is enrolled under 7 AAC 43.1090 according to the rates and methodologies set out in this section.

(b) For care coordination services provided under 7 AAC 43.1041, the department will reimburse a unit of service at the lesser of the

(1) amount charged by the provider to the public; or

(2) maximum allowable amount specified for that unit of service in Table I-5 of the home and community-based waiver services: care coordination section of the *Alaska Medicaid Provider Billing Manual;* the descriptions and billing codes for those services are provided in the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services's (CMS) *Healthcare Common Procedure Coding System (HCPCS) 2003,* as amended from time to time, and adopted by reference; the June 2003 revision of Table I-5 of the home and community-based waiver services: care coordination section of the *Alaska Medicaid Provider Billing Manual* is adopted by reference.

(c) For specialized medical equipment and supplies provided under 7 AAC 43.1055, the department will reimburse a unit at the lesser of the

(1) amount charged by the provider to the public; or

(2) maximum allowable amount specified for that unit in Table I-4 of the durable medical equipment (DME) and supplies section of the *Alaska Medicaid Provider Billing Manual* or in the department's *Letter DME FYO2-004;* the descriptions and billing codes for those items are provided in the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services's (CMS) *Healthcare Common Procedure Coding System (HCPCS) 2003,* as amended from time to time, and adopted by reference; the September 1999 revision of Table I-4 of the durable medical equipment (DME) and supplies section of the *Alaska Medicaid Provider Billing Manual* is adopted by reference; the department's *Letter DME FY02-004,* dated March 13, 2002 is adopted by reference.

(d) For specialized private duty nursing services provided under 7 AAC 43.1051, the department will reimburse a unit of service at the lesser of the

(1) amount charged by the provider to the public; or

(2) rate described in 7 AAC 43.456.

(e) For environmental modification services provided under 7 AAC 43.1054, the department will reimburse at 100 percent of billed charges to a home and community-based services provider. In addition, the department will reimburse the provider an administrative fee of two percent of the billed charges or $50, whichever is greater, if the provider

(1) is certified and enrolled under 7 AAC 43.1090(b)(1)(J); and

(2) acts as an organized health care delivery system under 42 C.F.R. 447.10 for the purpose of overseeing the purchase of an environmental modification for a recipient.

(f) For chore services provided under 7 AAC 42.1042, adult day services provided under 7 AAC 43.1043, day habilitation services provided under 7 AAC 43.1045, residential habilitation services provided under 7 AAC 43.1046, supported employment services provided under 7 AAC 43.1047, intensive active treatment services provided under 7 AAC 43.1048, respite care services provided under 7 AAC 43.1049, transportation

services provided under 7 AAC 43.1052, or meals services provided under 7 AAC 43.1053, the department will base reimbursement for a unit of service upon the

(1) rates established in Table I-4 of the home and community-based waiver services: home and community-based agency section of the *Alaska Medicaid Provider Billing Manual;* the June 2003 revision of Table I-4 of the home and community-based waiver services: home and community-based agency section of the *Alaska Medicaid Provider Billing Manual* is adopted by reference; or

(2) allowable direct service costs, as established under 7 AAC 43.1060, for the service provided, and allowances to compensate the provider for the provider's allowable administrative and general costs, as established under 7 AAC 43.1060, associated with providing the service; however, the department will not include an allowance under this paragraph for any administrative or general costs for

(A) out-of-home daily respite care services or family-directed respite care services under 7 AAC 43.1049;

(B) meals services under 7 AAC 43.1053; or

(C) any services provided by a home and community-based services provider acting as an organized health care delivery system under 42 C.F.R. 447.10.

(g) In determining reimbursement rates under (f) of this section, the department will consider only those costs identified in 7 AAC 43.1060 that are anticipated to be paid or borne by the provider. In evaluating the reasonableness of a provider's projected costs under (f) of this section and 7 AAC 43.1060, the department may conduct cost comparisons for similar services or items of expense and deny any cost that appears to be excessive.

(h) For residential supported living services provided under 7 AAC 43.1044, a residential supported living services provider may seek reimbursement for a unit of service either at the rate determined under (f) of this section or at the rate determined under this subsection. The department will base reimbursement under this subsection upon the following:

(1) for a provider that is licensed as an assisted living home under AS 47.33 for fewer than six residents, the department will use a base service rate of $44.52 per day;

(2) for a provider that is licensed as an assisted living home under AS 47.33 for six or more residents and does not provide 24-hour awake staff, the department will use a base service rate of $56.10 per day;

(3) for a provider that is licensed as an assisted living home under AS 47.33 for six or more residents and provides 24-hour awake staff, the department will use a base service rate of $67.68 per day;

(4) the amount of reimbursement to a provider under (1) - (3) of this subsection will be decreased by 26 percent of the base service rate per day if a recipient also receives adult day services under 7 AAC 43.1043 for three or more days in a seven-day period;

(5) the amount of reimbursement to a provider under (1) - (3) of this subsection will be increased by $17.37 per day if the recipient's needs warrant the hiring or

designation of additional staff by the provider to augment the care given to the recipient;

(6) a base service rate under (1) - (3) of this subsection will be adjusted to reflect regional differences in the cost of doing business, based on the region in which the provider is located; based upon the designated planning regions described in Table 1 of the *Alaska Commission on Aging State Plan for Services 2001 - 2003,* dated June 14, 2001 and adopted by reference, the rate adjustments are as follows:

(A) for the Anchorage region - no adjustment;

(B) for the southcentral region, other than Anchorage - 1.04;

(C) for the southeast region - no adjustment;

(D) for the interior region - 1.15;

(E) for the southwest region - 1.33;

(F) for the northwest region - 1.38;

(7) a service rate under (1) - (6) of this subsection will be adjusted to increase the rate by $8.65 per day; this increase is not subject to the regional adjustment under (6) of this subsection;

(8) subject to the availability of appropriations, a service rate determined under (1) - (6) of this subsection will be adjusted by the department by, and effective at the same time as, a cost of living percentage increase in benefit amounts under 42 U.S.C. 1382f.

(i) With the approval of the department, a residential supported living services provider that offers to provide service to a recipient at a rate lower than the rate determined under (f) or (h) of this section may be reimbursed at the lower rate.

(j) If a recipient has been determined eligible for Medicaid coverage under 7 AAC 43.020(a) (3)(B), the recipient's income, exclusive of the personal needs allowance and other deductions described in (k) of this section, is a prior resource for home and community-based waiver services. Once the department has determined the recipient's monthly liability under (k) of this section, the recipient shall pay that liability toward the cost of care for home and community-based waiver services. If a recipient is receiving residential supported living services under 7 AAC 43.1044, the recipient shall pay the liability first to the recipient's residential supported living services provider, and second to other home and community-based services providers if any monthly liability remains.

(k) The department will determine the recipient's monthly liability to pay for home and community-based waiver services by subtracting the following deductions from the recipient's monthly income:

(1) a personal needs allowance equal to the

(A) monthly income limit set in AS 47.07.020 (b)(6), if the recipient is not a resident of an assisted living home licensed under AS 47.33; or

(B) monthly income limit set in AS 47.07.020 (b) minus $260, if the recipient is a resident of an assisted living home licensed under AS 47.33;

(2) a deduction for mandatory withholding from earned or unearned income to cover federal, state, and local taxes;

(3) a deduction for taxes not subject to withholding but owed and paid;

(4) a deduction for income actually garnisheed for child support owed for the month of the recipient's liability; the deduction in this paragraph does not apply to

any amount of garnishment for which another deduction is provided in this subsection;

(5) a deduction for the amount of income needed to raise a spouse's income to the highest amount allowable under 42 U.S.C. 1396r-5(d)(3)(C) for a minimum monthly maintenance needs allowance;

(6) a deduction for an amount to maintain a family member, as defined in 42 U.S.C. 1396r-5(d)(1), in the home; if the family member is

(A) living with the recipient's spouse, the amount of the deduction will be calculated by subtracting the family member's monthly income from one-third of the highest amount allowable under 42 U.S.C. 1396r-5(d)(3)(C) for a minimum monthly maintenance needs allowance; or

(B) not living with the recipient's spouse, the deduction will be calculated by subtracting the family member's monthly income from the income standard applicable under 42 U.S.C. 1 396u-1 (b) to a household of the same size in which adults are not included for purposes of determining eligibility for Medicaid;

(7) a deduction for medical expenses; for purposes of this paragraph "medical expenses" means

(A) Medicare and other health insurance premiums that the recipient pays; and

(B) incurred but unpaid medical expenses not covered by Medicaid, by the Chronic and Acute Medical Assistance (CAMA) program under 7 AAC 48, or by private health insurance, including unpaid medical expenses outstanding before a recipient receives home and community-based waiver services.

(*l*) Notwithstanding 7 AAC 43.1060, the department will not approve an increase in the amount of reimbursement per unit of service for a service whose per unit amount of reimbursement has been determined using the methodology in (f)(2) of this section until July 1, 20076.

(m) Repealed 8/21/2005.

History: Eff. 5/15/2004, Register 170; am 6/27/2004, Register 170; am 7/1/2005, Register 175; am 8/21/2005, Register 175 ; am 7/1/2006, Register 178 Authority: AS 47.05.010 AS 47.07.030

Editor's note: Table I-5 of the home and community-based waiver services: care coordination section, Table I-4 of the durable medical equipment (DME) and supplies section, and Table I-4 of the home and community-based waiver services: home and community-based agency section of the *Alaska Medicaid Provider Billing Manual,* adopted by reference in 7 AAC 43.1058, may be obtained by contacting the Department of Health and Social Services, Division of Health Care Services, P.O. Box 110601, Juneau, Alaska 99811-0601.

The United States Department of Health and Human Services, Centers for Medicare and Medicaid Services's (CMS) *Healthcare Common Procedure Coding System (HCPCS) 2003,* adopted by reference in 7 AAC 43.1058, may be obtained by contacting the Superintendent of Documents, United States Government Printing Office, Washington,

DC 20402, and may be reviewed at the Department of Health and Social Services, Division of Health Care Services, P.O. Box 110601, Juneau, Alaska 99811-0601.
The *Alaska Commission on Aging State Plan for Services: 2001 - 2003,* Table 1, adopted by reference in 7 AAC 43.1058 may be obtained by contacting the Department of Health and Social Services, Division of Senior and Disability Services, P.O. Box 110680, Juneau, Alaska, 99811-0680. The *Alaska Commission on Aging State Plan for Services: 2001 - 2003* is also posted on the Department of Health and Social Services, Alaska Commission on Aging's Internet web site at http://www.alaskaaging.org.

7 AAC 43.1060. Determination of administrative and general cost rate

(a) A home and community-based services provider seeking an administrative and general cost rate for services reimbursed under 7 AAC 43.1058(f) must comply with the applicable requirements of this section. If a provider does not comply with those requirements, the department will calculate a reimbursable unit rate based solely on the allowable direct service costs for the service provided.
(b) The department will approve an administrative and general cost rate for a home and community-based services provider at the time of initial certification under 7 AAC 43.1090 and annually thereafter, at the beginning of the waiver year in which the rate is payable. When first applying for provider certification and no later than 30 days before the start of each following waiver year, a provider seeking an administrative and general cost rate shall submit to the department the following information on a form or in a format approved by the department:

(1) a proposed operating budget for the provider's next fiscal year that sets out all anticipated funding sources and amounts, including recipient contributions to room and board if applicable, and that breaks anticipated costs into the categories of allowable direct service costs, non-allowable direct service costs, allowable administrative and general costs, and non-allowable administrative and general costs;

(2) a calculation of the administrative and general cost rate for the provider that is determined by dividing the provider's total allowable administrative and general costs by the sum of the provider's total allowable and non-allowable direct service costs and the provider's total non-allowable administrative and general costs; however, a provider's administrative and general cost rate may not exceed 18 percent of the sum of the provider's total allowable and non-allowable direct service costs and the provider's total non-allowable administrative and general costs, unless the provider provides only residential supported living services under 7 AAC 43.1044; if a provider provides only residential supported living services under 7 AAC 43.1044, that provider's administrative and general cost rate may not exceed 25 percent of the sum of the provider's total allowable and nonallowable direct service costs and the provider's total non-allowable administrative and general costs.

(c) Upon review of the information provided under (b) of this section and any additional information provided under this subsection, the department may ask for clarification, request additional information, or approve the provider's administrative and general cost

rate. The department will provide written notification to the provider of the final approved rate.

(d) In this section,

(1) "allowable direct service costs" include

(A) personal service costs, including salaries, annualized hourly wages, contract labor payments, and stipends paid for direct care staff and associated benefit costs such as payroll taxes and insurance; whatever form these costs take, they must be commensurate with compensation paid for similar staff positions performing similar duties for the provider;

(B) travel costs for recipients and providers including transportation, per diem, and meal allowances; these costs may not be charged at rates that exceed those allowed under the general government bargaining unit employees' agreement with the state in effect for July 1, 2000 - June 30, 2003; for purposes of this subparagraph, the travel cost rates set out in article 30, sections 30.01 - 30.04 and 30.07 - 30.08 of the general government bargaining unit employees' agreement with the state for July 1, 2000 - June 30, 2003 are adopted by reference;

(C) the costs of items or services purchased for recipients that are necessary to carry out their approved plans of care; and

(D) room and board costs for

(i) respite care services provided under 7 AAC 43.1049 in a nursing facility, acute care hospital, intermediate care facility for the mentally retarded or persons with related conditions (ICF/MR) assisted living home licensed under AS 47.33, or foster home licensed under AS 47.35; or

(ii) meals that are provided as part of a unit of adult day services provided under 7 AAC 43.1043, as part of a unit of day habilitation services provided under 7 AAC 43.1045, or in a unit of meals service provided under 7 AAC 43.1053;

(2) "non-allowable direct service costs" include

(A) items or services purchased for recipients that are not necessary to carry out their approved plans of care; and

(B) room and board costs other than those described in (1)(D) of this subsection;

(3) "allowable administrative and general costs" include

(A) board of directors' expenses, including travel and training costs directly associated with board functions on behalf of the provider, but excluding lobbying activities;

(B) administrative support costs, including the costs of

(i) personal services and associated benefits, training, and travel of the provider's executive director and its secretarial, clerical, accounting, and other administrative staff;

(ii) office equipment, including leased equipment, supplies, postage, related professional subscriptions, and associated procurement costs;

(iii) facility operations, including rent, interest on capital loans, utilities, equipment, security systems, and routine maintenance; and

(iv) professional dues for professional staff;

(C) contractual costs for consulting, legal, and financial accounting and auditing services;

(D) public relations and community education expenses related to advertisements, brochures, newsletters, marketing, surveys, and staff and community development activities; and

(E) insurance expenses, including professional liability, automobile and facility coverage, and bonding; and

(4) "non-allowable administrative and general costs" include

(A) lobbying expenses;

(B) fund raising expenses;

(C) contingency funds;

(D) fines, penalties, and bad debts;

(E) contributions or donations;

(F) entertainment expenses, including meals, banquets, gratuities, and decorations;

(G) organization dues that are based on a percentage of grant award amounts; and

(H) other costs not allowed under requirements or special conditions related to other state grant awards to the provider.

(e) Notwithstanding the requirements of this section, a home and community-based services provider may choose to obtain an indirect cost rate agreed upon by the federal government and the home and community-based services provider.

History: Eff. 12/19/93, Register 128; am 5/15/2004, Register 170 Authority: AS 47.05.010 AS 47.07.030

7 AAC 43.1070. Reimbursable leaves of absence Repealed. **History: Eff. 12/19/93, Register 128; readopt 8/7/96, Register 139; repealed 5/15/2004, Register 170**

7 AAC 43.1080. Restrictions on residential supported living services reimbursement (a) Unless waived in writing by the department under (b) of this section, the department will not reimburse for residential supported living services provided under 7 AAC 43.1044 to a recipient if that recipient's approved plan of care was prepared by a care coordination agency provider that has a close familial or business relationship with the residential supported living services provider.

(b) The limitation on reimbursement of certain residential supported living services providers under (a) of this section may be waived by the department for the benefit of the recipient, subject to any conditions that the department may impose, based on one of the following considerations:

(1) another care coordination agency provider is not reasonably available to serve the recipient;

(2) the person rendering the care coordination service is not subject to supervision or control by the owner, administrator, or staff of the residential supported living services provider and does not have a close familial or business relationship with the residential supported living services provider or its owner or administrator.

(c) In this section,

(1) "close business relationship" means

(A) having a 15 percent or greater ownership, partnership, or equity interest in the other provider or its owner; or

(B) having a 15 percent or greater ownership, partnership, or equity interest in any other business or commercial activity in which the other provider or its owner or administrator also has a 15 percent or greater ownership, partnership, or equity interest;

(2) "close familial relationship" includes the person's spouse, a parent, sibling, or child of the person, and the spouse of the person's parent, sibling, or child;

(3) "owner" means a person having a 15 percent or greater ownership, partnership, or equity interest.

History: Eff. 12/19/93, Register 128; am 5/15/2004, Register 170 Authority: AS 47.05.010 AS 47.07.030

7 AAC 43.1090. Provider certification and enrollment (a) To be certified by the department as a provider of a home and community-based waiver service, the provider must meet the applicable certification criteria, including provider qualifications and program standards, set out in the department's *Home and Community Based Waiver Services Certification Application Packet,* revised as of February 12, 2004 and adopted by reference.

(b) The department will enroll the following provider types to provide home and community-based waiver services if the provider is certified by the department under (a) of this section as a provider of particular home or community-based waiver services, and if the provider has entered a medical provider agreement under 7 AAC 43.065:

(1) as a home and community-based services provider, for

(A) chore services provided under 7 AAC 43.1042;

(B) adult day services provided under 7 AAC 43.1043;

(C) day habilitation services provided under 7 AAC 43.1045;

(D) residential habilitation services provided under 7 AAC 43.1046;

(E) supported employment services provided under 7 AAC 43.1047;

(F) intensive active treatment services provided under 7 AAC 43.1048;

(G) respite care services provided under 7 AAC 43.1049;

(H) transportation services provided under 7 AAC 43.1052;

(I) meals services provided under 7 AAC 43.1053; or

(J) environmental modification services provided under 7 AAC 43.1054;

(2) as a care coordination agency provider, for care coordination services;

(3) as a residential supported living services provider, for residential supported living services provided under 7 AAC 43.1044;

(4) as a durable medical equipment provider under 7 AAC 43.925(e) , for specialized medical equipment and supplies provided under 7 AAC 43.1055,

unless the department has awarded a contract to a particular provider to act as the single source of a particular item or procedure under 7 AAC 43.925(d) ;

(5) as a private duty nursing provider under 7 AAC 43.456, for specialized private duty nursing services provided under 7 AAC 43.1051.

(c) Notwithstanding (a) of this section,

(1) without requiring certification, the department will enroll a contractor licensed under AS 08.18 as a home and community-based services provider, for environmental modification services provided under 7 AAC 43.1054, if the

(A) department determines that the contractor is in compliance with the applicable provisions of 7 AAC 43.1054; and

(B) contractor has entered a medical provider agreement under 7 AAC 43.065; and

(2) a provider of transportation that is enrolled under 7 AAC 43.500 - 7 AAC 43.530 to provide transportation under the Medicaid program need not be certified by the department in order to enroll under (b) of this section to provide transportation services under 7 AAC 43.1052.

(d) If a recipient plans to obtain services out of state, the recipient's care coordination agency provider must document that the recipient has chosen the out-of-state provider freely, and must have a written agreement with the out-of-state provider setting out the quality assurance responsibilities of the care coordination agency provider and the out-of-state provider. Payment will be made directly to the out-of-state provider.

History: Eff. 12/19/93, Register 128; readopt 8/7/96, Register 139; am 5/15/2004, Register 170; am 12/2/2005, Register 176 Authority: AS 47.05.010 AS 47.07.030 AS 47.07.050

Editor's note: The Department of Health and Social Services's Home and Community Based Waiver Services Certification Application Packet, dated February 12, 2004 and adopted by reference in 7 AAC 43.1090, may be obtained by writing to the Department of Health and Social Services Division of Senior and Disabilities Services, P.O. Box 110680, Juneau, Alaska 99811-0680, or may be inspected at the office of the Division of Senior and Disabilities Services, 240 Main Street, Suite 602, Juneau, Alaska.

Effective 8/7/96, Register 139, the Department of Health and Social Services readopted 7 AAC 43.1090 in its entirety, without change, under AS 47.05 and AS 47.07. Executive Order No. 72 transferred certain rate-setting authority to the department.

7 AAC 43.1100. Provider disenrollment and decertification (a) The department may disenroll and decertify an enrolled provider of a home and community-based waiver service

(1) if the department determines that the provider is no longer qualified for certification as required under 7 AAC 43.1090 for a home and community-based service;

(2) for grounds and under procedures set out in 7 AAC 43.950 - 7 AAC 43.985; or

(3) if the provider fails to meet applicable requirements in the department's *Home and Community Based Waiver Services Certification Application Packet* adopted by reference in 7 AAC 43.1090(a).

(b) Providers who are disenrolled or decertified by the department under this section may appeal that decision under 7 AAC 43.980.

History: Eff. 12/19/93, Register 128; readopt 8/7/96, Register 139; am 5/15/2004, Register 170 Authority: AS 47.05.010 AS 47.07.030 AS 47.07.050

Editor's note: Effective 8/7/96, Register 139, the Department of Health and Social Services readopted 7\n AAC 43.1100 in its entirety, without change, under AS\n 47.05 and AS\n 47.07. Executive Order No. 72 transferred certain rate-setting authority to the department.

7 AAC 43.1110. Definitions In 7 AAC 43.1000 - 7 AAC 43.1110, unless the context requires otherwise,

(1) "acute care hospital" has the meaning given "general acute care hospital" in 7 AAC 12.990;

(2) "administrative and general costs" means those expenses that are common to the overall operation of a provider providing home and community-based waiver services and that are not directly assignable to or borne by a specific program or recipient of a home and community-based waiver service;

(3) "applicant" means an individual who has applied for home and community-based waiver services but has not yet been determined eligible for those services;

(4) "care coordination agency provider" means a provider that the department has enrolled under 7 AAC 43.1090 to provide care coordination services under 7 AAC 43.1041;

(5) "contingency funds" means funds that have been accumulated but not expended;

(6) "escort" means an individual who accompanies a recipient to or from a service using a transportation provider enrolled under 7 AAC 43.1090;

(7) "habilitation services" means services that help recipients acquire, retain, or improve skills related to activities of daily living and self-help, social, and adaptive skills necessary to enable the recipient to reside in a non-institutional setting that is provided in a recipient's home, a shared care environment, an assisted living home licensed under AS 47.33, or a foster home licensed under AS 47.35;

(8) "home and community-based services provider" means a provider that the department has enrolled under 7 AAC 43.1090 to provide one or more home and community-based waiver services;

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

(10) "nursing facility" means a facility certified under 7 AAC 43.170 - 7 AAC 43.280 to provide services as a skilled nursing facility (SNF) or as an intermediate care facility (ICF);

(11) "physiatrist" means a physician who specializes in that branch of medicine using physical therapy, physical agents, such as light, heat, water, and electricity, and mechanical apparatus, in the diagnosis, prevention, and treatment of bodily disorders known as physiatrics;

(12) "recipient" means an individual who has been determined eligible for home and community-based waiver services under 7 AAC 43.1010;

(13) "recipient category" means a category listed in 7 AAC 43.1010(d)(1);

(14) "recipient's representative" means a parent, guardian, or other individual with legal authority to act on the recipient's behalf;

(15) "residential supported living services provider" means a provider that the department has enrolled under 7 AAC 43.1090 to provide residential supported living services under 7 AAC 43.1044;

(16) "waiver year" means the year in effect in a multiple-year waiver period approved under 42 U.S.C. 1396n(c) that begins July 1 and ends June 30.

History: Eff. 12/19/93, Register 128; am 3/3/2001, Register 157; am 5/15/2004, Register 170 Authority: AS 47.05.010 AS 47.07.030