Kevin Meyer
Lieutenant Governor
State Capitol
Juneau, Alaska 99811
907.465.3520
WWW.LTGOV.ALASKA.GOV

530 West 7th Ave, Suite 1700
Anchorage, Alaska 99501
907.269.7460
LT.GOVERNOR@ALASKA.GOV

OFFICE OF THE LIEUTENANT GOVERNOR
ALASKA

MEMORANDUM

TO: Triptaa Surve
Department of Health and Social Services

FROM: April Simpson, Office of the Lieutenant Governor
465.4081

DATE: March 1, 2021

RE: Filed Permanent Regulations: Department of Health and Social Services

Department of Health and Social Services regulations re: Medicaid coverage and payment, home and community-based waiver services: streamlined determinations for nursing facility level of care (NFLOC) (7 AAC 125.028(a)(2); 7 AAC 127.145(a)(2); 7 AAC 130; 7 AAC 169.900(d)(31))

Attorney General File:	2020200487
Regulation Filed:	3/1/2021
Effective Date:	3/31/2021
Print:	238, July 2021

cc with enclosures: Harry Hale, Department of Law
Judy Herndon, LexisNexis

ORDER ADOPTING CHANGES TO REGULATIONS
OF THE DEPARTMENT OF HEALTH & SOCIAL SERVICES

The attached 38 pages of regulations, dealing with Streamlining the Assessment Process for Medicaid Nursing Facility Level of Care Determinations for Waiver Services, are adopted and certified to be a correct copy of the regulation changes that the Department of Health and Social Services adopts under the authority of AS 47.05.010, AS 47.05.012, AS 47.07.030, AS 47.07.036, AS 47.07.040, and AS 47.07.045, and after compliance with the Administrative Procedure Act (AS 44.62), specifically including notice under AS 44.62.190 and 44.62.200 and opportunity for public comment under AS 44.62.210.

This action is not expected to require an increased appropriation.

In considering public comments, the Department of Health & Social Services paid special attention to the cost to private persons of the regulatory action being taken.

The regulation changes adopted under this order take effect on the 30th day after they have been filed by the lieutenant governor, as provided in AS 44.62.180.

Adam Crum Digitally signed by Adam Crum
Date: 2021.02.25 08:53:28 -09'00'

Adam Crum, Commissioner
Department of Health & Social Services

April Simpson, for

FILING CERTIFICATION

I, Kevin Meyer, Lieutenant Governor for the State of Alaska, certify that[1] on March 1st, 2021, at 3:01 p.m., I filed the attached regulations according to the provisions of AS 44.62.040 - 44.62.120.

April Simpson
for Lieutenant Governor Kevin Meyer

Effective: March 31, 2021.

Register: 238, July 2021

FOR DELEGATION OF THE LIEUTENANT GOVERNOR'S AUTHORITY

I, KEVIN MEYER, LIEUTENANT GOVERNOR OF THE STATE OF ALASKA, designate the following state employees to perform the Administrative Procedures Act filing functions of the Office of the Lieutenant Governor:

Josh Applebee, Chief of Staff
Kady Levale, Notary Administrator
April Simpson, Regulations and Initiatives Specialist

IN TESTIMONY WHEREOF, I have signed and affixed the Seal of the State of Alaska, in Juneau, on December 11th, 2018.

K. Mey

KEVIN MEYER
LIEUTENANT GOVERNOR

7 AAC 125.028(a)(2) is amended to read:

(2) a change to the recipient's eligibility to receive home and community-based waiver services under 7 AAC 130, including a change to the recipient's **support** plan [OF CARE] under 7 AAC 130.217 that may duplicate personal care services;

(Eff. 1/26/2012, Register 201; am 7/22/2017, Register 223; am 3/31/2021, Register 238)

Authority: AS 47.05.010 AS 47.07.030

7 AAC 127.145(a)(2) is amended to read:

(2) a change to the recipient's eligibility to receive home and community-based waiver services under 7 AAC 130, including a change to the recipient's **support** plan [OF CARE] under 7 AAC 130.217, or any other changes to health care services that may duplicate the recipient's Community First Choice personal care services;

(Eff. 10/1/2018, Register 227; am 3/31/2021, Register 238)

Authority: AS 47.05.010 AS 47.07.036 AS 47.07.040
AS 47.07.030

7 AAC 130.200 is amended to read:

7 AAC 130.200. Purpose. The purpose of this chapter is to offer to individuals that meet the eligibility criteria in 7 AAC 130.205 the opportunity to choose to receive home and community-based waiver services as an alternative to institutional care. Those services, when implemented through a person-centered **support** plan [OF CARE], provide opportunities for eligible individuals to receive services in the community and to maximize engagement in

community life. The individual, those individuals chosen by the individual to participate in service planning, and the providers selected by the individual to render services, work in collaboration to align services and supports in a person-centered practice that provides the full benefits of community living, and contributes to the achievement of the individual's goals. (Eff. 2/1/2010, Register 193; am 11/3/2012, Register 204; am 7/1/2013, Register 206; am 11/5/2017, Register 224; am 3/31/2021, Register 238)

Authority: AS 47.05.010 AS 47.07.040 AS 47.07.045
AS 47.07.030

7 AAC 130.206(f) is amended to read:

(f) The department will conduct an assessment in accordance with 7 AAC 130.213, and make a level-of-care determination in accordance with **7 AAC 130.215(3)** [7 AAC 130.215(d)(3)]. Following notification of the department's determination, the care coordinator shall develop and submit to the department a support plan in accordance with 7 AAC 128.010, [AND THE PROVISIONS OF] 7 AAC 130.217, and 7 AAC 130.218 [FOR A PLAN OF CARE].

(Eff. 10/1/2018, Register 227; am 1/1/2021, Register 236; am 3/31/2021, Register 238)

Authority: AS 47.05.010 AS 47.07.040 AS 47.07.045
AS 47.07.030

7 AAC 130.207 is repealed and readopted to read:

7 AAC 130.207. Application for home and community-based waiver services. (a) To

apply for home and community-based waiver services under this chapter

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

(A) an individual must participate in the person-centered intake process approved by the department; in this subparagraph, "person-centered intake process" means the process undertaken to help an individual understand the individual's unmet needs and to explore the resources available to meet those needs; and

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

(2) for the recipient category of individuals with intellectual and developmental disabilities, an individual must

(A) first, submit to the department a completed *Intellectual & Developmental Disabilities (DD) Registration and Review* form, adopted by reference in 7 AAC 160.900; and

(B) next, follow the process set out in 7 AAC 130.206(b) and (d).

(b) The department will

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

application; unless the department receives the missing information or documentation not later than 15 business days after the date of the notice of an incomplete application, the department will deny the application; and

(2) for the recipient category in (a)(2) of this section, if the individual chooses to continue the application process, follow the application process set out in 7 AAC 130.206(b), after which the individual must follow the process set out in 7 AAC 130.206(b)(1) - (3) and the individual's care coordinator must follow the process set out in 7 AAC 130.206(d).

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

(1) conduct an assessment under 7 AAC 130.213;

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

(3) notify the applicant and care coordinator of the level-of-care determination,

except that the department may extend the notification timeframe for an additional 30 business days if the department, under 7 AAC 130.213(f), forwards an assessment or reassessment for review by an independent qualified health care professional in accordance with AS 47.07.045(b) and 7 AAC 130.219(e)(4). (Eff. 7/1/2013, Register 206; am 7/1/2015, Register 214; am 10/1/2018, Register 227; am 3/31/2021, Register 238)

Authority: AS 47.05.010 AS 47.07.040 AS 47.07.045

AS 47.07.030

The introductory language of 7 AAC 130.209(a) is amended to read:

7 AAC 130.209. Expedited application, assessment, level-of-care determination, and support plan [OF CARE]. (a) The department will conduct an expedited review of a complete application that is submitted in accordance with **7 AAC 130.207** [7 AAC 130.207(a)] if the applicant has no natural supports to meet the applicant's needs and the applicant qualifies because of

. . .

7 AAC 130.209(d) is amended to read:

(d) Not 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 **support** plan [OF CARE] to the department for approval in accordance with 7 AAC 130.217 and 7 AAC 130.218.

7 AAC 130.209(e) is amended to read:

(e) Not later than 10 days after the department receives the complete **support** plan [OF CARE], the department will notify the recipient and the recipient's care coordinator of the department's approval or disapproval of specific services identified in the **support** plan [OF CARE]. (Eff. 7/1/2013, Register 206; am 7/1/2015, Register 214; am 11/5/2017, Register 224; am 3 /31 / 2021, Register 238)

Authority: AS 47.05.010 AS 47.07.040 AS 47.07.045
AS 47.07.030

7 AAC 130.211(a)(2) is amended to read:

(2) provide to the department a complete application in accordance with **7 AAC 130.207** [7 AAC 130.207(a)], and relevant and contemporaneous documentation that

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

(B) indicates the applicant's need for home and community-based waiver services.

(Eff. 7/1/2013, Register 206; am 11/5/2017, Register 224; am 10/1/2018, Register 227; am 3/31/2021, Register 238)

Authority: AS 47.05.010 AS 47.07.040 AS 47.07.045
AS 47.07.030

7 AAC 130.213 is repealed and readopted to read:

7 AAC 130.213. Assessment. (a) If an application under 7 AAC 130.211 and supportive diagnostic documentation reasonably indicate the need for services described in 7 AAC 130.211(a), the department will conduct an assessment of the applicant's physical, emotional, and cognitive functioning to determine the

(1) recipient category under 7 AAC 130.205(d) for which the applicant is eligible; and

(2) level of care under 7 AAC 130.215 that the applicant requires.

(b) If the department determines that an applicant meets the level-of-care requirement under 7 AAC 130.215, the department will send notice to the care coordinator for development

of a support plan in accordance with 7 AAC 130.217 and 7 AAC 130.218.

(c) To request an evaluation to determine whether a recipient has a continuing need for home and community-based waiver services, the recipient must submit a new application with current information in accordance with 7 AAC 130.207 not later than 90 days before the expiration of the period covered by the preceding level-of-care approval. The recipient must submit a new application in order to continue receiving home and community-based services after the expiration of the previous period.

(d) For recipients enrolled in the recipient categories specified in 7 AAC 130.205(d)(1), (2), and (4), the department will

(1) evaluate the recipient to determine if the recipient continues to meet the eligibility requirements of 7 AAC 130.205(d) and level-of-care requirement under 7 AAC 130.215 by conducting

(A) an assessment for

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

(ii) every third year after the recipient's second year of enrollment, if there has been no change in the recipient's condition; and

(B) an interim level-of-care review for each year an assessment does not occur; if the interim level-of-care review indicates that the recipient has experienced a material change in condition, the department will conduct an assessment; and

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

(e) For recipients enrolled in the recipient category specified in 7 AAC 130.205(d)(3), if

the new application indicates a need for continuing services, the department will

(1) either

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

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

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

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

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

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

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

department will

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

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

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

(h) The department may schedule and conduct an assessment or reassessment by teleassessment for an applicant or recipient who submits to the department an application in accordance with 7 AAC 130.207. If the department selects an applicant or recipient for a teleassessment, the department may request that the applicant or recipient provide information to the department about the residential setting of the applicant or recipient before the teleassessment is scheduled. (Eff. 7/1/2013, Register 206; am 7/1/2015, Register 214; am 11/5/2017, Register 224; am 3/31/2021, Register 238)

Authority: AS 47.05.010 AS 47.07.040 AS 47.07.045
AS 47.07.030

The introductory language of 7 AAC 130.215(1) is amended to read:

(1) for the recipient category of children with complex medical conditions, the department will determine, based on the results of the department's *Nursing Facility Level of*

Care Assessment Form for Children, adopted by reference in 7 AAC 160.900, **or an interim level-of-care review,** whether

. . .

The introductory language of 7 AAC 130.215(2) is amended to read:

(2) for the recipient category of adults with physical and developmental disabilities, the department will determine, based on the results of the department's *Consumer Assessment Tool (CAT)*, adopted by reference in 7 AAC 160.900, **or an interim level-of-care review,** whether the applicant has both a physical disability and a developmental disability, and whether

. . .

The introductory language of 7 AAC 130.215(4) is amended to read:

(4) for the recipient category of older adults or adults with physical disabilities, the department will determine, based on the results of the department's *Consumer Assessment Tool (CAT)*, adopted by reference in 7 AAC 160.900, **or an interim level-of-care review,** whether

. . .

(Eff. 7/1/2013, Register 206; am 3/31/2021, Register 238)

Authority: AS 47.05.010 AS 47.07.040 AS 47.07.045

AS 47.07.030

7 AAC 130.217 is amended to read:

7 AAC 130.217. Support plan [PLAN OF CARE] development and amendment. (a) Not less than once every 12 months, the care coordinator shall submit a **support** plan [OF CARE], based on the current needs of the recipient, the most recent assessment**, interim level-of-care review,** or reassessment conducted under 7 AAC 130.213, and the level-of-care determination made in accordance with 7 AAC 130.215. After an assessment**, interim level-of-care review,** or reassessment under 7 AAC 130.213, and after receiving the department's notice that the recipient meets the level-of-care requirement under 7 AAC 130.215, the care coordinator shall

(1) inform the recipient regarding

(A) the care coordinator's relationship as an employee of any provider certified under 7 AAC 130.220 and of any relationship described in 7 AAC 130.240(e);

(B) the full range of home and community-based 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 **support** plan [OF CARE]; the care coordinator shall support the recipient in the recipient's exercising the right to free choice of providers;

(2) consult, in person or by electronic mail, telephone, or videoconference, with each member of a planning team that meets the requirements of 7 AAC 130.218(b);

(3) prepare in writing, in a format provided by the department, a **support** plan [OF CARE] developed in accordance with this section and 7 AAC 130.218;

(4) secure the signature of

(A) the recipient or recipient's representative indicating that the recipient or recipient's representative

(i) agrees to the **support** plan [OF CARE];

(ii) is aware of any relationship between the care coordinator and any provider certified under 7 AAC 130.220 and of any relationship described in 7 AAC 130.240(e);

(B) each provider representative indicating the provider agrees to render the services as specified in the **support** plan [OF CARE]; and

(C) each individual on the planning team to verify participation in the development of the recipient's **support** plan [OF CARE]; and

(5) submit the **support** 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 **support** plan [OF CARE], and the department has approved a later submission date, the care coordinator shall submit the **support** plan [OF CARE] not later than

(A) 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 130.215;

(B) 30 days before expiration of the current plan year.

(b) The department will approve a **support** plan [OF CARE] if the department determines that

(1) the services specified in the **support** plan [OF CARE] are sufficient to prevent institutionalization and to maintain the recipient in the community;

(2) each service listed on the **support** plan [OF CARE]

(A) is of sufficient amount, duration, and scope to meet the needs of the recipient;

(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 this chapter; and

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

(c) Not later than 30 business days after the department receives the complete **support** plan [OF CARE], the department will notify the recipient, the recipient's representative, and the recipient's care coordinator of the department's approval or disapproval of specific services.

(d) A recipient's care coordinator shall

(1) prepare an amendment to the recipient's **support** plan [OF CARE] if

(A) 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) the recipient needs an increase or decrease in the number of service units approved under (a) - (c) of this section or in a prior amendment to the **support** plan [OF CARE]; and

(3) submit the **support** plan [OF CARE] amendment to the department not later than 10 business 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 **support** plan [OF CARE] amendment, and the department has approved a later submission date.

(e) Not later than 30 business days after the department receives a complete **support** plan [OF CARE] amendment, the department will notify the recipient, the recipient's representative, and the recipient's care coordinator of the department's approval or disapproval of specific services. (Eff. 7/1/2013, Register 206; am 7/1/2015, Register 214; 11/5/2017, Register 224; am 10/1/2018, Register 227; am 3/31/2021, Register 238)

Authority: AS 47.05.010 AS 47.07.040 AS 47.07.045
AS 47.07.030

7 AAC 130.218 is amended to read:

7 AAC 130.218. Person-centered practice. (a) Based on capacity and interest in participation, the recipient of home and community-based waiver services shall lead the planning process that results in a **support** plan [OF CARE] under 7 AAC 130.217 and this section.

(b) The planning process must

(1) recognize and support the recipient as central to the process with the authority to specify goals and needs, to request meetings at times and locations convenient to the recipient, and to revise the **support** plan [OF CARE] when necessary;

(2) include the recipient, the recipient's representative, individuals chosen by the

recipient to participate in the planning process, and the providers selected by the recipient to render home and community-based waiver services other than providers of

(A) transportation services under 7 AAC 130.290;

(B) environmental modification services under 7 AAC 130.300; or

(C) specialized medical equipment under 7 AAC 130.305;

(3) respond to recipient requests in a timely manner;

(4) reflect cultural considerations;

(5) provide information the recipient needs to make informed choices regarding services and supports; the information must be in plain language, and presented in a manner accessible to a recipient with disabilities or limited English proficiency; and

(6) include strategies for solving conflicts or disagreements that might arise during the process, including conflict-of-interest guidelines for all planning participants.

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

(1) address the clinical and support needs identified through a functional assessment conducted in accordance with 7 AAC 130.213;

(2) reflect the recipient's strengths and the recipient's preferences for delivery of services and supports;

(3) identify the elements important to the recipient to achieve the quality of life the recipient wishes, including the recipient's goals and desired outcomes;

(4) identify

(A) the services and supports, paid and unpaid, that will assist the recipient to achieve the recipient's goals and desired outcomes;

(B) the providers of those services and supports, including natural supports; and

(C) for each service

(i) the number of units, the frequency, and the projected duration of that service; and

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

(5) document the options for services and supports that were offered to the recipient under (b)(5) of this section;

(6) reflect that the setting in which the recipient resides is chosen by the recipient;

(7) document any modification of the requirements for provider-owned or operated residential settings in accordance with 7 AAC 130.220(p);

(8) reflect the risk factors and measures in place to minimize risks, including an individualized backup plan;

(9) identify the individuals responsible for monitoring the plan;

(10) use plain language, and be written in a manner that is both accessible to a recipient with disabilities or limited English proficiency and makes the **support** plan [OF CARE] understandable by the recipient and the individuals important in supporting the recipient;

(11) be finalized and agreed to in accordance with 7 AAC 130.217(a)(4); 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 the one established in the **support** plan [OF CARE], must be documented and attached to the **support** plan [OF CARE] submitted to the department for consideration and approval; and

(12) be distributed to the recipient and all others involved in developing the **support** plan [OF CARE].

(d) The providers, recipient, and individuals chosen by the recipient to participate in the planning process must ensure that

(1) unnecessary or inappropriate services and supports are not included in the **support** plan [OF CARE] developed in accordance with (c) of this section; and

(2) the settings in which home and community-based services are rendered are integrated in, and support full access to, the greater community. (Eff. 11/5/2017, Register 224; am 3/31/2021, Register 238)

Authority: AS 47.05.010 AS 47.07.040 AS 47.07.045
AS 47.07.030

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

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

130.213;

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

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

7 AAC 130.219(e) is amended to read:

(e) 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 130.217 and 7 AAC 130.218 [AS PART OF A REASSESSMENT] to determine the recipient's continuing eligibility for services was not submitted by the recipient, the recipient's representative, or the recipient's care coordinator at least 30 days before expiration of the current plan year;

(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 **assessment, interim level-of-care review, or** reassessment, conducted in accordance with 7 AAC 130.213(c) - (f), indicates the condition that made the recipient eligible for services has materially improved since the previous assessment, and

(A) the annual assessment and determination**, or the interim level-of-**

care review and determination, have been reviewed in accordance with AS 47.07.045(b)(2) using the department's

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

(ii) *Material Improvement Reporting for IDD Participants Under The Age of Three,* adopted by reference in 7 AAC 160.900, if the recipient is younger than three years of age and in the recipient category of individuals with intellectual and developmental disabilities;

(iii) *Material Improvement Reporting for IDD Participants Age Three or Over*, adopted by reference in 7 AAC 160.900, if the recipient is three years of age or older and in the recipient category of individuals with intellectual and developmental disabilities; or

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

(6) the recipient or the recipient's representative misrepresents the recipient's physical, intellectual, developmental, or medical condition in an effort to obtain services that are not medically necessary or for which the recipient does not qualify;

(7) the recipient has a documented history of failing to cooperate with the delivery of services identified in the **support** plan [OF CARE] prepared under 7 AAC 130.217 and 7 AAC 130.218, or of placing caregivers or other recipients at risk of physical injury, and no other providers 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 has been unable obtain cooperation with service delivery or to mitigate the risk of physical injury to a caregiver or other recipients 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**;** [.]

(8) the recipient or the recipient's representative fails to take an action or to submit documentation required under 7 AAC 130.209 - 7 AAC 130.218.

(Eff. 7/1/2013, Register 206; am 7/1/2015, Register 214; am 11/5/2017, Register 224; am 3/31/2021, Register 238)

Authority: AS 47.05.010 AS 47.07.040 AS 47.07.045
AS 47.07.030

The introductory language of 7 AAC 130.220(p) is amended to read:

(p) A provider that owns or controls a residential setting may modify the setting requirements in (o)(2) of this section for a specific, assessed need of a recipient, only after the provider attempts positive interventions and other less intrusive methods of meeting the need,

and these attempts prove unworkable. The modification must be approved in the **support** plan [OF CARE] developed in accordance with 7 AAC 130.217 and 7 AAC 130.218, and must be supported by a written record that includes

. . .

(Eff. 2/1/2010, Register 193; am 7/1/2013, Register 206; am 7/1/2015, Register 214; am 7/1/2016, Register 218; am 11/5/2017, Register 224; am 10/1/2020, Register 235; am 1/1/2021, Register 236; am 3/31/2021, Register 238)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

The introductory language of 7 AAC 130.227(b)(3) is amended to read:

(3) the recipient's **support** plan [OF CARE] developed in accordance with 7 AAC 130.217 and 7 AAC 130.218 specifies that the recipient needs

. . .

(Eff. 7/1/2013, Register 206; am 7/1/2015, Register 214; am 11/5/2017, Register 224; am 4/24/2020, Register 234; am 3/31/2021, Register 238)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

The introductory language of 7 AAC 130.229(a)(2) is amended to read:

(2) if justified for safe management of the recipient's behavior that requires intervention as described in the **support** plan [OF CARE] developed in accordance with 7 AAC 130.217 and 7 AAC 130.218

. . .

(Eff. 7/1/2013, Register 206; am 7/1/2015, Register 214; am 11/5/2017, Register 224; am 3/31/2021, Register 238)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

7 AAC 130.231(a)(3) is amended to read:

(3) are approved under 7 AAC 130.217 and 7 AAC 130.218 as part of the recipient's **support** plan [OF CARE]; and

7 AAC 130.231(b) is amended to read:

(b) A request for services for a recipient under this section must show that

(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 **support** plan [OF CARE];

(3) the absence is justified as

(A) a medical necessity documented by a physician licensed under AS 08.64;

(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 **support** plan [OF CARE]; or

(C) a vacation;

(4) the absence will be for a period of at least 24 hours; the total period for which the recipient may receive services under this section may not exceed 30 days during the period that a **support** plan [OF CARE] is in effect;

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

(6) the home and community-based waiver services provider 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.

The introductory language of 7 AAC 130.231(c) is amended to read:

(c) Notwithstanding (b)(4) of this section, the department may approve a temporary absence of more than 30 days during the period that a **support** plan [OF CARE] is in effect, if

• • •

(Eff. 7/1/2013, Register 206; am 11/5/2017, Register 224; am 3/31/2021, Register 238)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

7 AAC 130.240(a)(2)(B) is amended to read:

(B) developed under the provisions of 7 AAC 130.217 and 7 AAC 130.218 for a **support** plan [OF CARE].

The introductory language of 7 AAC 130.240(c) is amended to read:

(c) The department will pay the monthly care coordination service rate beginning the first of the month that the recipient is enrolled under 7 AAC 130.219(b) and has a support plan approved in accordance with the provisions of 7 AAC 130.217 and 7 AAC 130.218 for a **support** plan [OF CARE], for the following ongoing activities provided in accordance with (b) of this section:

• • •

The introductory language of 7 AAC 130.240(d) is amended to read:

(d) The department will waive the monthly in-person visit requirements for a recipient who lives in a remote community or location if the **support** plan [OF CARE] documents that

• • •

(Eff. 2/1/2010, Register 193; am 7/1/2013, Register 206; am 7/1/2015, Register 214; am 11/5/2017, Register 224; am 10/1/2018, Register 227; am 3/31/2021, Register 238)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

7 AAC 130.250(a)(3) is amended to read:

(3) are approved under 7 AAC 130.217 and 7 AAC 130.218 as part of the recipient's **support** plan [OF CARE]; and

(Eff. 2/1/2010, Register 193; am 7/1/2013, Register 206; am 7/1/2015, Register 214; am 11/5/2017, Register 224; am 3/31/2021, Register 238)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

7 AAC 130.255(a)(3) is amended to read:

(3) are approved under 7 AAC 130.217 and 7 AAC 130.218 as part of the recipient's **support** plan [OF CARE];

(Eff. 2/1/2010, Register 193; am 7/1/2013, Register 206; am 11/5/2017, Register 224; am 1/1/2021, Register 236; am 3/31/2021, Register 238)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

7 AAC 130.265(a)(3) is amended to read:

(3) are approved under 7 AAC 130.217 and 7 AAC 130.218 as part of the recipient's **support** plan [OF CARE];

The introductory language of 7 AAC 130.265(c)(1) is amended to read:

(1) a recipient's care coordinator must demonstrate, to the department's satisfaction in the recipient's **support** plan [OF CARE] developed under 7 AAC 130.217 and 7 AAC 130.218, that the following criteria were evaluated to determine that a family home habilitation services site is appropriate to provide services to the recipient:

• • •

The introductory language of 7 AAC 130.265(c)(4)(C) is amended to read:

(C) demonstrate to the department's satisfaction, in an amendment to the

support plan [OF CARE] under 7 AAC 130.217(d), that

. . .

(Eff. 2/1/2010, Register 193; am 7/1/2013, Register 206; am 7/1/2015, Register 214; am 11/5/2017, Register 224; am 10/1/2018, Register 227; am 1/1/2021, Register 236; am 3/31/2021, Register 239)

Authority: AS 47.05.010 AS 47.07.036 AS 47.07.040
AS 47.07.030

7 AAC 130.267 is amended to read:

7 AAC 130.267. Acuity payments for qualified recipients. (a) The department will pay for additional services under this section that

(1) are provided for a recipient who is qualified under (b) of this section and is receiving

(A) residential supported-living services under 7 AAC 130.255 that are assigned the procedure code described in 7 AAC 145.520(h); or

(B) group-home habilitation services under 7 AAC 130.265(f) that are assigned the procedure code described in 7 AAC 145.520(h)**;** [.]

(2) are requested in accordance with (c) of this section;

(3) the department determines to be necessary, based upon evaluation of the supporting documentation submitted in accordance with (d) or (e) of this section; and

(4) receive prior authorization.

(b) For purposes of this section, a qualified recipient is one that

(1) needs services that exceed those authorized in the recipient's current **support** plan [OF CARE] under 7 AAC 130.217 and 7 AAC 130.218; and

(2) because of the recipient's physical condition or behavior, needs direct one-to-one support from direct care workers whose time is dedicated solely to providing services under (a)(1) of this section to that one recipient 24 hours per day, seven days per week, in all environments in which the recipient functions.

(c) To request additional services under this section, the care coordinator responsible under 7 AAC 130.217 and 7 AAC 130.218 for the recipient's **support** plan [OF CARE] must submit

(1) written documentation that

(A) describes how the recipient's physical condition or behavior justifies the support described in (b) of this section;

(B) lists each intervention tried or in use to address the recipient's physical condition or behavior, and whether the intervention was successful or unsuccessful;

(C) indicates how additional services under this section would be consistent with services approved as part of the recipient's **support** plan [OF CARE] under 7 AAC 130.217 and 7 AAC 130.218; and

(D) addresses how the acuity payment under this section would be used to improve management of the recipient's physical condition or behavior; and

(2) the supporting evidence required under (d) or (e) of this section, as appropriate.

(d) If the recipient needs the support described in (b)(2) of this section because of the recipient's physical condition, in whole or in part, the request for additional services must include, in addition to the information required under (c) of this section,

(1) a copy of the recipient's most recent medical evaluation conducted as part of an assessment under 7 AAC 130.213 specific to the recipient's **support** plan [OF CARE] under 7 AAC 130.217 and 7 AAC 130.218;

(2) a record of the recipient's dates of hospital admission and discharge or of other medical interventions during the 30 days immediately preceding the date of the request;

(3) a copy of the recipient's clinical record under 7 AAC 105.230(d)(6) documenting 24 hours of activity for each of the 30 days immediately preceding the date of the request; and

(4) a description of how administration of medication is managed, and how other recurring medical treatments are managed.

(e) If the recipient needs the support described in (b)(2) of this section because of the recipient's behavior, in whole or in part, the request for prior authorization must include, in addition to the information required under (c) of this section, a copy of the recipient's

(1) most recent medical and psychological evaluations conducted as part of an assessment under 7 AAC 130.213 specific to the recipient's **support** plan [OF CARE] under 7 AAC 130.217 and 7 AAC 130.218; and

(2) clinical record under 7 AAC 105.230(d)(6) documenting 24 hours of activity for each of the 30 days immediately preceding the date of the request.

(f) The department will not approve additional services under this section for more than

12 consecutive months.

(g) The department may terminate authorization for services under this section at any time if the department verifies that the recipient's physical condition or behavior no longer requires additional services under this section.

(h) A provider who receives an acuity payment under this section shall

(1) provide workers to provide the services described in (b)(2) of this section; and

(2) ensure that at least one worker is awake at all times to provide those services.

(Eff. 4/1/2012, Register 201; am 7/1/2013, Register 206; am 7/1/2015, Register 214; am **11/5/2017** [11//2017], Register 224; am 3/1/2018, Register 225; am 3/31/2021, Register 238)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

7 AAC 130.270(a)(4) is amended to read:

(4) are approved under 7 AAC 130.217 and 7 AAC 130.218 as part of the recipient's **support** plan [OF CARE]; if a recipient is under 22 years of age, the **support** 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

(Eff. 2/1/2010, Register 193; am 7/1/2013, Register 206; am 7/1/2015, Register 214; am 10/1/2017, Register 223; am 11/5/2017, Register 224; am 3/31/2021, Register 238)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

7 AAC 130.275(a)(2) is amended to read:

(2) that are approved under 7 AAC 130.217 and 7 AAC 130.218 as part of the recipient's **support** plan [OF CARE];

(Eff. 2/1/2010, Register 193; am 3/1/2011, Register 197; am 7/1/2013, Register 206; am 7/1/2015, Register 214; am 11/5/2017, Register 224; am 7/1/2018, Register 226; am 3/31/2021, Register 238)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

7 AAC 130.280(a)(2) is amended to read:

(2) are approved under 7 AAC 130.217 and 7 AAC 130.218 as part of the recipient's **support** plan [OF CARE];

(Eff. 2/1/2010, Register 193; am 7/1/2013, Register 206; am 7/1/2015, Register 214; am 11/5/2017, Register 224; am 1/1/2021, Register 236; am 3/31/2021, Register 238)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

7 AAC 130.285(a)(2) is amended to read:

(2) are approved under 7 AAC 130.217 and 7 AAC 130.218 as part of the recipient's **support** plan [OF CARE]; and

7 AAC 130.285(b)(4) is amended to read:

(4) are included in the recipient's **support** plan [OF CARE].

(Eff. 2/1/2010, Register 193; am 7/1/2013, Register 206; am 11/5/2017, Register 224; am

4/24/2020, Register 234; am 3/31/2021, Register 238)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

7 AAC 130.290(a)(2) is amended to read:

(2) are approved under 7 AAC 130.217 and 7 AAC 130.218 as part of the recipient's **support** plan [OF CARE];

7 AAC 130.290(e)(3) is amended to read:

(3) transportation to destinations that are over 20 miles from the recipient's residence, unless approved by the department in the recipient's **support** plan [OF CARE];

(Eff. 2/1/2010, Register 193; am 7/1/2013, Register 206; am 7/1/2015, Register 214; am 11/5/2017, Register 224; am 3/31/2021, Register 238)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

7 AAC 130.295(a)(3) is amended to read:

(3) are approved under 7 AAC 130.217 and 7 AAC 130.218 as part of the recipient's **support** plan [OF CARE]; and

(Eff. 2/1/2010, Register 193; am 7/1/2013, Register 206; am 11/5/2017, Register 224; am 3/31/2021, Register 238)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

7 AAC 130.300(a)(2) is amended to read:

(2) are approved under 7 AAC 130.217 and 7 AAC 130.218 as part of the recipient's **support** plan [OF CARE]; and

7 AAC 130.300(b)(2)(A) is amended to read:

(A) meet the recipient's needs for accessibility identified in the recipient's **support** plan [OF CARE];

(Eff. 2/1/2010, Register 193; am 7/1/2013, Register 206; am 7/1/2015, Register 214; am 11/5/2017, Register 224; am 3/31/2021, Register 238)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

7 AAC 130.305(a)(1)(B) is amended to read:

(B) stating that the specific item requested is appropriate for the recipient and consistent with the **support** plan [OF CARE];

7 AAC 130.305(a)(3) is amended to read:

(3) is approved under 7 AAC 130.217 and 7 AAC 130.218 as part of the recipient's **support** plan [OF CARE]; and

(Eff. 2/1/2010, Register 193; am 3/1/2011, Register 197; am 7/1/2013, Register 206; am 11/5/2017, Register 224; am 6/2/2019, Register 230; am 4/24/2020, Register 234; am 3/31/2021, Register 238)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

7 AAC 130.319 is repealed and readopted to read:

7 AAC 130.319. Definitions. In this chapter, unless the context requires otherwise,

(1) "active teaching or training" means the use of appropriate measures or interventions that are evidence-informed, address objectives described in a recipient's approved support plan, lead to positive outcomes, and engage a recipient during each unit of service;

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

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

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

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

(6) "care coordination agency provider" means a provider that the department has certified under 7 AAC 130.220 to provide care coordination services under 7 AAC 130.240;

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

(8) "habilitation" means active teaching or training that

(A) assists a recipient to acquire, retain, or improve the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings; and

(B) is planned to help a recipient reach the level of physical, mental, and social functioning that the recipient has the capacity to engage in and benefit from;

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

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

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

(12) "natural supports" means

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

(B) the care and supports that are

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

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

(13) "primary caregiver" means an individual

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

care for a recipient; and

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

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

(A) lives

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

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

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

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

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

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

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

(18) "residential habilitation" means habilitation provided in a location that is

(A) a recipient's private residence; or

(B) a facility licensed under AS 47.32 that provides

(i) a structured setting with supervision and care;

(ii) shelter, food, household maintenance, and transportation;

(iii) encouragement, assistance, and guidance as necessary with activities of daily living described in 7 AAC 125.030(b);

(iv) social and recreational activities and opportunities both in the home and in the community; and

(v) arrangements for medical services if the need is indicated in the recipient's medical records;

(19) "residential supported-living services provider" means a provider that the department has certified under 7 AAC 130.220 to provide residential supported-living services under 7 AAC 130.255;

(20) "risk of institutionalization" means it is likely that the recipient's current condition would require the recipient to be relocated, within the support plan year, from the recipient's current residence to an acute care hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities;

(21) "teleassessment" means the use of audio, visual, or data communication methods to complete an assessment. (Eff. 2/1/2010, Register 193; am 11/3/2012, Register 204; am 7/1/2013, Register 206; am 7/1/2015, Register 214; am 11/5/2017, Register 224; am 10/1/2018, Register 227; am 10/1/2020, Register 235; am 3/31/2021, Register 238)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

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

(31) repealed 3/31/2021;

(Eff. 2/1/2010, Register 193; am 8/25/2010, Register 195; am 12/1/2010, Register 196; am

1/1/2011, Register 196; am 1/15/2011, Register 197; am 2/9/2011, Register 197; am 3/1/2011, Register 197; am 10/1/2011, Register 199; am 12/1/2011, Register 200; am 1/26/2012, Register 201; am 3/8/2012, Register 201; am 4/1/2012, Register 201; add'l am 4/1/2012, Register 201; am 5/11/2012, Register 202; am 10/16/2012, Register 204; am 11/3/2012, Register 204; am 12/1/2012, Register 204; am 12/2/2012, Register 204; am 1/1/2013, Register 204; am 1/16/2013, Register 205; am 7/1/2013, Register 206; add'l am 7/1/2013, Register 206; am 11/3/2013, Register 208; am 1/1/2014, Register 208; am 2/2/2014, Register 209; am 3/19/2014, Register 209; am 3/22/2014, Register 209; am 5/18/2014, Register 210; am 2/26/2015, Register 213; am 3/15/2015, Register 213; am 7/1/2015, Register 214; am 5/1/2016, Register 218; am 6/16/2016, Register 218; am 6/16/2016, Register 218; am 7/22/2017, Register 223; am 11/5/2017, Register 224; am 3/1/2018, Register 225; am 10/1/2018, Register 227; am 1/1/2019, Register 228; am 3/24/2019, Register 229; am 6/2/2019, Register 230; am 6/13/2019, Register 230; am 7/1/2019, Register 231; am 10/25/2019, Register 232; am 11/10/2019, Register 232; am 4/24/2020, Register 234; am 5/21/2020, Register 234; am 6/25/2020, Register 234; am 10/1/2020, Register 235; am 10/4/2020, Register 236; **am 1/1/2021** [ADD'L AM 1/1/2021], Register 236; am 3/31/2021, Register 238)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

The 37th paragraph of the editor's note following 7 AAC 160.900 is changed to read:

The [APPLICATION FOR ALI/APDD/ CCMC/CFC (NEW AND RENEWAL),] *Adult Day Services Condition of Participation*, *Care Coordinator Certification Application*, *Care Coordination Services and Long Term Services and Supports Targeted Case Management*

Conditions of Participation, *Community First Choice Chore Services Conditions of Participation*, *Day Habilitation Services Conditions of Participation*, *Developmental Disabilities (DD) Registration and Review* form, *Material Improvement Reporting for ALI/APDD Waivers*, *Material Improvement Reporting for CCMC Waivers*, *Material Improvement Reporting for IDD Participants Age Three or Over*, *Material Improvement Reporting for IDD Participants Under the Age of Three*, *Meal Services Conditions of Participation*, *Nursing Facility Level of Care Assessment Form for Children*, *Provider Conditions of Participation for Home and Community-Based Waiver Services and Community First Choice Chore Services*, *Residential Habilitation Services Conditions of Participation*, *Residential Supported-Living Services Conditions of Participation*, *Supported Employment Services Conditions of Participation*, *Transportation Services Conditions of Participation*, *Environmental Modification Services Conditions of Participation*, and *Nursing Oversight and Care Management Conditions of Participation*, adopted by reference in 7 AAC 160.900(d), 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 website at http://dhss.alaska.gov/dsds.

MEMORANDUM

State of Alaska
Department of Law

To: The Honorable Kevin Meyer
Lieutenant Governor

Date: February 26, 2021

File No.: 2020200487

Thru: Susan R. Pollard DS SRP
Chief Assistant Attorney General
and Regulations Attorney
Legislation and Regulations Section

Tel. No.: 465-3600

From: Steven C. Weaver *scw*
Senior Assistant Attorney General
Legislation and Regulations Section

Re: Department of Health and Social Services regulations re: Medicaid coverage and payment, home and community-based waiver services: streamlined determinations for nursing facility level of care (NFLOC) (7 AAC 125.028(a)(2); 7 AAC 127.145(a)(2); 7 AAC 130; 7 AAC 160.900(d)(31))

The Department of Law has reviewed the attached regulations of the Department of Health and Social Services against the statutory standards of the Administrative Procedure Act. Based upon our review, we find no legal problems. This memorandum constitutes the written statement of approval under AS 44.62.060(b) and (c) that authorizes your office to file the attached regulations. The regulations were adopted by Department of Health and Social Services after the close of the public comment period. The regulations and their conforming changes update Medicaid coverage and payment regulations regarding home and community-based waiver services, to establish a streamlined process to determine the nursing facility level of care (NFLOC) for most applicants for and recipients of those services.

The Department of Health and Social Services would like to see these regulations in effect on or before April 1, 2021. Accordingly, we ask for a filing date on or before March 2, 2021.

The August 13, 2020 public notice and the February 25, 2021 adoption order both state that this action is not expected to require an increased appropriation. Therefore, a fiscal note under AS 44.62.195 is not required.

SCW

cc w/enc.: Hon. Adam Crum, Commissioner
Department of Health and Social Services

Triptaa Surve, Regulations Contact
Department of Health and Social Services

John Lee, Director
Division of Senior and Disabilities Services
Department of Health and Social Services

Jetta Whittaker
Division of Senior and Disabilities Services
Department of Health and Social Services

Paul R. Peterson, Assistant Attorney General
Human Services Section

NOTICE OF PROPOSED CHANGES ON MEDICAID NURSING FACILITY LEVEL OF CARE DETERMINATIONS FOR WAIVER SERVICES IN THE REGULATIONS OF THE DEPARTMENT OF HEALTH & SOCIAL SERVICES.

BRIEF DESCRIPTION

The Department of Health & Social Services proposes to change regulations by streamlining the assessment process for Medicaid nursing facility level of care determinations for waiver services.

The Department of Health & Social Services proposes to adopt regulation changes in Title 7 of the Alaska Administrative Code, dealing with the Medicaid nursing facility level of care determinations for waiver services, including the following:

- **7 AAC 130. Medicaid Coverage; Home and Community-Based Waiver Services, and 7 AAC 160.900 Medicaid Program; General Provisions; Requirements adopted by reference,** are proposed to be changed as follows: Amend regulations and definitions to streamline the assessment process for nursing facility level of care determinations for waiver services.

You may comment on the proposed regulation changes, including the potential costs to private persons of complying with the proposed changes, by submitting written comments to the State of Alaska, Department of Health & Social Services, Division of Senior and Disabilities Services, Attention: Jetta Whittaker, P.O. Box 110680, Juneau, Alaska 99811-0680. Additionally, Department of Health and Social Service will accept comments by facsimile at (907) 465-1170 and by electronic mail at jetta.whittaker@alaska.gov . The comments must be received not later than 5:00 p.m. on September 30, 2020.

You may provide oral comments relevant to the proposed action **via telephone** at the hearing to be held on September 15, 2020, 12:00 p.m. – 1:00 p.m., **by calling 1- (800) 315-6338 and using code 34773737# at the prompt. Please note that in-person attendance will not be permitted at the hearing site because of the public health and safety concerns associated with the COVID – 19 pandemic. Please prepare to share your oral comments by telephone only.** If you call to provide oral testimony, you should be on the line **before** the hearing begins at 12:00 p.m. The Department of Health & Social Services will give priority to those who call in before 12:30 p.m. The Department of Health & Social Services may, before the hearing begins, limit the time allotted for each person providing oral testimony. The time limit may be necessary to conclude the hearing in the time provided.

You may submit written questions relevant to the proposed action to Jetta Whittaker, by e-mail at jetta.whittaker@alaska.gov or mail at the State of Alaska, Department of Health & Social Services, Division of Senior and Disabilities Services, Attention: Jetta Whittaker, P.O. Box 110680, Juneau, Alaska 99811-0680. The questions must be received at least 10 days before the end of the public comment period. The Department of Health and Social Services will aggregate its response to substantially similar questions and make the questions and responses available on the Alaska Online Public Notice System.

If you are a person with a disability who needs a special accommodation in order to participate in this process, please contact Jetta Whittaker by electronic mail at jetta.whittaker@alaska.gov or (907) 465-1605 not later than September 4, 2020, to ensure that any necessary accommodations can be provided.

A copy of the proposed regulation changes is available on the Alaska Online Public Notice System and by contacting Jetta Whittaker at jetta.whittaker@alaska.gov or (907) 465-1605.

After the public comment period ends, the Department of Health & Social Services will either adopt the proposed

regulation changes or other provisions dealing with the same subject, without further notice, or decide to take no action. The language of the final regulation may be different from that of the proposed regulation. **You should comment during the time allowed if your interests could be affected.**

Statutory authority: AS 47.05.010; AS 47.05.012; AS 47.07.030; AS 47.07.040; AS 47.07.045.

Statutes being implemented, interpreted, or made specific: AS 47.05.010; AS 47.05.012; AS 47.07.030; AS 47.07.040; AS 47.07.045.

Fiscal information: The proposed regulation changes are not expected to require an increased appropriation.

DATE: August 11, 2020.
/s/Adam Crum
Commissioner,
Department of Health & Social Services
State of Alaska.

ADDITIONAL REGULATION NOTICE INFORMATION
(AS 44.62.190(d))[1]

1. Adopting agency: Department of Health & Social Services (DHSS)

2. General subject of regulation: Streamlining the assessment process for nursing facility level of care determinations for waiver services.

3. Citation of regulation (may be grouped): 7 AAC 130, 7 AAC 160.900.

4. Department of Law file number, if any: 2020200487

5. Reason for the proposed action:
   ( ) Compliance with federal law or action (identify):_____
   ( ) Compliance with new or changed state statute
   ( ) Compliance with federal or state court decision (identify):_____
   ( ) Development of program standards
   (X) Other (identify): DHSS budget reductions that affect the process for making eligibility determinations.

6. Appropriation/Allocation: Medicaid Services/Senior & Disabilities Services

7. Estimated annual cost to comply with the proposed action to:
   A private person: $0
   Another state agency:$0
   A municipality:$0

8. Cost of implementation to the state agency and available funding (in thousands of dollars): None.

	Initial Year FY 2021	Subsequent Years
Operating Cost	$0	$0
Capital Cost	$0	$0
1002 Federal receipts	$	$
1003 General fund match	$	$
1004 General fund	$	$
1005 General fund/ program	$	$
Other (identify)	$0	$0

9. The name of the contact person for the regulation:
Name: Jetta Whittaker
Title: Health Program Manager III
Address: 240 Main Street, Suite 600, Juneau, AK 99801
Telephone: (907) 464-1605
E-mail address: jetta.whittaker@alaska.gov

10. The origin of the proposed action:
__X__ Staff of state agency
_____ Federal government
_____ General public
_____ Petition for regulation change
_____ Other (identify):_____

11. Date & Prepared by: Digitally signed by Jetta Whittaker Date: 2020.04.10 14:21:37 -08'00'
[signature]
Name (printed): Jetta Whittaker
Title (printed): Health Program Manager III
Telephone: (907) 465-1605

ANCHORAGE DAILY NEWS
AFFIDAVIT OF PUBLICATION

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STATE OF ALASKA
THIRD JUDICIAL DISTRICT

Lisi Misa being first duly sworn on oath deposes and says that she is a representative of the Anchorage Daily News, a daily newspaper. That said newspaper has been approved by the Third Judicial Court, Anchorage, Alaska, and it now and has been published in the English language continually as a daily newspaper in Anchorage, Alaska, and it is now and during all said time was printed in an office maintained at the aforesaid place of publication of said newspaper. That the annexed is a copy of an advertisement as it was published in regular issues (and not in supplemental form) of said newspaper on

08/13/2020

and that such newspaper was regularly distributed to its subscribers during all of said period. That the full amount of the fee charged for the foregoing publication is not in excess of the rate charged private individuals.

Signed _____

Subscribed and sworn to before me
this 1st day of October 2020.

_____
Notary Public in and for
The State of Alaska.
Third Division
Anchorage, Alaska

MY COMMISSION EXPIRES
7/14/2024

NOTARY PUBLIC
JADA L. NOWLING
STATE OF ALASKA
MY COMMISSION EXPIRES July 14, 2024

NOTICE OF PROPOSED CHANGES ON MEDICAID NURSING FACILITY LEVEL OF CARE DETERMINATIONS FOR WAIVER SERVICES IN THE REGULATIONS OF THE DEPARTMENT OF HEALTH & SOCIAL SERVICES.

The Department of Health & Social Services proposes to adopt regulation changes in Title 7 of the Alaska Administrative Code, dealing with the Medicaid nursing facility level of care determinations for waiver services, including the following:

• **7 AAC 130. Medicaid Coverage; Home and Community-Based Waiver Services, and 7 AAC 160.900 Medicaid Program; General Provisions; Requirements adopted by reference,** are proposed to be changed as follows: Amend regulations and definitions to streamline the assessment process for nursing facility level of care determinations for waiver services.

You may comment on the proposed regulation changes, including the potential costs to private persons of complying with the proposed changes, by submitting written comments to the State of Alaska, Department of Health & Social Services, Division of Senior and Disabilities Services, Attention: Jetta Whittaker, P.O. Box 110680, Juneau, Alaska 99811-0680. Additionally, Department of Health and Social Service will accept comments by facsimile at (907) 465- 1170 and by electronic mail at jetta.whittaker@alaska.gov . The comments must be received not later than 5:00 p.m. on September 30, 2020.

You may provide oral comments relevant to the proposed action via telephone at the hearing to be held on September 15, 2020, 12:00 p.m. – 1:00 p.m., **by calling 1- (800) 315-6338 and using code 34773737# at the prompt. Please note that in-person attendance will not be permitted at the hearing site because of the public health and safety concerns associated with the COVID – 19 pandemic. Please prepare to share your oral comments by telephone only.** If you call to provide oral testimony, you should be on the line **before** the hearing begins at 12:00 p.m. The Department of Health & Social Services will give priority to those who call in before 12:30 p.m. The Department of Health & Social Services may, before the hearing begins, limit the time allotted for each person providing oral testimony. The time limit may be necessary to conclude the hearing in the time provided.

You may submit written questions relevant to the proposed action to Jetta Whittaker, by e-mail at jetta.whittaker@alaska.gov or mail at the State of Alaska, Department of Health & Social Services, Division of Senior and Disabilities Services, Attention: Jetta Whittaker, P.O. Box 110680, Juneau, Alaska 99811-0680. The questions must be received at least 10 days before the end of the public comment period. The Department of Health and Social Services will aggregate its response to substantially similar questions and make the questions and responses available on the Alaska Online Public Notice System.

If you are a person with a disability who needs a special accommodation in order to participate in this process, please contact Jetta Whittaker by electronic mail at jetta.whittaker@alaska.gov or (907) 465-1605 not later than September 4, 2020, to ensure that any necessary accommodations can be provided.

A copy of the proposed regulation changes is available on the Alaska Online Public Notice System and by contacting Jetta Whittaker at jetta.whittaker@alaska.gov or (907) 465-1605.

After the public comment period ends, the Department of Health & Social Services will either adopt the proposed regulation changes or other provisions dealing with the same subject, without further notice, or decide to take no action. The language of the final regulation may be different from that of the proposed regulation. **You should comment during the time allowed if your interests could be affected.**

Statutory authority: AS 47.05.010; AS 47.05.012; AS 47.07.030; AS 47.07.040; AS 47.07.045.

Statutes being implemented, interpreted, or made specific: AS 47.05.010; AS 47.05.012; AS 47.07.030; AS 47.07.040; AS 47.07.045.

Fiscal Information: The proposed regulation changes are not expected to require an increased appropriation.

DATE: August 11, 2020.
/s/Adam Crum
Commissioner,
Department of Health & Social
Services State of Alaska.

Published: August 13, 2020

AFFIDAVIT OF NOTICE OF PROPOSED REGULATION AND FURNISHING OF ADDITIONAL INFORMATION

I, Jetta Whittaker, Health Program Manager III, of the Department of Health & Social Services, under penalty of perjury, certify the following:

As required by AS 44.62.190, notice of the proposed adoption of changes to Streamlining the Assessment Process for Nursing Facility Level of Care Determinations for Waiver Services (7 AAC 130, 7 AAC 160.900), specifically, 7 AAC 130. Medicaid Coverage; Home and Community-Based Waiver Services, and 7 AAC 160.900 Medicaid Program; General Provisions; Requirements adopted by reference, has been given by being

(1) published in a newspaper or trade publication;
(2) furnished to every person who has filed a request for notice of proposed action with the state agency;
(3) furnished to appropriate state officials;
(4) furnished to interested persons;
(5) furnished to the Department of Law, along with a copy of the proposed regulation;
(6) furnished electronically to incumbent State of Alaska legislators;
(7) posted on the Alaska Online Public Notice System as required by AS 44.62.175(a)(1) and (b) and 44.62.190(a)(1).

As required by AS 44.62.190, additional regulation notice information regarding the proposed adoption of the regulation changes described above has been furnished to interested persons and those in (2), (4) and (6) of the list above. The additional regulation notice information also has been posted on the Alaska Online Public Notice System.

There is no notary public or other official empowered to administer oaths available to notarize this document as a result of social distancing requirements implemented statewide.

I certify under penalty of perjury that the foregoing is true.

Jetta Whittaker

Digitally signed by Jetta Whittaker
Date: 2020.10.20 16:37:26 -08'00'

[original or password-protected electronic signature]
Jetta Whittaker, Health Program Manager III

State of Alaska
Juneau, AK 99801.

AFFIDAVIT OF AGENCY RECORD OF PUBLIC COMMENT

I, Jetta Whittaker, Health Program Manager III, of the Department of Health & Social Services, under penalty of perjury, state the following:

In compliance with AS 44.62.215, the Department of Health & Social Services has kept a record of its use or rejection of factual or other substantive information that was submitted in writing and orally as public comment and that was relevant to the accuracy, coverage, or other aspect of the Department of Health & Social Services regulation on Streamlining the Assessment Process for Nursing Facility Level of Care Determinations for Waiver Services (7 AAC 130, 7 AAC 160.900), specifically, 7 AAC 130. Medicaid Coverage; Home and Community-Based Waiver Services, and 7 AAC 160.900 Medicaid Program; General Provisions; Requirements adopted by reference.

There is no notary public or other official empowered to administer oaths available to notarize this document as a result of social distancing requirements implemented statewide.

I certify under penalty of perjury that the foregoing is true.

Jetta Whittaker

Digitally signed by Jetta Whittaker
Date: 2020.10.20 16:39:36 -08'00'

[original or password-protected electronic signature]
Jetta Whittaker, Health Program Manager III

State of Alaska
Juneau, AK 99801.

AFFIDAVIT OF ORAL HEARING

I, Caroline Hogan, Health Program Manager IV, of the Department of Health & Social Services, under penalty of perjury, state the following:

On September 15, 2020, at 12:00 p.m., via teleconference and without in-person attendance because of the public health and safety concerns related to the COVID-19 pandemic, I presided over a public hearing held under AS 44.62.210 for the purpose of taking testimony in connection with the adoption of changes to 7 AAC 130, 160.900. Streamlining the Assessment Process for Nursing Facility Level of Care Determinations for Waiver Services, specifically, 7 AAC 130. Medicaid Coverage; Home and Community-Based Waiver Services, and 7 AAC 160.900 Medicaid Program; General Provisions; Requirements adopted by reference.

There is no notary public or other official empowered to administer oaths available to notarize this document as a result of social distancing requirements implemented statewide.

I certify under penalty of perjury that the foregoing is true.

Caroline Hogan Digitally signed by Caroline Hogan
Date: 2020.10.22 07:23:30 -08'00'

[original or password-protected electronic signature]
Caroline Hogan, Health Program Manager IV

State of Alaska
Juneau, AK 99801.