1. INPATIENT HOSPITAL SERVICES: All hospitalizations must be physician-prescribed. The maximum hospital length of stay for any single admission is three days except for
   a. Psychiatric admissions authorized by the department's utilization review contractor, and
   b. Maternal and newborn hospital stays related to childbirth, which are limited to 48 hours of inpatient stay for a normal vaginal delivery and 96 hours of inpatient stay for a cesarean delivery.
   c. General acute care hospitals, reimbursed under the Diagnosed Related Group (DRG) methodology, are exempt from continued stay authorizations.

Hospitals must secure a continued stay authorization from the division, or its designee, for patients to exceed the three-day maximum length of stay. The 48-hour and 96-hour maximum stay for maternal and newborn hospitalizations can be exceeded with a continued stay authorization.

Selected surgical procedures and medical diagnoses require preadmission certification from the department or its designee. Organ transplants must be prior authorized by the department or its designee. Coverage for organ transplants is limited to kidney, corneal, skin, bone, heart, lung, heart & lung, and bone marrow transplants for adults; and liver transplants for adults with biliary atresia or another form of end-stage liver disease. Children under 21 years of age will receive all medically necessary organ transplants. Coverage for transplants also extends to coverage for outpatient immunosuppressive therapy. Organ transplants and requisite related medical care will be covered at an available transplant center either within the state or at a transplant center located outside the state that has been authorized by the division.

2. a. OUTPATIENT HOSPITAL SERVICES: "Outpatient hospital services" excludes services not generally furnished by most hospitals in the state, such as outpatient psychiatric and substance abuse treatment services.

3. LABORATORY AND RADIOLOGY SERVICES: Laboratory and radiology services must be medically necessary and ordered by a physician or other licensed practitioners acting within their scope of practice. Medically necessary diagnostic mammograms are covered. Laboratory tests are performed by a laboratory certified in accordance with the Clinical Laboratory Improvement Amendments (CLIA), at 42 CFR 493. Other laboratory and radiology services are furnished in an office or similar facility other than a hospital outpatient department or clinic and meet the State's provider qualifications. All medically necessary lab and radiology services are furnished without limitations. Selected laboratory and radiology services, however, require prior authorization.

4. a. NURSING FACILITY: Placement in a nursing facility, ordered by a physician, providing a skilled level of nursing care requires prior authorization by the department. Pre-admission Screening and Resident Review (PASRR) is required for admission and continued stay in nursing facilities.

4. b. EPSDT ENHANCED SERVICES:

   1) Private Duty Nursing

   Medicaid recipients under twenty-one (21) years of age may receive medically necessary private duty nursing services in accordance with 42 § CFR 440.80.
   Private-duty nursing services are provided in a family setting, to Medicaid recipients under twenty-one (21) years of age experiencing a life-threatening illness and requiring more individual and continuous care than is available from a visiting nurse or is routinely provided by the nursing staff of a hospital, a skilled nursing facility or an intermediate care facility.

   Private-duty nursing services are provided with the intent to prevent admission to, or promote early discharge from, an acute care or long-term care facility. Services must be provided in accordance with a plan of care approved by the recipients attending physician, and include,

assessment; administration of treatment related to technological dependence, and; monitoring and maintaining parameters, machinery, and interventions.

Private-duty nursing does not include housekeeping, laundry, shopping, meal preparation, or transportation.

2) Podiatry

Medicaid recipients under twenty-one (21) years of age may receive medically necessary podiatry services in accordance with the provisions of 42 § CFR 440.60(a).

Podiatry services are provided to a Medicaid recipient who has been found to need medical services relating to specific conditions of the ankle or foot, when a physician has prescribed the treatment; and the treatment provided is within the scope of practice of the enrolled and licensed treating podiatrist. Nutrition Services

3) Nutrition Services

Medicaid recipients under twenty-one (21) years of age determined to be at high risk nutritionally may receive nutrition services including, one initial assessment in a calendar year and up to twelve (12) hours of nutritional counseling and follow-up care after the initial assessment in a calendar year.

Nutrition services are delivered in accordance with 42 § CFR 440.60(a)upon a determination that the Medicaid recipient is at high risk nutritionally by a physician, an advanced nurse practitioner, or another licensed or certified health care practitioner . Requests exceeding the original twelve (12) hours of service in a calendar year can be prior authorized by the State Medicaid Agency if the additional hours are medically necessary.

4) Chiropractic Services

Medicaid recipients under twenty-one (21) years of age who have a demonstrated medical need, receive chiropractic services in accordance with 42 § CFR 440.60. Chiropractic services are provided by a chiropractor holding an active state license and meeting the requirements of 42 CFR 405.232(b).

Covered chiropractic services are identified in the CPT Fee Schedule for Chiropractic Services table adopted by reference in regulation. The Alaska Medicaid Program allows manual manipulation to correct a subluxation of the spine, and x-rays necessary for diagnosis, if the subluxation of the spine resulted in a neuromusculoskeletal condition for which manual manipulation is the appropriate treatment. If there is no x-ray to support that a subluxation exists, the recipient's record must contain complete documentation of the examination results justifying manual manipulation for the subluxation of the spine.

5) Dental Services

Dental services for children are covered as specified in federal statute governing EPSDT when provided by a licensed dentist, including an orthodontist, or a certified dental health aide supervised by a dentist.

The Alaska Medicaid Program allows diagnostic examination and radiographs as needed for routine and emergency dental care; preventive care; restorative care; endodontics; periodontics; prosthodontics; oral surgery; anesthesia and sedation; professional; and office visits if an antibiotic is prescribed or administered without any further billable treatment that day.

EPSDT Services, continued

The Alaska Medicaid Program allows for limited, interceptive, and comprehensive orthodontic treatment. Except for cases involving the treatment of a cleft palate, which is a specific type of orthodontic treatment, recipients of limited, interceptive, and comprehensive orthodontic treatment must not have a history of caries in the six months before starting treatment.

6) Emergency Hospital Services

Emergency hospital services, as defined in 42 CFR § 440.170(e), are covered for recipients under age 21.

7) Behavior Analysis Services

In accordance with 1905(a)(6), Alaska covers the services of a Licensed Behavior Analyst pursuant to their scope of practice within the state.

In accordance with 1905(a)(6), Alaska covers the services of a Licensed Assistant Board Certified Behavior Analyst (BCBA) pursuant to its scope of practice within the state.

In accordance with 1905(a)(6), Alaska covers the services of a Behavior Technician working under the supervision of a Licensed Behavioral Analyst pursuant to their scope of practice within the state. The Licensed Behavior Analyst bills for all Behavior Technician services furnished.

8) Vision Services

Medically necessary eye examinations, refractions, eyeglasses, and fitting fees are covered once per calendar year. The Medicaid agency may cover additional vision services subject to a determination of medical necessity and prior authorization by the Medicaid agency or its designee.

Eyeglasses are purchased for recipients under a competitively bid contract.

Medicaid recipients under twenty-one years of age receive vision services, including diagnosis and treatment of defects in vision and eyeglasses, in accordance with sections 1905(a)(4)(B) and 1905(r)(2) of the Social Security Act, subject to a determination of medical necessity and prior authorization by the Medicaid agency or its designee.

4. c. FAMILY PLANNING SERVICES: Fertility services not covered.

5. a. PHYSICIAN SERVICES: Physicians' services are provided in accordance with regulations at 42 CFR 440.50. A surgical procedure that could be considered experimental, investigative, or cosmetic is not covered unless that procedure is medically necessary in the course of treatment for injury or illness and has been prior authorized by the medical review section of the division or its designee.

6. b. OPTOMETRIST SERVICES: Annual vision examinations and preventive services for individuals 21 years of age or older are provided to beneficiaries based on the calendar year, or when an attending ophthalmologist or optometrist finds health reasons for additional covered vision services. For recipients twenty-one (21) years of age and older, additional vision services in a calendar year are subject to a determination of medical necessity and prior authorization by the Medicaid agency or its designee.

6. d.1 DIRECT ENTRY MIDWIFE SERVICES: Direct entry midwife services are those services for the management of prenatal, intrapartum, and postpartum care that a direct-entry midwife is authorized to provide under the scope of practice of their state license.

6. d.2 In accordance with 42 CFR § 440.60, licensed and qualified pharmacists acting within their scope of practice as defined in state law. Pharmacists, pharmacy interns, and pharmacy technicians are qualified providers of COVID-19 vaccinations per the HHS COVID-19 PREP Act Declaration and authorizations. Qualified pharmacy interns and qualified pharmacy technicians are working under the supervision of a licensed pharmacist.

6. d.3 In accordance with 42 CFR § 440.60(a), the following licensed providers acting within their scope of practice as defined by state law: Licensed Psychologists, Licensed Clinical Social Workers, Licensed Marriage and Family Therapists, and Licensed Professional Counselors.

6. d.4 In accordance with 42 CFR § 440.60(a), licensed advanced practice registered nurses (APRNs) are covered for services within their scope of practice in accordance with state law, who may or may not hold state-granted independent prescriptive authority. When APRNs do not have independent prescriptive authority in the state, the APRN operates within the scope of their collaborative practice agreement for the purposes of prescribing and dispensing legend drugs.

6. d.5 In accordance with 42 CFR § 440.60(a), Alaska Medicaid covers services provided by licensed advanced practice dental hygienists when performed within their scope of practice as defined by state law.

7. a-d. HOME HEALTH SERVICES: Home health services are offered in accordance with 42 CFR 440.70. Home health services must be prior authorized by the State Medicaid Agency or its designee.

   c. Equipment and appliances that require prior authorization by the State Medicaid Agency or its designee are listed in the provider manual.

9. **CLINIC SERVICES**:

Community Behavioral Health Provider –

A. **Definition of services -** The Medicaid agency or designee will reimburse a community behavioral health services provider for the provision of approved services for the treatment of diagnosable behavioral health disorders, including mental health and substance use disorders, provided to eligible Medicaid beneficiaries.

B. Prior authorization and limitations

The following services do not need prior authorization if provided within the following service limits:

i. Any combination of individual, group, and family therapy not to exceed 30 hours per state fiscal year.

ii. Psychiatric assessment not to exceed four per recipient per state fiscal year.

iii. Psychological testing not to exceed six hours per recipient per state fiscal year.

iv. Pharmacologic management not to exceed one visit per week during the first four weeks of treatment, one visit bi-weekly (every two weeks) for up to eight weeks, and thereafter not to exceed one visit per month.

v. If an individual is not already receiving services, one integrated mental health, and substance use intake assessment or a combination of one mental health intake assessment, and one substance use intake assessment.

vi. If an individual is subject to a current behavioral health treatment plan, one integrated mental health and substance use intake assessment or a combination of one mental health intake assessment and one substance use intake assessment every six months.

vii. Short-term crisis intervention services not to exceed 22 hours per state fiscal year.

viii. Screening and brief intervention services.

ix. Medication administration services as provided in the recipient's behavioral health treatment plan.

x. One medical evaluation of a recipient in an opioid use disorder treatment program per admission for that opioid use disorder treatment program including (A) consultation and referral; (B) verification of one year of addiction; and (C) establishing dosage for methadone or another agonist or partial agonist.

xi. Methadone or Antabuse administration for medication-assisted treatment as prescribed by a physician for substance use disorder.

xii. Behavioral health screening using an evidence-based tool to determine eligibility for admission to a treatment program, limited to one screening per program admission for new or returning recipients.

If an organization anticipates exceeding the service limits, it is required to submit a prior authorization request to the State Medicaid Agency or its designee, documenting the medical necessity for the additional services.

Mental Health Physician Clinic–

A. Definition of services – The Medicaid agency or designee will reimburse a mental health physicians' clinic for the provision of approved state plan services for the treatment of diagnosable mental health disorders provided to Medicaid eligible beneficiaries.

B. Prior **authorization and limitations**

The following services do not need prior authorization if provided within the following service limits:

i. Any combination of individual, group, and family therapy not to exceed 30 hours per state fiscal year.

ii. Psychiatric assessment not to exceed four per recipient per state fiscal year.

iii. Psychological testing not to exceed six hours per recipient per state fiscal year.

iv. Pharmacologic management not to exceed one visit per week during the first four weeks of treatment, one visit bi-weekly (every two weeks) for up to eight weeks, and thereafter not to exceed one visit per month.

v. If an individual is not already receiving services - one integrated mental health and substance use intake assessment or a combination of one mental health intake assessment and one substance use intake assessment.

vi. If an individual is subject to a current behavioral health treatment plan – one integrated mental health and substance use intake assessment or one mental health intake assessment every six months.

vii. Short-term crisis intervention services not to exceed 22 hours per state fiscal year.

If an organization anticipates exceeding the service limits, it is required to submit a prior authorization request to the State Medicaid Agency or its designee, documenting the medical necessity for the additional services.

Ambulatory Surgery Center

A. **Definition of services:** Ambulatory surgical center (ASC) means any distinct entity operating exclusively for providing surgical services to patients not requiring hospitalization, and in which the expected duration of services would not exceed 24 hours following an admission. (42 CFR 416.2)

B. **Providers and qualifications**: Ambulatory surgical centers must comply with all current federal (42 CFR 416.25 – 416.54) and state enrollment requirements, have a system to transfer patients requiring emergency admittance or overnight care to a licensed, Medicaid-enrolled facility following any surgical procedure performed, and have a department approved utilization review plan.

C. **Prior authorization and limitations**: Services requiring prior authorization are noted on the current ASC fee schedule

End Stage Renal Disease Clinics

A. **Definition of services:** End stage renal disease services include comprehensive outpatient dialysis and related services including labs and drugs, home dialysis training and support services, or both.

B. **Providers and qualifications**: The end stage renal disease provider must comply with all current federal (42 CFR 494.1 – 494.20) and state enrollment requirements and be enrolled as a Medicare provider.

C. **Prior authorization and limitations**: The facility may bill a maximum of one peritoneal dialysis treatment per day, and a maximum of three hemodialysis treatments per week. Treatment limits may be exceeded based on a medical necessity determination.

10. **DENTAL SERVICES**: See attached Sheet to Attachment 3.1-A, page 3a

11. **PHYSICAL THERAPY AND RELATED SERVICES**: See Attachment 3.1-A, page 24a-24c

12. PRESCRIBED DRUGS:

a. Covered outpatient drugs are drugs:
   i. dispensed only upon a prescription; and
   ii. for which the United States Food and Drug Administration (FDA) requires a national drug code (NDC) number; and
   iii. Alaska covers outpatient drugs in accordance with Section 1902(a)(54) and 1927 of the Social Security Act.

b. a compounded prescription if at least one ingredient is a covered outpatient drug as defined in (a) above and the recipient's drug therapy needs cannot be met by commercially available dosage strengths or forms of the therapy; the claim for a compounded prescription is submitted using the national drug code (NDC) number and quantity for each covered outpatient drug in the compound; not more than 25 covered outpatient drugs are reimbursed in any compound.

10. Dental Services

Dental services for recipients age 21 or older are limited to emergency treatment for the relief of pain and acute infection, and the following additional services up to an annual threshold of $1150 per Medicaid recipient, which may be exceeded with prior authorization from the State Medicaid Agency or its designee:

(a) routine diagnostic examination and radiographs;
(b) preventive care;
(c) restorative care;
(d) certain endodontic services;
(e) periodontics;
(f) prosthodontics;
(g) oral surgery; and
(h) professional consultation

Alaska Medicaid excludes from reimbursement the following:

(a) behavior management for adults;
(b) indirect pulp capping;
(c) panoramic radiograph more than once per year;
(d) final restorations in amalgam or resin for more than five surfaces;
(e) dental sealants;
(f) restoration of etched enamel or deep grooves without dentin involvement;
(g) inlays, overlays, or three-fourth crowns;
(h) endodontic apical surgery or retrograde fillings;
(i) periodontal surgery;
(j) implant and implant-related dental services;
(k) orthodontic services;
(l) immediate, interim, and temporary dentures;
(m) dental characterization and personalization, and precision attachments;
(n) experimental dental procedures;
(o) space maintainers;
(p) tobacco counseling, which is considered a component of periodic and comprehensive evaluations and may not be billed separately;
(q) local anesthesia, which is considered a component of covered dental procedures and may not be billed separately;
(r) anesthesia or sedation in conjunction with a non-covered service or a service for which service limits have been reached.

12.b. Dentures

Recipients age 21 and older are limited to dentures up to an annual threshold of $1150 per Medicaid recipient, which may be exceeded with prior authorization from the State Medicaid Agency or its designee. When upper and lower dentures are necessary, and the annual threshold is not adequate to cover the cost of the dental claim, the Department may authorize twice the annual threshold. When authorizing twice the annual threshold for dentures, the maximum amount authorized is the remaining amount from the current fiscal year and the entire amount allotted for the succeeding fiscal year. The recipient is not allowed a new or additional annual threshold for the succeeding year beyond that already paid for the dentures.

(2) Drugs not otherwise specifically excluded from payment may be covered only after prior authorization has been obtained by the Division. These drugs may be further limited on the minimum and maximum quantities per prescription or on the number of refills to discourage waste and address instances of fraud or abuse by individuals. The Division will ensure a response to each prior authorization request is provided within 24 hours. In emergency situations, at least a 72-hour supply of the covered outpatient prescription may be dispensed.

(3) A pharmacy shall maintain documentation of receipt of prescribed drugs by recipients. The documentation may be kept as a signature log showing which prescription numbers are received or as mailing labels if prescribed drugs are mailed to the recipient.

(4) A provider that dispenses drugs in unit doses to a recipient in a nursing home or other long term care facility shall return unused medications to the pharmacy and the claim shall be adjusted.

Description of Service Limitations

(3) The following drugs are not covered:

(a) drugs that are prohibited from receiving federal Medicaid matching funds under 42 CFR 441.25, as amended October 1, 1981;

(b) drugs, except for birth control drugs and drugs listed in 12. a. (a)(1)(c) of this attachment if dispensed in an unopened container, for which more than a 30-day supply is ordered per prescription
and

(c) brand name multi-source drugs when a therapeutically equivalent generic drug is on the market unless the prescriber writes on the prescription "The brand-name medically necessary drug" or "allergic to the inert ingredients of the generic drug." The information may be submitted electronically or telephonically. Telephonic information must be documented by the prescriber in the recipient's record.

(4) The state will be negotiating supplemental rebates in addition to, and separate from, Federal rebates authorized in Title XIX. The following supplemental rebate policies are in compliance with the requirements of Section 1927 of the Act:

a. The state is in compliance with reporting requirements for utilization and restrictions to coverage. Pharmaceutical manufacturers can audit utilization data.

b. The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verification.

c. CMS has authorized the State of Alaska to enter into the Michigan multi-state pooling agreement (MMSPA) also referred to as the National Medicaid Pooling Initiative (NMPI) for drugs provided to Medicaid beneficiaries. The NMPI Supplemental Rebate Agreement (SRA) and the Amendment to the SRA submitted to CMS on February 28, 2008 have been authorized for pharmaceutical manufacturers' existing agreements through their current expiration dates. The updated NMPI SRA submitted to CMS on September 16, 2013 has been authorized for renewal and new agreements with pharmaceutical manufacturers for drugs provided to Medicaid beneficiaries.

d. Supplemental rebates received by the State under these agreements in excess of those required under the national drug rebate agreements are shared with the federal government on the same percentage basis as applied under the national rebate agreements.

e. All drugs covered by the supplemental rebate program, regardless of any prior authorization requirement, comply with provisions of the national drug rebate program.

f. For drug classes under review by the Pharmacy and Therapeutics (P&T) Committee, a manufacturer's payment of supplemental rebate(s) may result in its product being covered without documentation of medical necessity if it meets therapeutic equivalency criteria and is recommended by the committee.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency: Alaska

MEDICAID PROGRAM: REQUIREMENTS RELATING TO
COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

Citation (s)	Provision (s)
1935(d)(1)	Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency ——— Alaska ———

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

Citation (s)		Provision (s)
1927(d)(2) and 1935(d)(2)	1.	The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit Part D.
	X	**The following excluded drugs are covered:**
	X	(a) agents when used for anorexia, weight loss, weight gain – limited to Megace Oral Suspension
	☐	(b) agents when used to promote fertility
	X	(c) agents when used for cosmetic purposes or hair growth – limited to all cosmetic drugs
	☐	(d) agents when used for the symptomatic relief cough and colds
	X	(e) prescription vitamins and mineral products, except prenatal vitamins and fluoride – limited to prescription Vitamins (oral vitamins, folic acid, Vitamin A, Vitamin Vitamin D, and analogs, Vitamin B complex when Medically necessary)
	X	(f) non-prescription drugs – limited to laxatives and bismuth preparation, Vaginal antifungal creams and suppositories, Nonoxyl 9 contraceptives, Bacitracin topical ointment, loratadine, omeprazole

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

Citation(s)		Provision(s)
1927 42 CFR 447.201 42 CFR 440	X	(g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee (see specific categories below)
	X	(h) barbiturates **(Except for dual eligible individuals effective January 1, 2013 when used in the treatment of epilepsy, cancer or a chronic mental health disorder as Part D will cover those indications)**
	X	(i) benzodiazepines **(Except for dual eligible individuals effective January 1, 2013 as Part D will cover all indications)**
	X	(j) smoking cessation (except for dual-eligibles beginning January 1, 2006.)

(The Medicaid agency lists specific category of drugs below)

(k) Drugs for weight gain (Anabolic Steroids); Megace Oral Suspension

(l) All cosmetic drugs are covered except hair growth drugs, which are not covered

(m) Prescription vitamins: oral vitamins, folic acid, Vitamin A, Vitamin K, Vitamin D, and analogs, Vitamin B Complex when medically necessary.

(n) Prescription drugs: laxatives and bismuth preparations, vaginal antifungal creams and suppositories, Nonoxyl 9 contraceptives, Bacitracin Topical Ointment, Tobacco cessation drugs, loratadine, omeprozole.

Description of Service Limitations

12.c. **Prosthetic devices**

Prosthetic devices are provided when prescribed by a physician or other licensed practitioner operating within their scope of practice.

12.d. **Eyeglasses**

Medicaid recipients twenty-one (21) years of age and older may receive one complete pair of eyeglasses and a fitting per two calendar years without prior authorization. A recipient may obtain a two-year supply of contact lenses in lieu of glasses if determined medically necessary. A recipient may obtain an additional pair of glasses or an additional supply of contact lenses subject to a determination of medical necessity and prior authorization by the Medicaid agency or its designee.

The following vision products and services require prior authorization – based on medical necessity – from the Medicaid agency or its designee: ultraviolet coating, prism lenses, specialty lenses, specialty frames, and tinted lenses.

The department excludes the following vision products and services for Medicaid recipients twenty-one (21) years of age and older: aspherical lenses, progressive or no-line multi-focal lenses, vision therapy services, polarized lenses, and anti-reflective or mirror coating.

Eyeglasses are purchased for recipients under a competitively bid contract.

13. Diagnostic, Screening, Preventive, and Rehabilitative Services

Note: From October 1, 2020, through September 30, 2025, the state assures that MAT to treat OUD as defined in section 1905(ee)(1) of the Social Security Act (the Act) is covered exclusively under section 1905(a)(29) of the Act.

13.a. **Diagnostic services** are provided in accordance with 42 CFR 440.130(a).

13.a.1 **Mammography coverage** is limited to diagnostic mammograms necessary to detect breast cancer.

13.b. **Screening mammograms** are covered at the age and frequency schedule of the American Cancer Society.

13.c. **Preventive Services**

Coverage and provider qualifications are in accordance with 42 CFR 440.130. Alaska Medicaid covers all preventive services described in 45 CFR 147.130, including

- Evidence-based items or services with an A or B rating by the United States Preventive Services Task Force (USPSTF);
- Immunizations for use in children, adolescents, and adults that are recommended by the Advisory Committee on Immunization Practices (ACIP), and their administration, are covered without cost sharing. Changes to ACIP recommendations are incorporated into coverage and billing codes as necessary.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings are provided based on the current guidelines in the American Academy of Pediatrics Bright Futures periodicity schedule for screenings and follow-up visits;

Description of Service Limitations

- With respect to women, evidence-informed preventive care and screenings are provided based on the contents of this section and the current Health Resources and Services Administration (HRSA) Women's Preventive Services guidelines; and
  - Any qualifying coronavirus preventive service, which means an item, service, or immunization intended to prevent or mitigate coronavirus disease 2019 (COVID-19) and that is, for the individual involved –
    - An evidenced-based item or service with a rating of A or B in the current recommendations of the USPSTF; or
    - An immunization recommended by ACIP and adopted by the Director of the CDC.
  - Medically necessary vaccines per ACIP guidelines noted at https://www.cdc.gov/vaccines/hcp/acip-recs/index.html are covered for Alaska Medicaid recipients if unavailable at no cost to the provider.

Pursuant to EPSDT, no limitations on services are imposed for individuals under 21 years of age if determined to be medically necessary and prior authorized by Alaska Medicaid.

13.d. **Rehabilitative behavioral health disorder services** covered by Medicaid under the state plan are limited to the services listed in this section. For purposes of this section, behavioral health disorders include both mental health and substance use disorders. Services in this section are provided in accordance with 42 CFR 440.130(d)

To be eligible to provide Medicaid behavioral health services covered by the state plan, a provider must be enrolled in Medicaid with the Medicaid agency and must be one of the following:

(1) **Community behavioral health services provider (CBHS)** - a provider approved by the Medicaid agency or its designee to provide behavioral health services;

A community behavioral health service provider agency must be an enrolled provider in good standing with the state and receiving reimbursement from the department; if providing behavioral health clinic services, must have a documented formal agreement with a physician to provide general direction and direct clinical services as needed; must collect and report the statistics, service data, and other information requested by the department; must participate in the department's service delivery planning; must maintain a clinical record for each recipient; must have policies and procedures in place; may not deny treatment to an otherwise eligible recipient due to the recipient's inability to pay for the service; may not supplant local funding available to pay for behavioral health services or programs with money received under a grant-in-aid program; must be dual diagnosis capable program or dual diagnosis enhanced program; must ensure that all recipients have given informed consent; must report to the department any recipient who is missing or deceased; must submit to the department a record of a criminal history background check for each member of the provider's staff upon request.

(2) **Mental health professional clinician** - an individual who is working for an enrolled community behavioral health services provider who has a master's degree or more advanced degree in psychology, counseling, child guidance, community mental health, marriage and family therapy, social (sentence *continued on the next page*)

work, or nursing and is performing community behavioral health services that are within that individual's field of expertise;

(3) **Licensed mental health professional** – an individual enrolled in Alaska Medicaid or working for a community behavioral health services provider, holding an active license to practice as a marital and family therapist, clinical social worker, professional counselor, or psychologist in good standing in the State of Alaska, and operating within their scope of practice;

(4) **Psychologist** – an individual enrolled in Alaska Medicaid, holding an active license in good standing to practice as a psychologist in the State of Alaska and operating within their scope of practice as defined by state law;

(5) **Licensed behavior analyst (L.B.A.)** – an individual working for a community behavioral health service provider, with an active license in good standing to practice in the State of Alaska, and operating within their scope of practice;

(6) **Behavioral health aide (B.H.A.)** – an individual working for a community behavioral health service provider with an active certification in good standing, as a Behavioral Health Practitioner, Behavioral Health Aide I, Behavioral Health Aide II, or Behavioral Health Aide III, issued by the Federal Community Health Aid Program Certification Board (CHAP-CB) established under 25 U.S.C. 1616*l*, working within the scope of the individual's authorized practice. BHAs are supervised by a mental health professional clinician when employed by a CBHS;

(7) **Substance use disorder counselor** – an individual working for a community behavioral health services provider, and holding any current, valid certificate from the National Association for Alcoholism and Drug Abuse Counselors, the International Certification and Reciprocity Consortium, the Alaska Commission for Behavioral Health Certification, or the Alaska Native Tribal Health Consortium Behavioral Health Aide Program, and operating under the supervision of a mental health professional clinician, licensed mental health professional, psychologist, physician, physician's assistant, or advanced practice registered nurse;

(8) **Behavioral health clinical associate** – an individual working for a community behavioral health services provider who may have less than a master's degree in psychology, social work, counseling, or a related field with specialization or experience in providing rehabilitation services to recipients with severe behavioral health conditions and operating under the supervision of a mental health professional clinician, licensed mental health professional, psychologist, physician, physician's assistant, or advanced practice registered nurse;

(9) **Physician** – a physician enrolled in Alaska Medicaid, holding an active license to practice in good standing in the State of Alaska, and operating within their scope of practice;

(10) **Physician's Assistant (P.A.)** – an individual enrolled in Alaska Medicaid, holding an active license to practice in good standing in the State of Alaska, and operating within the scope of their collaborative practice agreement;

(11)**Advanced practice registered nurse (A.P.R.N.)** – an individual enrolled in Alaska Medicaid, holding an active license to practice in good standing in the State of Alaska, who may or may not hold state-granted independent prescriptive authority. When APRNs do not have independent prescriptive authority in the state, the APRN operates within the scope of their collaborative practice agreement for the purposes of prescribing and dispensing legend drugs;

(12)**Licensed practical nurse (L.P.N.)** – an individual working for an eligible and enrolled behavioral health rehabilitation services provider, holding an active license to practice in good standing in the State of Alaska, operating within their scope of practice under the supervision of a licensed registered nurse, licensed advanced practice registered nurse, licensed physician, licensed physician's assistant, or licensed dentist; and

(13)**Certified nursing aide (C.N.A.)** – an individual working for an eligible and enrolled behavioral health rehabilitation services provider, holding a State of Alaska certification and operating within their scope of practice under the supervision of a licensed nurse.

The state assures that any willing and qualified provider operating within the scope of their license or certification under state or federal law who delivers the services listed below to eligible recipients may receive Medicaid reimbursement regardless of the setting in which the service is furnished.

Pursuant to EPSDT, no limitations on services listed in this section are imposed for individuals under 21 years of age, if determined to be medically necessary and prior authorized by Alaska Medicaid.

(1) **Screening Services** used to determine whether a Medicaid-eligible individual may need behavioral health intervention or treatment are covered by Medicaid. The types of screenings eligible for reimbursement by the Medicaid agency or its designee include.

(a). **Behavioral Health Screening Services** include the use of an evidence-based tool. This behavioral health screening is used with a recipient before an intake assessment for diagnosis and treatment is conducted.

Provider Qualifications: Behavioral health screenings may be conducted by a community behavioral health services provider and any other providers eligible to bill Medicaid for services and who perform screening services as a regular duty within the scope of their knowledge, experience, and education.

Service Limitations: Behavioral health screenings may be provided to a recipient without prior authorization by the Medicaid agency or its designee and are limited to one screening per program admission for new or returning recipients. This limit may be exceeded with prior authorization based on medical necessity. The provider must include the results of the screening in the recipient's clinical record, including any action taken or recommended based on the recipient's responses.

(b). **Screening and Brief Intervention Services** consists of a nonmandatory screening through self-report questionnaires, structured interviews, or similar screening techniques to detect substance use problems and to identify the appropriate level of intervention. If the screening is positive for substance use problems, the provider may provide brief intervention services that involve motivational discussion focused on raising the recipient's awareness of their substance use, the potentially harmful effects of that substance use, and encouraging positive change. Brief intervention services may include provider feedback, goal setting, coping strategies, identification of risk factors, information, and advice. If a screening shows a recipient is at a severe risk of substance use problems, is already substance dependent, or has received brief intervention or treatment for substance use and was non-responsive, the recipient should receive a referral to a program that meets his or her needs.

Provider Qualifications: A community behavioral health services provider, mental health professional clinician, licensed mental health professional, psychologist, licensed behavior analyst, substance use disorder counselor, behavioral health clinical associate, physician, physician's assistant, advanced practice registered nurse, licensed practical nurse, certified nursing aide, or certified behavioral health aide working within their scope of training and operating under the supervision of a mental health professional clinician and enrolled with Alaska Medicaid.

Service Limitations: Screening and brief intervention services may be provided to a recipient without prior authorization by the Medicaid agency or designees.

(c). **Intake Assessments:** used to determine whether a Medicaid-eligible individual has a diagnosable behavioral health disorder and is covered by Medicaid.

Provider Qualifications: As further described below, the provider types eligible to provide intake assessments include mental health professional clinicians, licensed physicians, licensed physician assistants, and licensed and certified advanced nurse practitioners who are operating and working within the scope of their professional education, training, and experience in accordance with state law. The types of professional behavioral health intake assessments allowable by the Medicaid agency or its designee include the following –

(i) **Mental Health Intake Assessment:** This assessment is used to determine and document the recipient's mental status and social and medical history, the nature and severity of any identified mental health disorder, a diagnosis consistent with the Diagnostic and Statistical Manual of Mental Disorders, International Classification of Diseases, or Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC:0-3R), treatment recommendations that form the basis of a subsequent behavioral health treatment plan, and functional impairment. The mental health intake assessment is conducted upon admission to services and updated during the

course of active treatment, as necessary. A mental health intake assessment must be documented in the recipient's clinical record in accordance with state law.

Additional Provider Qualifications: If the mental health intake assessment is performed by a community behavioral health services provider, the assessment must be conducted in accordance with the specific requirements for community behavioral health services providers in state law.

Service Limitations: A qualified provider may furnish one mental health intake assessment in combination with a substance use intake assessment for an individual not currently receiving services based on a behavioral health treatment plan without prior authorization from the Medicaid agency or its designee if the assessment consists of face-to-face session(s) and a review of collateral information regarding the individual's condition. When based on a current behavioral health treatment plan, provision of this service is limited to one assessment every six months without prior authorization.

(ii) **Substance Use Intake Assessment:** This assessment is used to determine and document whether a Medicaid-eligible individual has a substance use disorder and functional impairment, the nature and severity of any identified substance use disorder, the correct diagnosis, treatment recommendations for the behavioral health treatment plan, and new information as it becomes available. These intake assessments are conducted upon admission to services and during active treatment as necessary and completed in accordance with state law. A substance use intake assessment must be documented in the recipient's clinical record in accordance with state law.

Additional Provider Qualifications: Substance use intake assessments must be rendered by a substance use disorder counselor, a behavioral health clinical associate, or other provider types in 13.d. of this section acting within the scope of their individual training, experience, and assigned job duties. A community behavioral health services provider may provide an assessment under this section if the service was rendered by an authorized provider and in accordance with state law.

Service limitations: A qualified provider may furnish one substance use intake assessment in combination with a mental health intake assessment for an individual not currently receiving services based on a behavioral health treatment plan without prior authorization from the Medicaid agency or its designee if the assessment consists of face-to-face session(s) and a review of collateral information regarding the individual's condition. When based on a current behavioral health treatment plan, an individual is limited to one assessment every six months without prior authorization.

(iii) **Integrated Mental Health and Substance Use Intake Assessment:** This assessment is used to determine and document whether a Medicaid-eligible individual has a mental health and/or substance use disorder(s) and any related functional impairments. The integrated intake assessment must meet the requirements for both the mental health and substance use intake assessments established by Alaska Medicaid or its designee and be updated by the provider as new information becomes available. An integrated intake assessment must be documented in the recipient's clinical record in accordance with state law.

Additional Provider Qualifications: If the mental health intake assessment performed by a community behavioral health services provider, the assessment must be conducted in accordance with the specific requirements for community behavioral health services providers in state law.

Service Limitations: A qualified provider may furnish one integrated intake assessment for an individual not currently receiving services based on a behavioral health treatment plan without prior authorization from the Medicaid agency or its designee if the assessment consists of face-to-face session(s) and a review of collateral information regarding the individual's condition. When based on a current behavioral health treatment plan, an individual is limited to one integrated intake assessment every six months without prior authorization.

(d). Behavioral Health Services are allowable within limitations as the rehabilitative services described in this section. Behavioral health rehabilitative services are provided to Medicaid-eligible recipients to remediate and ameliorate debilitating effects of substance use and mental health disorders for the maximum reduction of each disabling condition. These services help the recipient develop appropriate skills to improve overall functioning with the goal of maximum restoration.

Rehabilitative services for behavioral health disorders listed in this section provided to Medicaid-eligible individuals who reside in institutions for mental diseases (IMDs), nursing facilities, and/or acute care facilities are not eligible under the state plan.

Service Limitations: The following services are available for children under 21 years of age with an appropriate diagnosis resulting from an EPSDT screen or assessment. Pursuant to EPSDT, no limitations on services are imposed for individuals under 21 years of age if determined to be medically necessary and prior authorized by Alaska Medicaid. Services may be provided to seriously mentally ill and severely emotionally disturbed adults.

(i) **Therapy and Treatment** includes treatment, therapeutic interventions, and rehabilitative services designed to alleviate behavioral health disorders (mental, emotional and/or substance abuse related) and encourage growth and development while helping to prevent relapse of such conditions, including coaching and teaching life skills to restore functioning and support community

living and counseling focused on functional improvement, recovery, and relapse prevention. Also includes counseling and other therapeutic activities related to medication-assisted treatment for substance use disorders and the planning, delivery, and monitoring of a dynamic set of services that target specific behaviors identified in the assessment and treatment plan designed to improve functioning and enhance quality of life. Services are designed to improve the functioning level of the recipient through supporting or strengthening the behavioral, emotional, or intellectual skills necessary to live, learn, or work in the community. Services include:

Therapeutic behavioral services – include the restoration of knowledge, attitudinal, and skills-based competencies designed to restore the recipients functioning and support community living; counseling focused on functional improvement, recovery, and relapse prevention; encouraging and coaching.

(ii) **Medical Services** related to the treatment of behavioral health disorders are covered by Alaska Medicaid, including intake physicals or medical evaluation, medical decision counseling, and the management of medication, including narcotics, if provided according to the recipient's treatment plan and in accordance with the limitations provided under state law.

Provider Qualifications: Medical services are provided by medical personnel acting within the scope of their license for Medicaid recipients who are found in a treatment plan to need medical services while receiving behavioral health disorder services. Service providers include physicians, physician assistants, nurse practitioners, registered nurses, licensed practical nurses, and certified nursing aides.

(iii) **Medication Administration Services – SUD – i**nclude oral or injectable medications administered by medical personnel to a Medicaid-eligible recipient with an SUD assessment and documentation of medication compliance, and assessment and documentation of medication effectiveness and any side effects. Medication and administration services may be rendered by medical personnel to a recipient on the premises of a community behavioral health services provider or offsite at the recipient's home, school, or any other appropriate community setting.

Provider Qualifications: Medical personnel qualified to provide medication administration services include licensed physicians, physician assistants, advanced practice registered nurses, registered nurses supervised by a physician or an advanced practice registered nurse, or licensed practical nurses supervised by a physician or an advanced practice registered nurse.

(iv) **Pharmacological Management Services – SUD – a**re a type of medical service furnished to a Medicaid-eligible recipient with an SUD for the purposes of assessing the need for pharmacotherapy, prescribing appropriate medications,

and directly monitoring the recipient's response to medication, including documenting medication compliance, assessing, and documenting side effects, and evaluating and documenting the effectiveness of the medication

Provider Qualifications: Authorized professionals for this service are limited to a licensed physician, licensed physician assistant, or licensed and certified advanced practice registered nurse, if the authorized provider is working within the scope of the provider's education, training, and experience, has prescriptive authority, and is enrolled with Alaska Medicaid as a dispensing provider. The authorized provider must directly provide pharmacological management services and monitor the effects thereafter.

Service Limitations: Pharmacologic management services should not exceed one visit per recipient per week during the first four weeks after the recipient begins receiving pharmacologic management services, one visit biweekly (every two weeks) for eight weeks, and, thereafter, not to exceed one visit per recipient per month as long as the recipient is receiving a behavioral health service covered by Alaska Medicaid unless more frequent monitoring is required by the specific medication prescribed or the recipient has an atypical clinical reaction to the medication.

Note: From October 1, 2020, through September 30, 2025, the state assures that MAT to treat OUD as defined at section 1905(ee)(1) of the Social Security Act (the Act) is covered exclusively under section 1905(a)(29) of the Act

(v) **Medication-Assisted Treatment** is a type of pharmacological service prescribed by an authorized practitioner that, in combination with counseling and behavioral therapies, provides a "whole-patient" approach to the treatment of substance use disorders. Medications used in MAT are approved by the Food and Drug Administration (FDA), consistent with 42 U.S.C. 1396r-8(k)(2), clinically driven, and tailored to meet each patient's needs.

Provider Qualifications: physicians, physician assistants, and advanced practice registered nurses in a community behavioral health services provider who is performing the service in a substance use disorder treatment program as a regular duty within the scope of their knowledge, experience, and education, and any other licensed or certified providers operating within their scope of practice under state law.

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Description of Service Limitations

(4) School-Based Rehabilitative Services

School-based rehabilitative services are health-related services that:

1. address the physical or mental disabilities of a child,
2. are recommended by health care professionals, and
3. are identified in a child's Individual Education Plan (IEP) or Individual Family Service Plan (IFSP).

School-based services are delivered by providers operating within the scope of their practitioner's license and/or certification pursuant to State law and federal regulations, at 42 CFR 440.110, which specify the following qualifications for licensure:.

- Physical therapists must have graduated from a school of physical therapy approved by the Council on Medical Education and Hospitals of the American Medical Association, or the American Physical Therapy Association and pass the board exam.
- Occupational therapists must have successfully completed a curriculum approved by the Committee of Allied Health Education and Accreditation of the American Medical Association or the American Occupational Therapy Association and pass the board exam.
- Speech pathologists must possess a Certificate of Clinical Competence in speech-language pathology from the American Speech-Language-Hearing Association or have completed the equivalent educational requirements and work experience necessary for it or have completed the academic program and be currently acquiring the work experience to qualify.
- Audiologists must have a master's or doctorate in audiology from an accredited educational institution and also have EITHER a Certificate of Clinical Competence in Audiology from the ASHA, or is in the process of completing the year of supervised clinical experience required for the Certificate of Clinical Competence from ASHA..

A physician or other practitioner of the healing arts operating within the scope of their practice must prescribe physical and occupational therapy services. A physician or other practitioner of the healing arts operating within the scope of their practice must refer patients for speech, hearing, and language services provided by, or under the direction of, speech pathologists or audiologists.

School-based rehabilitative services include:

1. physical and occupational therapy evaluations, and treatments,
2. speech evaluations and therapy treatments, and
3. audiological services.
4. evaluation, screening and assessment components that identify a child's need for physical, occupational, speech –language-hearing therapies when the evaluations lead to the child receiving these services within their IEP.

Description of Service Limitations

14. **INSTITUTIONS FOR MENTAL DISEASES FOR AGE 65 OR OLDER:** Services in institutions for mental diseases for individuals age 65 or over are provided if placement is prior authorized by the Division of Mental Health or the Professional Review Organization on contract with the Division.

15. **INTERMEDIATE CARE FACILITY SERVICES:** Placement in a nursing facility offering an intermediate level of nursing care or in an ICF/MR require prior authorization by the Division of Medical Assistance.

16. **INPATIENT PSYCHIATRIC FACILITY SERVICES:**

(1) Inpatient psychiatric facility services for individuals under 21 are provided if placement is prior authorized by the Division of Mental Health or PRO or the state's designee.

(2) Rehabilitative services, including appropriate therapies, are provided for severely emotionally disturbed children in a JCAHO-accredited residential facility.

20. **EXTENDED SERVICES TO PREGNANT WOMEN:** All state plan services are provided for pregnant women through 60 days after pregnancy ends. Nutrition services are provided by registered dietitians to high-risk pregnant women. Prior authorization is required in most cases, and visits are limited to seven per pregnancy.

24. **OTHER MEDICAL CARE:**

a. Transportation: Non-emergency medical transportation must be authorized in advance by the medical review section of the Division of Medical Assistance or its fiscal agent. Non-emergency transportation must occur on weekdays during normal working hours. Emergency medical transportation is covered to the nearest facility offering emergency medical care. The services of an emergency air ambulance or an accompanying escort must be authorized no later than the first working day following the travel. Ground ambulance service is approved only for a one-way trip at a time.

d. Nursing Facility Services for Children: Nursing facility placement for patients under age 21 requires prior authorization by the Division of Medical Assistance.

Description of Service Limitations

f. **Personal Care Services**:

Covered services are limited to non-technical hands-on assistance with activities of daily living (ADLs), which include bathing, dressing, and grooming, problems with instrumental activities of daily living (IADLs), such as shopping and cleaning necessary to maintain the health and safety of the recipient, and other problems that require trained care. Personal care services must be provided in either the recipient's home, or other locations necessary to assist with the activities of daily living, but may not be provided in institutions. Allowable services must be defined in a service plan developed as a result of a functional assessment approved by the state-authorized Personal Care Agency (PCA) or the Alaska Department of Health and Social Services (DHSS).

Services must be provided only through a qualified PCA agency by health care paraprofessionals called Personal Care Assistants (PCAs). The PCAs must have completed a state approved PCA training program, except in cases where:

- the personal care agency has determined that the recipient or their representative is capable of specifying the training requirements for the personal care assistant and supervising them;
- the personal care agency has trained the recipient or their representative in their responsibilities; and
- the personal care assistant has successfully completed the recipient-specific training provided by the recipient or their representative.

To be a representative, an individual must be directly involved in the recipient's day-to-day care and available to assume the responsibility of managing the recipient's care, including directing the care as it occurs in the home. Legally responsible relative of the recipient are excluded from payment for personal care services

Personal care services do not include:

(1) application of dressings involving prescription medication and aseptic techniques; invasive body procedures – including injections and insertion or removal of catheters; tracheostomy care; tube or other enteral feedings; medication administration; or care and maintenance of intravenous equipment. However, personal care assistants may perform these tasks under the following conditions:

- the recipient of services, or their representative, is capable and willing to delegate such functions, which are within the purview of individuals and their unpaid caregivers to perform;
- the recipient or representative is capable and willing to supervise the administration of these tasks; and
- the personal care agency or the department has determined that the recipient or their representative is capable of delegating the tasks and perform these supervisory functions.

(2) heavy chore services in the home, including cleaning floors and furniture not used directly by the recipient, laundry not incidental to the recipient's care, cutting firewood, and shopping for groceries and other household items not required specifically for the health and maintenance of the consumer;

(3) any task the personal care agency, supervising nurse, or division determines, as a result of the assessment, could reasonably be performed by the consumer of a member of the consumer's household;

(4) respite care intended primarily to relieve a member of the consumer's household, a family member, or a caregiver other than a personal care assistant from the responsibility of caring for the consumer; and

(5) supervision, babysitting or care of any other household members, social visitation, general monitoring for equipment failure, home maintenance, or pet care, except for a certified service animal.

Personal care services may be provided through two different qualified Personal Care Agency (PCA) Models:

Agency Based Personal Care Assistance (ABPCA): The beneficiary may choose a personal care agency in the agency-based model, which provides services through an agency that oversees, manages, and supervises the beneficiary's care. The ABPCA agency hires, schedules, develops a backup plan if the regularly scheduled personal care assistant (PCA) is unavailable, and dispatches PCAs.

Consumer Directed Personal Care Assistance (CDPCA): The beneficiary may choose a consumer directed personal care assistance model, which provides administrative support to the consumer who manages his or her own care by hiring, firing, and supervising his or her own PCA. The CDPCA will assess the recipient's needs every twelve months or more frequently if necessary, and must develop a backup plan with the recipient or a legal representative. The CDPCA agency must ensure that basic elements required for enrollment of each individual PCA are met.

Provider Qualifications: The state does not limit personal care agencies to private or non-profit.

To qualify for certification as a PCA agency, the agency must meet the applicable certification criteria set out in the department's Personal Care Assistant Agency Certification Application packet. ABPCA and CDPCA agencies must employ a Program Administrator who has attended mandatory state training. For the ABPCA agency type only, the agency must also employ a Registered Nurse.

At both CDPCA and ABPCA agencies, the personal care assistant must be at least 18 years of age, must meet all the requirements of the model as described in state regulations, including successful completion of First Aid and CPR training within the last two years, must be individually enrolled to bill Medicaid, must pass a criminal background check, must not have been denied a health care provider license or certification for a reason related to patient services, and must be able independently to assist the recipient with the specific Activity of Daily Living and services.

Additionally, to be a personal care assistant for an ABPCA, the assistant must be a licensed nurse, or CNA, or a community health aide, or have successfully completed a training approved by the State, or completed an equivalent training five years prior to applying to be employed as a PCA. Training requirements for personal care assistants working in ABPCA agencies include at least 40 hours of instruction, given by a nurse licensed by the State of Alaska, in infection control, bowel and bladder care, nutrition and food planning and preparation, physical transfers, assistance with self-administration of medication, blood pressure, temperature, respiration, developmental disabilities and physical and mental illnesses, body systems, mechanics and disorders, death and dying, use of equipment necessary to perform the tasks of a PCA, universal precautions, and affecting PCAs such as record keeping, confidentiality, reporting Medicaid fraud.

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