1. CMS is not mandating group homes be six or under. Section 5 of the comments of the final rule states "It is not the intent of this rule to prohibit congregate settings from being considered home and community based settings." Later in the response to a question about the number of people in a residence CMS states "We do not believe there is a maximum number beneath which we could determine with certainty that the setting would meet the requirements of HCB setting. The focus should be on the experience of the individual in that setting." Why would Alabama lift the Grandfathering of homes that were built at the behest of DMH when it is not being required by CMS?

The CMS response "It is not the intent…….community based settings" does speak to a commenters concern regarding "some of the more creative congregated living arrangements may be disqualified." However, the entire context of the response reiterates the spirit of the final rule which is personal rights should not be curtailed because of where the person lives or because there is a need for HCBS. The state plan HCBS must be delivered in a setting that meets the HCB setting requirements as set forth in this rule. CMS acknowledges that for some settings, implementing these requirements will require a change in operational protocol and provide for reasonable transition time to facilitate such changes.

The CMS response to commenter recommending establishment of a maximum limit to the number of individuals living in a provider-owned or controlled residential setting does speak to "focus should be on the experience of the individual in the setting." CMS states, "In addition, we respect a state's right to establish state laws to implement such a requirement regarding size." CMS further states, "Our experience through our work with other federal Departments and current research indicates that size can play an important role in whether a setting has institutional qualities and may not be home and community based."

DMH/DDD implemented the limitation of six individuals or less living in a DMH/DDD certified residential facility/home effective 10/1/2009. The purpose was to help foster a "home-like" quality for all individuals being served. Larger configurations were considered, partly to accommodate the homes acquired through federal housing initiatives.

Approved Waiver Amendment excerpt: on Apr 7, 2010

Providers of residential habilitation must be certified by the Department of Mental Health. Small settings are encouraged. No new home will be certified for residence of more than six individuals, nor will new clusters of adjacent homes be certified. The only exception is that previously certified homes with more than six residents will be allowed to rebuild at the previous size, to allow the same individuals the choice to continue residing with people they know.

The original waiver renewal proposal posted on the DMH/DDD website indicated a phase out of large configurations.

Proposed Waiver Renewal excerpt: posted June 2014

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

To ensure that residential and non-residential settings do not isolate individuals receiving HCBS from the broader community, the Division has partnered with CQL and implemented new standards based on the Basic Assurances (c) and Positive Outcome Measures (c), focused on employment first initiatives, and expanded self-directed services. The Department of Mental Health no longer maintains or operates a state ICF/IDD. This has enabled the Division to be completely community based in the delivery of waiver services for individuals with Intellectual Disability. This waiver offers residential services, day services, and support services. Residential services may be delivered in a certified residential facility or in the person's own home, day services may be delivered in a facility or in the community, support services may be delivered in the person's home, at a certified residential facility, at a day facility, at work, or in the community. A large majority of day and support services may be self-directed either in the individual's family home or in their own home. Certified Residential Facility homes are typically 3 person homes, but must be 6 person or less. There are some homes that have been grandfathered in and exceed this threshold, but as part of the Division Transition Plan, both of these larger home types will be phased out. The exception to this includes Specialized Medical Residential homes and Specialized Behavioral Service homes. These homes are necessary to meet the needs of a special population. Specific requirements to provide services in either of these types of homes are listed in the Department of Mental Health/Division of Developmental Disabilities Certification Application Package for Community Programs. Day services typically begin in a facility but during the course of a day may transition individuals into various activities outside the facility that may include: volunteering in the community, assisting local community organization or local places of worship, participating in self advocacy events, or leisure and socialization activities. Support services are designed to assist an individual in accessing the community, to learn skills that will allow for more independence, maintenance of well-being (i.e. therapies), and help promote and provide a safe and accessible environment.

Facility Capacity Limit:

New Facilities: limit of 6; Grandfathered Facilities: none larger than 12.

Upon listening to stakeholder concerns and meeting with U.S. Department of Housing and Urban Development/Multifamily Project Management in Birmingham, regarding the phase out of large settings DMH/DDD has revised the waiver language:

Revised Waiver Renewal excerpt: submitted to CMS on July 2, 2014.

Certified Residential Facility homes are typically 3 person homes, but must be 6 person or less. There are some homes that have been grandfathered in and exceed this threshold, but as part of the Division's Transition Plan, these homes will be assessed just as others to ensure they have the quality of Home and Community Based settings. These larger homes are typically funded through affordable housing initiatives and some specific to supporting people with disabilities. Due to the federal requirements, such as HUD lending, homes must remain fully operational. Unless

federal law is changed reducing occupancy or phasing out these homes is not prohibitive.

*NOTE: The last sentence will need to be rephrased to read: "Unless federal law is changed reducing occupancy or phasing out, these homes are not prohibited.

2. Why was HUD not informed of this change?

It is not the practice of DMH to notify home mortgage lenders or grantors of changes that are required by CMS. That said, DMH/DDD met with HUD's Chief of Multifamily Project Management in Birmingham, AL. The meeting helped DMH/DDD better understand the strict constraints on provider agencies utilizing programs established by Section 811 Supportive Housing for Persons with Disabilities and Section 202 Supportive Housing for the Elderly Program. Identifying all HUD homes operated by the DMH/DDD contracted providers for ID/DD Services is part of the proposed ID Waiver Transition Plan. To this end HUD (MPM) has offered to help identify these sites and the corresponding agreements for each. Additionally, the DMH/DDD will be providing housing coordination through the Money Follows the Person grant. The intent is to identify low income housing initiatives that result in assisting people in institutional care to find residences that are typical for persons without disabilities, so that moving forward, housing for people with disabilities is less likely to run afoul of CMS requirements for community living.

3. DMH was required during the funding process of the HUD properties to signed letters of support and agree to provide occupants. Does DMH not consider those agreements binding any longer?

DMH would like to review all documentation as it relates to the agreement between providers of ID Waiver services and HUD that required DMH letters of support. DMH will stand by any letters of agreement regarding HUD properties until such time as CMS or HUD or both change any legal or funding barriers to more community integrated settings.

4. Why were the waiver changes specifically about the grandfathering of homes greater than six beds not put through the subcommittee process as described in Section 5 Part I of the waiver packet?

The DMH/DDD attempts to cover any upcoming changes to policies and procedures, including changes to the waiver, during our monthly meetings. Most items identified in the waiver renewal and the transition plan are items discussed with stakeholders either through the DD Subcommittee meeting, break-out work groups (i.e. waiver services workgroup, supported employment workgroup), periodical training, and regional office meeting. In addition, CMS guidance for non-compliant settings with its new rules, is that they will not be grandfathered. Therefore, DMH felt it necessary to include a strategy for attaining compliance in the waiver & transition plan. DMH believes that the change made in the waiver application from its original draft accommodates appropriate balance between the new CMS rules and provider needs in what would likely be presumed otherwise to be noncompliant residential sites.

5. Does this change not have to go before the Management Steering Committee process?

The Management Steering Committee is an advisory committee. The Management Steering Committee meets as needed to review reports and recommendations from Divisional sub committees and from the Divisions themselves, and to make recommendations to the Commissioner of the Department of Mental Health (DMH). While DMH/DDD attempts to identify policy and procedure changes in both the DD Subcommittee meetings as well as to the Management Steering Committee, it is not plausible to identify every possible change that needs to be made. Consequently, the DMH/DDD posted the proposed ID Waiver renewal on its state website for all stakeholders to review, after numerous discussions in multiple forums, that led to changes in the renewal application from the existing waiver, particularly in increasing inclusion-fostering services.

6. Why would the department seek to eliminate HUD subsidies for the ID community?

DMH/DDD is not seeking to eliminate HUD subsidies. DMH/DDD is seeking to adhere to the CMS HCB setting requirements. In doing so, we cannot ignore large configurations as part of our statewide assessment.

7. Are you aware many of these properties cannot be repurposed?

It is the DMH/DDD understanding that there are strict parameters set in place that governs HUD housing agreements.

8. Can Alabama afford to lose millions of dollars in federal subsidies?

No, given the flat/level/reduced funding for most state agencies, the state of Alabama cannot afford to lose millions of dollars in subsidies. Neither does DMH/DDD believe it has proposed anything in the submitted application that will contribute to such. To the contrary, the DDD has been very focused on ways to work with other federal/state/local agencies to identify ways to blend or “braid” funding streams. Through a partnership with AL Medicaid Agency, under the Money Follows the Person grant, the DDD will provide statewide housing coordinators. As previously mentioned, the purpose is to ensure that the most vulnerable of the population (including those with ID/DDD) have a resource and possible avenues to obtain affordable housing that meets the HCB setting requirements. Such collaboration has additionally resulted in additional grant funding through a US Department of Labor Disability Employment Initiative at $3M over 3 years.

9. Will DMH pay subsidies for the renters to find other accommodations?

The DDD would have to look at each individual person to determine if it would be possible to assist in subsidies. In general, the DMH has received level funding since 2008. This has caused limitations to discretionary spending with state dollars. As providers have indicated, the cost of providing services is continually increasing and additional dollars allocated to the DDD are typically provided to provider agencies to offset some of their costs. However, the Alabama Medicaid Agency has partnered with other agencies in seeking housing subsidy in a recent grant application and

DMH is pursuing strategies to repurpose existing dollars coming to Alabama to use as subsidy under rules affecting use of those dollars.

10. As these properties were built at the behest of the DMH, will DMH payoff the mortgages? If not do you expect providers to repay them?

The DDD understands that there are strict parameters set in place that governs HUD housing agreements. Putting a provider in jeopardy of foreclosure is not the intent. Likewise, it is not the intent, or within the budget resources of DMH to assume provider mortgages.

11. Are you aware some of these people bring in less than $200 per month?

The DDD is aware that most all of the ID Waiver participants have limited resources. This is the very reason that the DDD's focus has been on employment and increasingly on affordable housing.

12. Is the Governor aware this change has been made without input from providers, advocates or family members?

Input was requested by the DMH/DDD as evident by the posting the ID Waiver renewal on the Department's website. Based on comments during the DD Subcommittee, DDD has added items to the ID Waiver renewal and has edited some of the language. Specifically, the DDD has removed the language around phasing out large configuration housing.

13. Is the Governor aware of the economic impact this will have?

First, no change has been made. Second, on a routine basis, DMH seeks and has sought input on its services through multiple stakeholder advisory bodies, and has on this renewal application for months. An economic impact study was not conducted. However, the DDD has asked for and encouraged any detailed information regarding costs related to providing services, specifically regarding supported employment services. To date the DDD has had limited data submitted.

14. HUD provides transport for some of these individuals. Is the department going to pick up these costs?

Depending on what services are being provided, transportation is included in several waiver rates such as residential habilitation, day habilitation and the proposed emergency employment transportation and it would be the provider's responsibility to transport individuals to various locations.

15. A function of the IRBI is to pay providers fewer funds for congregate settings, does the department have the resources to pay for the "phase out" of these programs?

The Individualized Residential Budget Instrument (IRBI) is intended to reimburse based on staffing needs. This rate methodology was developed and approved via the rate setting committee which was a subset of the DDD Subcommittee. Paying providers fewer funds for larger settings is not a function of the IRBI.

16. How will the department phase out these programs?

The DMH/DDD has removed the phase out language from the ID Waiver renewal. That said, if it is determined by use of the steps identified in the proposed transition plan that sites are not compliant with the new rules, they will be phased out by requiring that people be served in ways that foster the independence, inclusion in the community and personal privacy and control consistent with the regulations and including but not limited to: 1) no longer certifying homes that are larger than four individuals unless they are specialized medical or behavioral settings or are government funded that require people with disabilities remain there for a specified period of time and 2) no longer back filling vacancies in large configurations with waiver participants.

17. Has an Economic impact study been completed? When will providers, advocates and families receive a copy?

An economic impact study was not conducted, beyond what CMS has published regarding HCBS rule compliance. However, the DDD has asked for and encouraged any detailed information regarding costs related to providing services, specifically regarding supported employment services. To date the DDD has had limited data submitted. Further, the DDD continues to advocate for appropriate revenue for services and has helped to develop some additional revenue for services.

18. A. Since SELN was brought in to help shape the waiver and services, why has the SELN report not been made public?

The SELN report has not been finalized. The DDD has a meeting scheduled in August 2014 to review the draft report.

B. At the initial provider meeting with SELN, they stated their report would be completed in four to 6 weeks. That meeting was held in October of 2013. If it has not been completed why not?

A draft template for DMH's review for correctness, state specificity and input was submitted to the DDD. Before that review and input could be completed, the DDD staff was in the midst of personal tragedies, a legislative session, work to modernize its stakeholder advisory structure, analyzing and adapting to new rules regarding HCBS waiver services, labor rules affecting community program workers, and Workforce Investment Act proposed changes that affect employment, etc. Also the DDD and stakeholders subsequently met with SELN staff and received additional, helpful, technical assistance, much of which has been incorporated in this renewal submission and is contemplated for future systems improvement, that made the early draft overcome by events. More recent deadlines such as submission of this waiver renewal and transition plan for HCBS Rule compliance took precedence. Technical assistance leading to systems improvement, rather than a written plan from SELN staff was the objective, which has been partially attained and continues to develop.

C. Why have providers not been given a rough draft?

The draft Findings and Observations template was for DMH review and input, prior to a final plan being completed.

D. Have funds been paid to SELN for the report?

The DDD, like most states, is a member of SELN; albeit a newer one, given emphasis on supporting people with disabilities in attaining and maintaining competitive and customized employment. Consultation, review of our program, technical assistance, not just the Findings and Observations report are parts of the membership.

E. If so how much and have they received full payment for their services?

The DDD paid for a partial year membership (prorated) to SELN for its first, partial year membership. The full year amount is for $35,000.00, and the year's worth of technical assistance, included a total of 6 days with 3-4 experts on the ground in Alabama providing us with numerous ideas on how we move Alabama off of the near bottom for competitive employment for people with IDD in the country. SELN participation was not a requirement of this waiver submission. However, the value of participation therein has been the process of engagement and input from Alabama stakeholders through focus groups and structured meetings. Those meetings included presentation of data from most of the states across the U.S. on their methods of increasing supports and services for helping people with IDD increasingly receive integrated, competitive employment at living wages. That invaluable input has resulted in many of the proposed service additions and definitions that DMH/DDD believes will significantly enhance the needed improvement to our system in Alabama. Further, it pales in comparison to the hundreds of millions of dollars provided for community service delivery in this state for people with IDD, but participation in SELN is already helping DMH to repurpose, and eventually expand dollars and services to the people we serve who need them.

19. A. The current IRBI limits the "Direct Personnel Hourly Wage" for weekend residential staff to a maximum of $1.86 per hour $5.39 below minimum wage. When will this be corrected?

This amount of $1.86/hour is a part of the overall daily rate of the IRBI and is billed 365 days, not just during the weekend hours.

For example, if a person is 1:1 and has 19 hour residential days and 5 additional weekend hours they are paid $338.32/day. Not one rate on weekdays and $1.86/hour on weekends.

B. The current IRBI limits the "Direct Personnel Hourly Wage" for level three individuals to $10.00 per hour but that number has not been adjusted for the Affordable Care Act and is now below minimum wage.

Direct Personnel Hourly Wage per IRBI	10.00
Social Security	00.45
Medicare	00.11

Health Insurance ($540 per Month * 12/2080 hours)	03.12
Retirement 5% (state rate)	00.36
Payable Hourly Wage	05.96

Please note Workmen's Compensation, SUI and training cost were not added. Those costs would further decrease the Payable Hourly Wage.

It has been the Departments comment in the past that $10 per hour translates into $30 per hour with three individuals in the home. This is incorrect, The IRBI adjusts the Direct Personnel Hourly Wage to $3.33 when three individuals are present in a home.

When will this be corrected?

The level three $10.25/hour is what the Department is willing and able to pay for the service. Your calculations above assume you are paying the direct care staff $10.00/hour and you are basing the benefits on that number. If you were to base the benefits on the assumption that the direct care worker is receiving minimum wage it would calculate like this:

Direct Personnel Hourly Wage	7.25
Social Security	.33
Medicare	.08
Payable Hourly Wage	7.66

This doesn't include a retirement package or insurance plan for the worker. It has not been the intent of the IRBI to cover retirement or insurance. The Department has limited funds and the IRBI allows us to currently serve the number of individuals on the waiver. The difference in $10.25/hour and $7.66/hour is available to allow for flexible pay and benefit packages.

20. A. Section 5 part I Public Input of the waiver packet, states the Management Steering Committee meets monthly. Why has the Management Steering Committee not met in the last six months?

The DMH has multiple advisory boards and arms of advisory boards. The DMH is continuing to meet with various advisory boards, including its Board of Trustees which is

the statutory advisory board and the Management Steering Committee's divisional coordinating subcommittees. The DMH/DDD's Advisory Subcommittee is the primary advisory body to this division and its services, especially the waiver services at issue in this renewal application. The Steering Committee, as exists in the current regulation, is a historic (several decades) advisory committee consisting mostly of community mental health center and other provider representatives. In order to have more inclusive stakeholder input, including family members, individuals with disabilities, waiver participants, advocates, small providers, Arc and other providers, this subcommittee was expanded at the direction of an earlier commissioner of DMH and has continued to meet on a regular basis. Recommendations and input into policy, procedures, budget items, and services (either through the waiver or the Medicaid state plan, etc.) are vetted through this advisory body.

The DMH, following a provider agency suggestion that the Management Steering Committee process be revisited, recently recommended restructuring and repurposing the Management Steering Committee, to formalize the broader stakeholder input and put it in DMH policy. These recommendations were presented and approved in both (DD and Mental Health/Substance Abuse) subcommittees. However, when the new language, repealing the old regulation in lieu of the new DMH policy was posted for public comment, some provider agency stakeholders voiced concerns about any changes and lobbied a legislative committee that reviews regulations to reject the regulatory repeal that would have afforded broader DD stakeholder representation than just a limited number of, primarily, a few provider entities under the old regulation. The DMH Commissioner has informed the primary stakeholder bodies responsible for blocking the repeal of the old regulation that he is open to working to reconcile this advisory framework but feels strongly that the broader voices for advice should be heard and that a more flexible way to adjust to the many and rapid changes in the service delivery system laws, funding and guidance, is through a departmental policy, rather than a regulation; hence the limited representation that we have had. Dialog to reconcile this overall advisory framework is anticipated in the future.

Meanwhile, since at this time the DDD has continued working with the somewhat broader, but not far enough yet Commissioner-directed framework, and the DD Subcommittee and stakeholders that participate in standard, scheduled monthly meetings, plus additional workgroup and sub-workgroup meetings in most months, this ensures broad and inclusive stakeholder participation for IDD services. The meetings typically include many more stakeholders than the designated members of the subcommittee or workgroup and everyone is heard, encouraged to be present and comment. Further it has been made clear to stakeholders that these bodies will continue to meet while the broader Management Steering Committee framework gets resolved.

B. Section 5 part I Public Input of the waiver packet states that Management Steering Committee's "divisional subcommittee's takes part in planning and recommending approval of, actions of the Division, including development of waiver services." Did this occur? Do the notes of these meeting show this occurring? In going through the subcommittee notes the changes to hourly services were mentioned but did not go through a formal approval. Does an emergency meeting need to be called to have these changes approved?

The DD Subcommittee adopted the use of smaller workgroups to focus on specific issues, such as waiver services, in order to streamline the planning process and accomplish goals. Minutes have been written and distributed. Proposals from this group have been vetted through the Subcommittee. Summaries of the proposed waiver renewal, focusing on new services or updated definitions and changes from per diems to hourly or sub-hourly units were discussed and changes and additions made in consideration of stakeholder input while the draft was developed. These comments were accepted after the draft was posted on the DDD's website for at least 30 days with much advanced announcement to stakeholders that they would be. The subcommittee and/or workgroup(s) continue to meet routinely, monthly unless otherwise notified due to conflicts. The make-up of the smaller workgroups include members of the Subcommittee and other stakeholders not formally assigned as Subcommittee members.

21. Rates for providers have gone unchanged since the 1990's and are unchanged in this waiver.

A. Is it DMH's position that costs to provide services have not increased since the 1990"s?

The DDD has provided for rate increases when possible. Since 2008 the DMH/DDD has been generally working on a flat funded budget. The DMH/DDD has downsized considerably to provide more home and community based care that also shifted millions of dollars in facility care to community providers serving the individuals affected. The DMH/DDD closed all developmental centers which resulted in significant staff reductions. The Division of MH/SAS also closed multiple state operated acute care hospitals resulting in significant staff reductions. While the DMH/DDD has not been able to provide for COLAs annually, there have been changes in payment. Several years ago the Department bought out "local match" of providers so that all clients on the waiver are now being paid by the Department's state dollars, this has resulted in freeing up those previously used local match dollars for other provider expenses.

During this time both DDD HCBS waivers were amended to include additional services to support providers and participants in shifting to a more integrated community based delivery model. The DMH/DDD has encouraged providers to utilize these services.

See attached spreadsheet for Rate History

B. With Providers continuing to go out of business does DMH feel it's in compliance with section 1902(a)(30)(A) of the act which states "payments for services must be consistent with efficiency, economy and quality of care and be sufficient to enlist enough providers"?

To date, the DDD continues to receive applications and is enrolling new service providers. The number of providers that have gone out of business due to service rates are unknown, however the number of providers that have discontinued contracting with the DMH/DDD is very small. The DDD believes that the current rate structure, even given limited increases, is still sufficient to enlist needed providers.

The DDD has been part of the SELN (State Employment Leadership Network) since 2012. DDD is a participant in the Rate Setting focus group. This has been a useful focus group for identifying rate structures of other states, among other aids. It becomes evident looking at other states' rates that no state system looks the same or pays the same rate for waiver services. It is also clear that for achieving optimum outcomes for people such as competitive employment, that states with some of the highest rates have some of the poorest outcomes and vice versa. That tells us that the priority of focus on how people are supported means more than just increasing rates.

C. Is it DMH's position that they have met the requirements under section 1902(a) as it pertains to public comment on rates methodologies during the waiver change process? If so when did that occur?

Yes. The DDD has had a long standing Rate Setting Taskforce that was established in 2001 to assist in the transition from monthly payments (cost reimbursement) to fee for service. It was during these initial meetings that members of the DD Subcommittee and other stakeholders met as part of the taskforce and agreed on the IRBI for setting residential service rates and set three tiered rates for day habilitation using the ICAP Service Score to determine which tier is appropriate for each individual. There has been no change to these rate methodologies. A memorandum was issued on March 26, 2003.

An additional level of day habilitation was added to accommodate those individuals that have challenging behavior or are medically fragile. Other services that have been added for supports have been set at rates that are comparable to other waiver services. For example, Housing Coordination and Benefits Planning have both been set for the

same rate as the Job Developer. These three services have similar requirements for training, education and/or experience. The Job Developer service has been in the waiver for several years with no rate change.

D. What is DMH's position on rate changes?

The DDD has provided for rate increases when possible. The DDD continues to work with stakeholders and receive technical advice from national and federal organizations focusing on funding and rate structures. The focus is on employment, more independent living, and self-directed services. When additional revenue is received from the state it will be used to enhance services and rates.

E. Should the department be adding staff, getting raises and creating new positions when providers have not received an increase in rates since the 1990's?

The Alabama Legislature appropriated additional funding for, and the DMH/DDD provided for merit raises in FY 13, the first time since 2008 that state employees were allowed to receive an annual raise. Many state employees do not benefit from the merit raises because they have topped out of their salary range. A cost of living increase would be the only way these employees would receive a raise. The state was also on a hiring freeze for many years. Once lifted the DMH/DDD began replacing much needed staff in vacated positions due to retirements. The DMH has seen a great deal of vacated positions due to many of our professionals retiring. Vacant positions are being filled to ensure adequate oversight is provided to the waiver programs. Not only does the waiver have mandated quality assurances that must be measured, tracked, and remediated, but the CMS Final Rule also requires states to become compliant within five years. With just these two compliance mandates the DDD needs to be fully staffed with professionals to have adequate oversight for funding to programs to be provided.

22. Is it DMH's position that CMS is defunding and therefore closing workshops? If CMS changes course will DMH?

CMS's position on not using HCBS funding for sheltered work has been clear for several years and so has the DDD's. The DDD will not pay for these types of services via the waiver. If CMS changes course then the DDD will assess said changes, seek input from all stakeholders, and revise stated goals if necessary. The DDD has no indication presently, though, that changes by CMS are contemplated.

23. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in Appendix B, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. Appendix B specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

This is done through the case management and the person centered planning process.

What is the average per capita expenses?

Cost analysis are available in Appendix J of the ID Waiver renewal which is posted on the DMH website.

24. Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver

Equitable distribution of waiver openings in all geographic areas covered by the waiver.

How are these two things accomplished?

Provider contracts are developed using the same format. Each year, at a minimum, contract language is reviewed and revised if necessary. Contracts are issued and signed by all providers that wish to continue contracting with the DDD. Any expectations included in a provider's contract related to a program (i.e. Targeted Case Management) will be included in all other provider contracts related to the same program.

The DDD currently utilizes a statewide waiting list process to place people into waiver services. The waiting list is based on the criticality of the person's needs. When there is an opening available in the waiver the DDD looks to the waiting list, by highest criticality, to utilize this opening. This process currently dictates the geographical locations of where a person chooses to receive services. The choice (among providers and services) process will further dictate the area and provider that a person ultimately selects.

25. Providers are only given 245 units for day and work services a year. That leaves 15 days per year providers don't receive payments. The state may take holidays but most providers are open 24 hours a day 365 days a year. Can this be fixed?

Providers are given 247 annual units for day/work services for each individual. This leaves 13 weekdays/year to cover holidays and individuals vacation days. Programs can only bill for the hours an individual works. If an individual works for more than 247 days/year it should be no problem for the Department to provide more billable units for the individual.

Residential programs that are open 24 hours/day 365 days a year are already given 365 units, or 365 less an absentee factor.

26. Appendix I of the waive packets states rates are determined by State to State Comparisons, current pricing for similar services. Under Section 5 part I of the waiver packet shouldn't those be made public?

Approved state waiver programs are posted on CMS's website where anyone who would like may review the programs and their identified rates. Similarly, a history of recent renewal rates and the current proposed rates are listed in the Appendix J to this proposed waiver renewal that was posted on the DMH/DDD website that these comments refer to.

27. Appendix I states provider are Re-evaluated as warranted based upon provider inquires. Do these need to be formal inquires? What are the procedures?

DMH as an operating agency engages state stakeholders on at least a monthly basis around issues concerning services, including rates. Since no significant change in rate methodology has occurred since the fee for service system was implemented approximately ten years ago, the biggest impact on rates has been the available appropriated funds to pay the match for waiver services. DMH will continue to hear from stakeholders regarding their needs and make budget requests accordingly.

Besides the above comments that were consolidated by a representative of one agency association for multiple stakeholder groups for IDD services that utilize the ID waiver, one of those statewide associations of providers of case management and direct services commented:

We would like guidance on how to build acceptable walls of separation within an agency if there is only one service provider and case management provider in an area.

The requirement set forth in the CMS Final Rule (CFR 42 Part 430 and 431) states, "Providers of State plan HCBS for the individual, or those who have an interest in or are employed by a provider of State plan HCBS for the individual, except when the state demonstrates that the only willing and qualified agent to perform independent assessments and develop plans of care in a geographic areas also provides HCBS, and the state devises conflict of interest protections including separation of agent and provider functions within provider entities, which are described in the State plan for medical assistance and approved by the Secretary, and individuals are provided with a clear and accessible alternative dispute resolution process." "This is only permitted to

address this potential problem of not having any entity available that is not a provider to perform these essential functions of independent assessment and person-centered service plan development (under any circumstances, determination of eligibility for the State plan HCBS benefit cannot be performed by a HCBS provider or entity with an interest in providers of HCBS). Without this exception, states would be unable to make State plan HCBS available to participants in these areas. If a state employs this exception it must guarantee the independence of this function(s) within the provider entity. In certain circumstances, we may require that states develop "firewall" policies, for example, separating staff that perform assessments and develop person-centered service plans from those that provide any of the services in procedures for individuals and representatives to appeal to the state. We also will not permit states to circumvent these requirements by adopting state or local policies that suppress enrollment of any qualified and willing provider.

There are two major concerns when case management agencies are also the provider of services: 1) oversight (quality, outcomes, etc.) and 2) the financial relationship. CMS has been including Conflict Free Case Management mandates in many initiatives including the Balancing Incentives Act and the 1915 (i) HCBS waiver. To this end, CMS offered this guidance:

1. Clinical or non-financial eligibility determination is separated from direct service provision.
2. Case managers and evaluators of the beneficiary's need for services are not related by blood or marriage to the individual.
3. There is robust monitoring and oversight.
4. Clear, well-known, and accessible pathways are established for consumers to submit grievances.
5. Grievances, complaints, appeals and the resulting decisions are adequately tracked and monitored.
6. State quality management staff oversees clinical or non-financial program eligibility determination and service provision business practices to ensure that consumer choice and control are not compromised.
7. State quality management staff track and document consumer experiences with measures that capture the quality of care coordination and case management services.
8. In circumstances when one entity is responsible for providing case management and service delivery, appropriate safeguards and firewalls exist to mitigate risk of potential conflict.
9. Meaningful stakeholder engagement strategies are implemented.

While CMS does not outline the method for developing firewalls, CMS has indicated they would be available for technical assistance. The DDD will likely access this or similar technical assistance, as well as work with all the stakeholders impacted by

conflicted case management to develop firewalls, implementation strategies of the firewalls, and the oversight process of agreed upon firewalls, if necessary. However, it is the intent of the DDD to develop adequate capacity for services and case management throughout the state, where there is conflict, so there is no conflict, as a first priority.

Summary of Protection and Advocacy Agency Comments & Response

ADAP (AL Disabilities Advocacy Program) provided comments to the Alabama Department of Mental Health/Alabama Medicaid Agency application to renew the ID waiver (see July 3, 2014 letter directed to Associate Commissioner Courtney Tarver) which categorized its comments into 5 areas: 1) increased community inclusion; 2) Alabama's definition of Developmental Disability (DD); 3) additional self-directed services opportunities; 4) truly individualized Person-Centered Planning, and 5) notice of rights.

ADAP provides positive feedback regarding the proposed ID waiver renewal as it relates to increased community inclusion. The areas noted include: 1) additional waiver services to support employment; 2) time limit on pre-vocational service; and 3) increase community integration through phase out of large residential configurations. ADAP states that DMH proposes to disallow approval of new group homes with more than 6 persons or other congregate settings, this language remains in the ID waiver renewal that has been submitted to CMS. However, the language regarding the phase out of configurations larger than 6 people that the ADAP letter refers to has been modified base on meetings with U.S. Department of Housing and Urban Development (HUD). The waiver language now reflects the continuation of larger configurations if that configuration is based on a HUD or similar governmental agreement that requires that people with disabilities live in the housing (while receiving services)

ADAP provides feedback regarding disappointment that the waiver application failed to expand Alabama's definition of DD to persons other that those with and ID Diagnosis. ADAP cites that Alabama remains one of only a handful of states that fails to serve the true DD population. Additionally, ADAP states that Alabama utilizes an overly restrictive definition of ID, requiring an IQ score of below 70. In response to ADAP's concerns, the DMH has been working with Alabama Medicaid Agency (AMA) on the development of a new waiver. This waiver, to be known as ACT II, is intended to follow services developed through the Money Follows the Person Grant recently approved by CMS. The DMH will be the Operating Agency for this waiver that will focus on transitioning people with DD and/or MI diagnosis from nursing homes to community settings. With the CMS Final Rule effective, DMH can begin developing this waiver with AMA.

ADAP provides feedback regarding self-directed services. First, acknowledging that DMH will continue to work on outreach and training regarding these services. Additionally, ADAP acknowledged efforts by DMH to expand self-directed services by adding the budgetary authority for individuals and/or families and increasing the number of services that can be directed. ADAP's only concern is the rate at which services, provided by unlicensed staff, is lower than the waiver rate paid to contracted providers. This rate structure has been in place from the beginning of implementation of self-directed services. The reason is to offset the cost of the fiscal intermediary services as well as the participant/family consultant which maintain integrity of the program and benefit individuals served and their families. The rate structure for licensed staff is equivalent to the rate paid to contracted providers. These services include: RN, LPN, Positive Behavior Supports, PT, OT, and ST. Additionally, items purchased under Specialized Medical Supplies, Adaptive Equipment, Adaptive Modification, PERS, and SE Emergency Transportation.

ADAP provides feedback on Individualized Person Centered Planning (PCP). ADAP gives details regarding the PCP process in AL and the fact that it is not standardized, "done differently throughout the state," and emphasizes that participants and their natural supports should have more information regarding services available to them. Specific to providing more information about waiver services, ADAP states that at a minimum all waiver services should be discussed at the person's PCP meeting. The DMH recognizes the fact that the PCP process differs around the state. The DMH has spent a considerable amount of time training on PCP development. The DMH/DDD developed a PCP format using the assistance of University of South FL nine years ago and that template has been posted on the departmental website. That said, the DDD recognizes the need for consistency throughout the state. In order for standardization to occur, a requirement has been added to the draft HCBS Rule Transition Plan that establishes one uniform format for all PCP. Additionally, the plan calls for a Personal Outcome Measures (POM) survey to be conducted with all participants. The PCP should be developed based on the information gained from the POM survey. This approach should ensure both individualized planning as well as consistency throughout the state.

Finally, ADAP provides feedback on Notice of Rights. ADAP commends DMH for improving its process for notifying waiver recipients of their rights concerning freedom of choice, basic personal rights, and due process rights. ADAP has two suggestions to further improve the rights information process. First, currently people that are participating in self-directed services do not have an option for a fair hearing when terminated from the program. ADAP recommends, at a minimum, an internal appeals process for those that have been involuntarily terminated. Second, ADAP would like for its contact information be more readily available to those being served. Specifically,

ADAP would like its contact information provided to recipients who experience a reduction in waiver services or are terminated from a waiver. ADAP acknowledges that DMH has a fair hearing process in the event of service reduction or termination from the waiver. However, ADAP information is not provided to the participant. DMH plans to address both of these issues internally. We believe both of these concerns can be easily rectified.

ADAP sums their comments with the following sentence, “If DMH puts the principles of the waiver application into practice and undertakes the suggestions in this letter, DMH will, indeed, improve the quality of life of ID waiver recipients by providing them with increased opportunities for a true community experience."