

ALABAMA DEPARTMENT OF MENTAL HEALTH  
**WAIVERS for Persons with  
INTELLECTUAL DISABILITIES**

*Waiver Renewal and Review of Services  
Effective 10/1/2019*

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*Training Date 10/31/2019*

# What is a Waiver?

- ▶ What are Medicaid State Plan Services

[http://www.medicaid.alabama.gov/content/Gated/7.6.1G\\_Provider\\_Manuals/7.6.1.2G\\_July\\_2018.aspx](http://www.medicaid.alabama.gov/content/Gated/7.6.1G_Provider_Manuals/7.6.1.2G_July_2018.aspx)

[http://www.medicaid.alabama.gov/content/Gated/7.3G\\_Fee\\_Schedules.aspx](http://www.medicaid.alabama.gov/content/Gated/7.3G_Fee_Schedules.aspx)

# Waiver Services

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## ▶ Statutory Services

- ▶ Day Habilitation \*Community Day Added
- ▶ Employment Supports
- ▶ Personal Care \*Limits/Supervisory Visits
- ▶ Prevocational Services \*Community Prevocational Added
- ▶ Residential Habilitation
- ▶ Respite

• Additions/Changes

## ▶ Other Services

- ▶ Adult Companion \*Supervisory Visits
- ▶ Benefits and Career Counseling
- ▶ Community Experience \* Limitations
- ▶ Community Specialist Services \*Deleted
- ▶ Environmental Accessibility Adaptations
- ▶ Housing Stabilization Services
- ▶ OT, ST, and OT Services
- ▶ Skilled Nursing Services
- ▶ PERS
- ▶ PBS \*Removed SD Options
- ▶ Medical Equipment \*Name Change to Assistive Technology
- ▶ Specialized Medical Supplies
- ▶ Supported Employment Transportation
- ▶ \*Supported Living Services

# REMEMBER!

## Waiver Services...

- ▶ ***Are not*** an entitlement
- ▶ ***Are not provided as a remedial benefit to the waiver participant or family but to improve the quality of life, improve health and safety, or increase the participant's independence and community integration***
- ▶ Waiver Services are provided based on the ***assessed needs*** of the participant

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- Quality Improvement
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## Appendix C: Participant Services

### C-1/C-3: Service Specification

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State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**  
Statutory Service

**Service:**  
Day Habilitation

**Alternate Service Title (if any):**

- HCBS Taxonomy:**
- Category 1:**  
04 Day Services
  - Sub-Category 1:**  
04020 day habilitation
  - Category 2:**
  - Sub-Category 2:**
  - Category 3:**
  - Sub-Category 3:**
  - Category 4:**
  - Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

**Category 4:**  
[Dropdown menu]

**Sub-Category 4:**  
[Dropdown menu]

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

Character Count: 3530 out of 12000

The setting in which the individual is receiving Supported Employment services comports fully with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, and to specific the individual's choice and assessed need as set forth in the person-centered ISP. Freedom of choice also includes the right to select any provider with an active provider agreement with the Department of Mental Health Division of Developmental Disabilities if the provider is available, willing, and able to provide the services needed, and choice of the setting in which services and supports are received which shall be integrated in, and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS. The ISP describes all the supports and services

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Character Count: 1796 out of 6000

The Department of Mental Health, Division of Developmental Disabilities requires certification of programs delivering Day Habilitation services. Standards are in Alabama Code, Chapters 580-3-23, and 580-5-30 A and B.

An applicant wishing to provide these services must provide written statements of the program facility's compliance with fire and health standards and submit these and other documentation to the Division of

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E
- Provider managed

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type
Agency	Certified Day Habilitation Program

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## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

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**Service Type:** Statutory Service  
**Service Name:** Day Habilitation

**Provider Category:**

Agency

**Provider Type:**

Certified Day Habilitation Program

#### Provider Qualifications

**License** *(specify):*

Character Count:0 out of 4000

**Certificate** *(specify):*

Character Count:55 out of 6000

Al. Administrative Code Chapters 580-3-23 and 580-5-33.

**Other Standard** *(specify):*

Character Count:1444 out of 12000

Day Habilitation training services will be delivered by a habilitation aide and supervised by a Qualified Intellectual Disabilities Professional (QIDP) in coordination with the individual's person centered plan.  
The Aide will work under supervision and direction of a Qualified Intellectual Disabilities Professional. The QIDP must provide and document supervision of, training for, and evaluation of Aide in the individual client record. The QIDP must assist the Aide as necessary as they provide individual Habilitation services as outlined by the person centered plan.

#### Verification of Provider Qualifications

**Entity Responsible for Verification:**

Character Count:27 out of 4000

DMH Certification Surveyors

# Day Habilitation Service-Facility Based

- ▶ Includes:
- ▶ Planning
- ▶ Training
- ▶ Coordination
- ▶ Support

To enable and increase independence, physical health, socialization and community integration, etc.

Included in the 4940 total allowable units in the 247 days

- ▶ Four levels based on the ICAP Score
- ▶ Can include transportation costs
- ▶ Day Hab is limited to 5 hours each day

## **Ratio:**

**Level 1: 1:15**

**Level 3: 1:8**

**Level 2: 1:12**

**Level 4: 1:1**

# Community Day Habilitation

- ▶ Expected to be delivered in the community. Can include activities, such as volunteering, community integrations activities designed to create an avenue of independence and autonomy. As all services, should be included in the person centered plan.
- ▶ Ratio: Level One 1:4 Rate \$4.16/\$4.80 per 15 minute unit
  - Level Two: 1:3 Rate \$4.76/\$5.40
  - Level Three: 1:2 Rate \$5.94/\$6.58
  - Level Four: 1:1 Rate \$9.06/\$9.70
- Counts toward the total 4940 units per year
- Community Day Habilitation should be delivered according to the individual person centered plan and in the ratio outlined above. Individuals with similar interest may be taken into the community based on common interests. A outing arranged for all individuals receiving facility day habilitation would not be considered community day habilitation.
- Day services can only be billed for 247 days (248 days in leap years)per waiver participant.

# Waiver Service: Community Experience

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**Community Experience can only be billed by those providers who have transformed and are providing 100% community based services**



## Two Distinct Service Types

- 1) Individual- one on one
- 2) Group- one to **three**

### Community Experience Group

- ▶ Customized for the individual
- ▶ Provided outside the person's residence
- ▶ Engaged in an activity to improve skills
- ▶ Present on the POC

### Individual Community Experience

- ▶ Is delivered one on one
- ▶ Need for Service based on ICAP and HRST Scores
- ▶ Behavioral Assessment may be indicated

Purpose: Improve access to the community through increased skills, natural supports and/or less paid supports

# Community Experience

- ▶ Community Experience services cannot be provided in the participant's home or during the same time the participant is receiving Residential Habilitation since community integration is part of that service.
- ▶ CEI/CEG can only be billed by providers of Day Habilitation during the normal day hab hours and cannot overlap residential service hours.
- ▶ Community Experience Group should not be used to facilitate group activities that normally would be provided by the Day Habilitation provider.

## Community Experience

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- ▶ Rate: 1:1 \$9.70 per 15 minute unit  
1:3 \$6.10 per 15 minute unit
- ▶ Limited to 5 hours per day
- ▶ Counts toward the total 4940 units per year
- ▶ Providers should not bill for Day Habilitation or Community Day Habilitation services
- ▶ Can include volunteering
- ▶ Should be driven by the person centered plan



# Supported Employment

**“Supported employment - individual employment supports- may also include support to establish or maintain self-employment, including home-based self-employment. Supported employment services are individualized and may include any combination of the following services: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, benefits and work incentives planning and management, transportation, asset development and career advancement services. Other workplace support services including services not specifically related to job skill training that enable the waiver participant to be successful in integrating into the job setting.”**

# Waiver Service Supported Employment

- ▶ Types: Small Group (2-8), and Individual
  - ▶ Small Group can include mobile crews
  - ▶ Business based workgroups employment
- ▶ Individual has 2 components: Job Developer and Job Coach
  - ▶ Job Development limited to 40 hours per year per participant
  - ▶ Job Coaching limited to 836 hours per year per participant as fading occurs (109/4 months, 65/4 months, 35/4 months)

Both services are intended for those requiring the service to obtain and maintain employment

Both services are intended to assist the individual in competitive integrated employment at, or above minimum wage

Both are intended to fade and replaced with natural supports

Both are billed in 15 minute increments

**Cannot** be provided in a sheltered workshop

Cannot be provided for volunteer work

Cannot be provided if VR services are available

Does not include transportation

# Supported Employment

- ▶ Assessment/Discovery is a one-time, time-limited and targeted service designed to help an individual, who wishes to pursue individualized, integrated employment or self-employment, to identify through person-centered assessment, planning and exploration: strong interests toward one or more specific aspects of the labor market, skills, strengths and other contributions likely to be valuable to employers or valuable to the community if offered through self-employment and conditions necessary for successful employment or self-employment.
- ▶ Discovery may involve a comprehensive analysis of the person's history, interviews with family, friends and support staff, observing the person performing work skills, and career research in order to determine the person's career interests, talents, skills, support needs and choice, and the writing of a Profile, which may be paid for through waiver funds in order to provide a valid assessment for Vocational Rehabilitation (VR) services which begin with the development of an Employment Plan through VR.

# Assessment/Discovery

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Discovery/Assessment is limited to no more than a ninety (90) day time period and should not overlap other services

- ▶ Is available for individual participants interested in employment.
- ▶ The expectation is that the majority of the process be performed outside of a facility so a true assessment is completed per individual.
- ▶ Discovery shall be limited to no more than 100 units/25 hours of service. The provider shall document each date of service, the activities performed that day, and the duration of each activity completed. Reimbursement for Assessment/Discovery should be billed at three distinct intervals during the process. The first billing for services occurs after one third, no more than 8 hours or 32 units, of the assessment/discovery process and requires documentation of activities performed that support the billing during the first period of the assessment process. The second billing for services occurs at the two thirds, no more than 8 hours or 32 units, of assessment/discovery process and also requires documentation of activities performed that support the billing during the second period of assessment process.
- ▶ The information developed through Discovery allows for activities of typical life to be translated into possibilities for integrated employment. Discovery results in the production of a detailed written Profile summarizing the process, learning and recommendations for next steps. The written Profile is due no later than ninety (90) days after the service commences. The final payment for assessment/discovery is billed after the completion of the report, and can include no more than 9 hours or 36 units of service. This service is limited to two assessments per each waiver participant, with the second assessment being conducted only if the participant changes service providers. To exceed the capped amount, documented justification should be sent to the Employment Coordinator at the Central Office, or the Employment Specialist at the Regional office. Approvals will then follow the established request for service procedures. No waiver participant can receive more than four assessment/discovery services over the lifetime of the waiver.
- ▶ Once an Assessment/Discovery is complete, the job development should begin with job placement as the expected outcome.

# Supported Employment Transportation

- ▶ Employment transportation is the provision of service to permit waiver participants access to and from their place of employment in the event that the support team is unable to facilitate transportation through other means.
- ▶ The Team's efforts to secure transportation must be documented in the case record. The provision of this service must be necessary to support the person in work related travel and cannot be reimbursed for merely transportation. This service shall not duplicate or replace the Medicaid non-emergency medical transportation program. In addition, this does not preclude other arrangements such as transportation by family or friend.
- ▶ It is the expectation that, as part of the person centered planning process and employment outcomes, that long term transportation to and from the worksite will be facilitated and arranged.
- ▶ Payments for this service will be reimbursed based on the IRS mileage rate and requires documentation (i.e. vendor receipt or travel log) of service or by mile. The unit of service is a mile.
- ▶ Transportation must be provided by public carriers (i.e. charter bus or metro transit bus) or private carriers (i.e. Taxicab). Commercial transportation, including day or residential provider agency - Must have a business license. All drivers must have a valid driver's license of appropriate type (e.g. commercial) for transport in Alabama. A list of transportation resources by county is posted on the Department of Mental Health's website.

# Supported Employment Transportation

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- ▶ The unit of service is a mile, to be reimbursed at the IRS federal mileage rate and is based on adequate documentation.
- ▶ Documentation for reimbursement includes actual receipts from public or private transportation providers or mileage logs and should also include progress toward obtaining long term transportation as part of measuring the employment outcomes.
- ▶ Payment made for mileage includes the provider's cost of an insurance waiver to cover any harm that might befall the participant as a result of being transported. The attendant must have a valid Alabama driver's license and his/her own insurance coverage as required by State law.
- ▶ The provider agency shall assure the attendant has a good driving record and receives in-service training on safety procedures when transporting a participant. It shall not replace transportation that is already reimbursable under day or residential habilitation nor the Medicaid non-emergency medical transportation program. This service is reserved for only those waiver participants who are employed. The planning team must also assure the most cost effective means of transportation, which would include public transport where available. Employment Transportation is not intended to replace generic transportation or to be used merely for convenience.

# Prevocational Services

**Experiential and  
interactive training**  
are just a few of our solutions ...



## Prevocational Services Federal Definition

“

Services that provide learning and work experiences, including volunteer work, where the individual can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings. Services are expected to occur over a defined period of time and with specific outcomes to be achieved, as determined by the individual and his/her service and supports planning team through an ongoing person-centered planning process, to be reviewed not less than annually or more frequently as requested by the individual. Individuals receiving prevocational services must have employment-related goals in their person-centered service plan; the general habilitation activities must be designed to support such employment goals. Competitive, integrated employment **in the community** for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities is considered to be the successful outcome of prevocational services”

”

# Let's Go to Work!!!

## Prevocational Services

- 1) Designed to create a pathway to employment
- 2) Teach Concepts: Attendance, Task Completion, Problem Solving, Interpersonal Relations and Safety
- 3) Does not include teaching specific job task
- 4) Employment Related goal must be on the Individual's Person Centered Plan
- 5) Should match job with the individual's interests, strengths, priorities, abilities, and capabilities



# Prevocational Services (continued)

- 6) Are delivered for the purpose of furthering habilitation goals leading to employment
- 7) Prepare the participant for integrated employment
- 8) Should enable attainment of the highest possible level of work
- 8) Prepare the participant to earn wages at or above minimum wage
- 9) Must address transportation needs
- 10) Can be delivered in the community
- 11) Is limited to 2470 units per individual over the lifetime of the waiver
- 12) Not available through VR or LEA
- 13) Requires supporting documentation of services delivered
- 14) Within the 2 year period, a referral to VR is expected

***CMS also says:***

***“Participation in prevocational services is not a required pre-requisite for individual or small group supported employment services provided under the waiver. Many individuals, particularly those transitioning from school to adult activities, are likely to choose to go directly into supported employment. Similarly, the evidence-based Individual Placement and Support (IPS) model of supported employment for individuals with behavioral health conditions emphasizes rapid job placement in lieu of prevocational services.”***

CMS Technical Guide 3.5 2015 Prevocational Service

# Community Prevocational Service

- <sup>25</sup> Follows the same guidelines and must be present in the person centered plan with the participant expressing a desire for employment
- Can be delivered in at places within the community. Can include a variety of activities, but all activities should be supported by the participant's individual goals for improvement in some areas
- **Rate \$24.40**
- Providers should document explicitly activities in the community and how that relates to the participant's goals
- Should count towards the 4940 total units
- **Unit is 1 hour**
- **Documentation should support the the PCP and the goals established designed to assist the participant to obtain employe**



# Benefits Planning

**A monthly check to you -**

**FOR THE REST OF YOUR LIFE  
•• BEGINNING WHEN YOU ARE  
26 65**

**GET YOUR SOCIAL SECURITY ACCOUNT NUMBER promptly**

**APPLICATIONS ARE BEING DISTRIBUTED AT ALL WORK PLACES**

**WHO IS ELIGIBLE •• EVERYBODY WORKING FOR SALARY OR WAGES (WITH ONLY A FEW EXCEPTIONS, SUCH AS AGRICULTURE, DOMESTIC SERVICE, AND GOVERNMENT WORK). APPLICATIONS FOR SOCIAL SECURITY ACCOUNTS ARE AVAILABLE THROUGH EMPLOYERS. IF YOU DO NOT GET ONE FROM YOUR EMPLOYER, ASK FOR ONE AT THE POST OFFICE.**

**HOW TO RETURN APPLICATION**

1. HAND IT BACK TO YOUR EMPLOYER, *or*
2. HAND IT TO ANY LABOR ORGANIZATION OF WHICH YOU ARE A MEMBER, *or*
3. HAND IT TO YOUR LETTER CARRIER, *or*
4. DELIVER IT TO LOCAL POST OFFICE, *or*
5. MAIL IT IN A SEALED ENVELOPE ADDRESSED: POSTMASTER, LOCAL

**DO IT NOW. NO POSTAGE NEEDED.**

*- Social Security Board*

**INFORMATION MAY BE OBTAINED AT ANY POST OFFICE**



# Benefits Planning Federal Definition

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“Career planning is a person-centered, comprehensive employment planning and support service that provides assistance for waiver program participants to obtain, maintain or advance in competitive employment or self-employment. It is a focused, time limited service engaging a participant in identifying a career direction and developing a plan for achieving competitive, integrated employment at or above the state’s minimum wage. The outcome of this service is documentation of the participant’s stated career objective and a career plan used to guide individual employment support.”



# Benefits Counseling and Reporting

Two distinct services:

- ❑ Benefits Counseling
- ❑ Benefits Reporting

# Benefits Counseling

- ▶ Benefits Counseling an intensive service provided by a Community Work Incentives Coordinator (CWIC) who will receive referrals from the BRSA, case managers, family and/or service providers.
- ▶ CWICs will provide intensive individualized benefits counseling, benefits analysis, develop a work incentive plan and ongoing benefits planning for a participant changing jobs or for career advancement.
- ▶ CWIC employed by ADRS, funded by ADMH/DD Division, but can be employed by a provider
- ▶ One in each regional office
- ▶ Billed in 15 minute increments Limited to 60 units/15 hours per year

# Benefits Reporting Service

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- ▶ The Benefits Reporting Service is designed to assist waiver participants/families to understand general information on how SSI/SSDI benefits are affected by employment.
- ▶ The BRS will be employed by a provider agency.
- ▶ The BRS will receive referrals from a variety of sources, including case managers, families, service providers, and CWIC housed in each region of the state.
- ▶ Once the participant enters employment, the BRS will be available to answer questions, assist in the execution the work incentive plan, and assist with the submission of income statement and/ or Impairment Related Work Expenses (IRWE) to SSA as required to the extent needed as indicated by the individual.
- ▶ The BRS must document services and activities. Unit is 15 minutes
- ▶ Limited to 12 units/3 hours per month (144 units/36 hours annually)

# *Personal Care Federal Definition*

**“A range of assistance to enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a disability. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the participant to perform a task. Personal care services may be provided on an episodic or on a continuing basis.”**

# Personal Care Services

- ▶ Includes:
  - ▶ Assistance with any ADL or IADLs
  - ▶ ADLs such as bathing, toileting, transfers and ambulation, skin care, grooming, dressing extension of therapies\* and exercises, routine care of adaptive equipment, meal preparation, assistance with eating, and incidental household cleaning and laundry.
- Limited to 12 hours per day for those living in the home with families
- Rate increase to \$4.12 per 15 minute unit
- ▶ IADLs include assistance with shopping, budgeting, using public transportation, social interaction, recreation and leisure activities
- ▶ Also includes accompaniment, coaching and minor problem solving
- ▶ Can include supervision only, but requires a plan approved by the RO.
- ▶ The DSP should be completing a **\*60** supervisory visit.



**Those participants currently receiving more than the 12 hour limit will continue to receive the amount of authorized services!!!**

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**A need assessment will have to be completed in order to reduce the number of hours for these participants. Need assessment must justify the reduction. Appeal rights provided**

**Exceptions can be made in the case of emergency situations either temporarily or permanently**

# Remember This...

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- ▶ “Personal care under the waiver may also include general supervision and protective oversight reasonable to accomplishing of health, safety and inclusion. The worker may directly perform some activities and support the client in learning how to perform others; the planning team (composed at minimum of the person and family, and a case manager or community specialist) shall determine the composition of the service and assure it does not duplicate, nor is duplicated by, any other service provided to the individual. ***A written description of what the personal care worker will provide to the person is required to be submitted to the state as part of or in addition to the plan of care, and will require approval by the Division of Developmental Disabilities and be subject to review by the Single State Agency for Medicaid.***”

# <sup>36</sup> Personal Care Transportation

- ▶ Must be incidental to Personal Care and not the main reason for the service and must be described in the PCP
- ▶ Must be needed to support participant's access to the community
- ▶ Must not be used to provide mere transportation (for convenience or replace generic transportation)
- ▶ Cannot replace transportation already reimbursable under day or residential services
- ▶ Cannot access NET



# Waiver Personal Care Service to Support Employment

- ▶ Assistance with ADL and IADL
- ▶ May be used to support an individual at the worksite
- ▶ Includes General Supervision
- ▶ Oversight reasonable for health, safety and inclusion
- ▶ Can include transportation to and from the job site
- ▶ Must support the employment goal as identified by the POC & PCP
- ▶ Can be self-directed
- ▶ **Rate Increase to \$6.00 per 15 minute unit**
- ▶ Can be a component of other services, but cannot comprise the entirety of the service.
- ▶ Cannot overlap another service



# Personal Care

- ▶ Not available to under age 21
- ▶ EPSDT
- ▶ Supervisory Visits 60 Days
- ▶ Limitations for participants living with parents or guardians
- ▶ Payment is 15 minute units

# Housing Stabilization



# Housing Stabilization/Community Integration

Housing Stabilization Service enables, waiver participants to maintain their own housing as set forth in the participant's approved plan of care (POC). Services must be provided in the home or a community setting. The service includes the following components:

- ▶ 1. Conducting a Housing Coordination and Stabilization Assessment identifying the participant's preferences related to housing (type, location, living alone or with someone else, identifying a roommate, accommodations needed, or other important preferences) and needs for support to maintain housing (including accessing housing, meeting terms of lease, and eviction prevention), budgeting for housing/living expenses, obtaining/accessing sources of income necessary for rent, home management, establishing credit and understanding and meeting obligations of tenancy as defined in lease terms.
- ▶ 2. Assisting participant with finding and securing housing as needed. This may include arranging or providing transportation.
- ▶ 3. Assisting participant in securing supporting documents/records, completing/submitting applications, securing deposits, and locating furnishings.
- ▶ 4. Developing an individualized housing stabilization plan based upon the Housing Coordination and Stabilization Assessment as part of the overall Person Centered Plan. Identify short and long-term measurable goal(s), establishes short and long-term goals, establish how goals will be achieved and how concerns will be addressed, and identifies where other provider(s) or services may be needed in order to achieve the goal(s).

# Housing Stabilization/Community Integration

- ▶ 5. Participating in Person-Centered plan meetings at redetermination and/or revision plan meetings as needed.
- ▶ 6. Providing supports and interventions per the Person-Centered Plan (individualized housing stabilization portion). Identify any additional supports or services needed outside the scope of Housing Stabilization Services and address among the team.
- ▶ 7. Communicating with the landlord and/or property manager regarding the participant's disability (if authorized and appropriate), detailing accommodations needed, and addressing components of emergency procedures involving the landlord and/or property manager.
- ▶ 8. If at any time the participant's housing is placed at risk (i.e., eviction, loss of roommate or loss of income), Housing Stabilization Services will provide supports to retain housing or locate and secure new housing or sources of income to continue community based supports which includes locating new housing, sources of income, etc.

# Housing Stabilization/Community Integration

- ▶ Housing Stabilization Service must be:
- ▶ a. Authorized and included in the participant's service plan;
- ▶ b. Necessary for the participant's safe transition to the community, or to increase independence;
- ▶ c. Exclusive of expenses for monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for pure diversion or recreational purposes; or that are not necessary for the participant's safe transit

# Supported Living Service

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- ▶ “Services that include training and assistance in maintaining a home of one’s own, or a home shared with other freely chosen housemates, in the community. A home of one’s own **means a residence not owned or controlled by any waiver service provider.** SLS supports include supports for maintaining home tenancy or ownership, managing money, preparing meals, shopping, maintaining positive relationships with neighbors, opportunities for participation in and contribution to the local community, supports to maintain personal appearance and hygiene, supports for interpersonal and social skills building through experience with family, friends and members of the broader community, and other activities needed to maintain and improve the capacity of an individual with an intellectual disability to live in the community. The services shall support and maximize the person’s independence through use of teaching, training, technology and facilitation of natural supports”

- ▶ The service shall support the individual's full integration into the community, ensure the person's choice and rights, and comport fully with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, including the provision of opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources. Further, supports shall be provided in a manner which ensures an individual's rights of privacy, dignity, respect and freedom from coercion and restraint; and which optimizes individual initiative, autonomy, and independence in making life choices. Any modification to one or more of these HCBS setting standards must be supported by the individual's specific assessed need and fully documented in the person-centered Individual Support Plan (ISP), along with a plan to reduce or eliminate the modification as soon as prudent, as required by federal regulation.
- ▶ The service also includes oversight and assistance in managing self-administered medication and/or medication administration as permitted under Alabama's Nurse Practice Act and performance of other non-complex health maintenance tasks, as permitted by State law. The SLS provider shall monitor the health care needs of the person supported and support the person to attend to their own health care needs and/or work with natural supports to ensure the person's health care needs are addressed.
- ▶ This service is appropriate for people who need intermittent staff support to remain in their own home and do not require 24/7 staffing. However, access to emergency supports as needed from the provider on a 24/7 basis is an essential component of this residential service and is what differentiates it from Personal Assistance services. The provider must also ensure each SLS participant has an emergency preparedness plan in place at all times, that is shared with the support coordinator, and the individual is supported to learn and practice this plan at regular intervals.

- ▶ Individuals receiving SLS may choose to receive services in a shared living arrangement. Other persons in the shared living arrangement may need differing levels of support, differing types of waiver services, or may participate in different HCBS programs, as permitted in state licensure law and regulation, as long as there is a willing, qualified provider who can safely and appropriately meet the needs of each individual in the home. No more than 3 persons receiving services will be permitted per residence.
- ▶ All individual goals and objectives for SLS, along with a description of needed SLS supports to achieve these goals and objectives, shall be established through **the person-centered planning process and documented in the person-centered ISP**. The **Circle of Support must consider the person's level of independence, availability of natural supports, ability to utilize technology, ability to rely on housemates, neighbors, etc. in establishing a Supported Living arrangement and the service delivery schedule**. The Supported Living service plan must be reviewed at least annually (and more often should a change of needs or circumstances warrant). Consideration should be given to the use of a Personal Emergency Response System and/ or other technology to increase independence, when appropriate. The ISP must reflect the routine supports that will be provided by Supported Living staff while recognizing flexibility may be needed and desired by the person supported.
- ▶ The **person may choose to live with one or two other persons supported and share living expenses or choose to live alone as long as sufficient financial resources are available to support the chosen arrangement**.
- ▶ Payment to providers is based on a monthly fee and service delivery must be appropriate to meet the individual needs and goals. Transportation may be necessary for some individuals and is included in the rate paid to the provider.

# Limitations

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- ▶ Reimbursement for SLS **shall not include** the cost of maintenance of the dwelling. Residential expenses (e.g., phone, cable TV, food, rent, mortgage, home/renters insurance, etc.) shall be paid by the person(s) supported and other residents in the home (if applicable), through mutual agreement reached by the persons sharing the dwelling.
- ▶ A person who is receiving SLS shall not be eligible to receive Personal Care, Companion or Transportation as separate services, except for Supported Employment Transportation and Personal Care at the Worksite. (if Personal Care is provide within the delivery of SLS services, the worker must use the EVV Authenticare System to clock in and out With these exceptions and the additional exception of transportation to and from medical services covered through the Medicaid State Plan, transportation shall be a component of SLS and shall be included in the reimbursement rate for the service.
- ▶ The SLS provider shall not own the person's place of residence under any circumstances. The provider shall not be a co-signer of a lease on the person's place of residence unless this is necessary for person to obtain lease and , the provider signs a written agreement with the person that states that the person will not be required to move if the primary reason is because the person desires to change to a different provider. The SLS provider shall not own, be owned by, or be affiliated with any entity that leases or rents a place of residence to a person supported if such entity requires, as a condition of renting or leasing, the person to move if the person desires to change to a different SLS provider.

# Limitations

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- ▶ SLS shall not be provided in any setting defined as an institutional setting under the federal Medicaid HCBS Settings Rule including inpatient hospitals, nursing facilities, and Intermediate Care Facilities for individuals with Intellectual Disabilities (ICFs/IID).
- ▶ Certain family member(s) of the person supported cannot be reimbursed to provide SLS i.e. spouse to spouse, parent to child, child to parent or either appointed as legal guardian and/or living with the person. Other family member(s) may be reimbursed to provide SLS if they otherwise meet the provider qualifications and hiring requirements for this service or are employed by an approved provider of SLS services.
- ▶ SLS shall not be provided in a home where a person supported lives with family members unless such family members are also persons receiving waiver services. Family member shall be interpreted to mean the mother, father, grandmother, grandfather, sister, brother, son, daughter, or spouse, whether the relationship is by blood, by marriage, or by adoption.
- ▶ SLS shall not be provided out-of-state. **A minimum of two face-to-face direct service visits lasting at least one hour in the home per week are required for each person receiving SLS, along with 24/7 availability of provider staff in case emergency supports are needed.**

# Residential Services

- ▶ May be provided group home certified by ADMH Certification.
- ▶ Residential Habilitation must relate to identified planned goals

- ▶ Selected by the individual
- ▶ Offers individualized services and supports as identified by the PCP enabling acquisition, retention or improvement of skills necessary to reside in a community based setting that supports independence and full integration into the broader community
- ▶ Offers opportunities to seek employment, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving HCBS services
- ▶ The individual has the right to a rental agreement that is fully enforceable
- ▶ Provides care, supervision and skills training in
  - Daily living
  - Home management
  - Community integration



# Specialized Medical Residential Service

- ▶ REQUIREMENTS
- ▶ 1. 24/7 LPN services. LPN serves as one of at least two staff on duty in a home with no more than 4 persons residing. LPN provides ongoing treatment and medical services and supports as identified by assessed needs of an RN, other Medical Professionals, and the person centered team.
- ▶ 2. RN services. The RN serves in an administrative capacity such as a Home Manager or QIDP. The RN provides clinical supervision to the LPN and oversees training, implementation and compliance with the Department of Mental Health's Nurse Delegation Program. Other duties may include serving as back-up staff in the absence of the LPN, procurement of needed specialized medical supplies and equipment, primary liaison between individuals receiving services and all required health care professionals, and annual nursing assessment, etc.
- ▶ 3. Physician services. The agency ensures that individuals have a primary care physician or group of physicians. The individual, their family, and/or their legal representative, to the extent possible, choose their primary care physician or group. The agency provides a comprehensive set of medical records to the primary care physician or group to include summary of current diagnoses, treatment modalities and their rationale, history of previous conditions and issues associated with current diagnoses and successful and failed treatments, etc.
- ▶ 4. Staff training. The agency ensures that all staff working with individuals supported are provided with specific training related to all aspects of person's medical situations, signs and symptoms related to specific conditions, and other specialized delegated treatments as outlined in the Nurse Delegation Program and Nurse Practice Act.
- ▶ 5. Medical needs. To qualify for a special medical services provider rate, individuals must have 3 or more medical conditions listed on the attached page. Individuals must be screened using the Health Risk Screening Tool (HSRT) and be rated at a Risk Level of 5 or 6.

# SPECIALIZED BEHAVIORAL SERVICES

## REQUIREMENTS

51

- 1. Board Certified Behavior Analyst (BCBA) Services-Support Plan. The agency must employ or have access to a BCBA to complete the functional assessment for persons identified to need a Behavior Support Plan (BSP). A Qualified Intellectual Disability Professional (QIDP) can write the plan based on the assessment. However, the BCBA should review and approve prior to review by the Behavior Program Review Committee (BPRC) and the Human Rights Committee (HRC).
- 2. BCBA-Medication Plan. Individuals who take Psychotropic Medication, a formal Psychotropic Medication Plan is required. A QIDP can develop the plan which, can be part of the BSP or a stand-alone document. However, the BCBA should review and approve prior to review by the BPRC and the HRC.
- 3. Staff training-Professional staff. The BCBA and QIDP must complete a set of courses established by ADMH which will be the core curriculum of behavioral services training. Included in the core curriculum will be the Behavioral Services Procedural Guidelines and other training as required and determined to be of best practice by the Director of Psychological and Behavioral Services. These guidelines provide greater detail regarding the provision of behavioral services in Alabama that include a list of approved procedures, acceptable methods of data collection, and content requirements of the BSP.

# Requirements Continued

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- ▶ 4. Staff Training-Direct Support Staff. All direct support staff who work with an individual who has a BSP and/or Psychotropic Medication Plan must be provided specific training on that person's plan, by the BCBA or QIDP, before they can work with the individual. This training is in addition to the initial and annual training requirements for management of challenging behaviors. The initial and annual refresher training should be provided by a certified trainer through a nationally recognized company.
- ▶ 5. Behavioral needs. To qualify for a special behavioral services provider rate, individuals must have an initial screening by a member of one of the Comprehensive Support Services Team (CSST) leaders, present a clear and present danger to self and/or others, Behavior Therapy Units and specialized behavioral services approved by the director of Psychological and Behavioral Services. Specialized rates will be approved in 6 month increments and be based on data collect/driven decision making.

## In-Home Habilitation- Removed in Renewal

- ▶ In home habilitation services are provided to recipients in their own homes, but not in group homes or other facilities. In-Home Habilitation Service is limited to 8 hours per day and cannot overlap other services.
- ▶ The service excludes the following:
  - ▶ ☐ Services, directly or indirectly, provided by a member of the individual ☐ immediate family;
  - ▶ ☐ Routine care and supervision which would be expected to be provided by a family;
  - ▶ ☐ Activities or supervision for which a payment is made by a source other than Medicaid; and
  - ▶ ☐ Room and board costs.
- ▶ Billing cannot exceed more than 8 hours per day



**Those participants currently receiving more than the 12 hour limit will continue to receive the amount of authorized services!!!**

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**A need assessment will have to be completed in order to reduce the number of hours for these participants. Need assessment must justify the reduction. Appeal rights provided**

# 55 Respite Service

- ▶ Respite care is a service provided in or outside a family's home to temporarily relieve the unpaid primary caregiver. Respite care provides short-term care to an adult or child for a brief period of rest or relief for the family from day to day care giving for a dependent family member.
- ▶ Respite care is a service provided in or outside a family's home to temporarily relieve the unpaid primary caregiver. Respite care provides short-term care to an adult or child for a brief period of rest or relief for the family from day to day care giving for a dependent family member.
- ▶ Respite care is dependent on the individual's needs as set forth in the plan of care and requires approval by the Division of Developmental Disabilities, subject to review by the Alabama Medicaid Agency. The limitation on in home and out of home Respite Care in combination shall be 4320 15-minute units of service (equals 1080 hours or 45 days) per participant per waiver year. Respite care out of the home is typically provided in a certified group home.



# Adult Companion Services (ID only)

- ▶ Non-Medical Care, supervision and socialization
- ▶ Supervise or assist with tasks such as, meal preparation, laundry and shopping, but do not perform these as discrete services
- ▶ Does not include hands on nursing care
- ▶ May perform light housekeeping incidental to the care and supervision of the individual
- ▶ Must be included in the PCP and on the POC
- ▶ Needed to prevent institutional placement
- ▶ Billed in 15 minute increments
- ▶ Supervisory visits must be completed every 90 days
- ▶ Can be self-directed

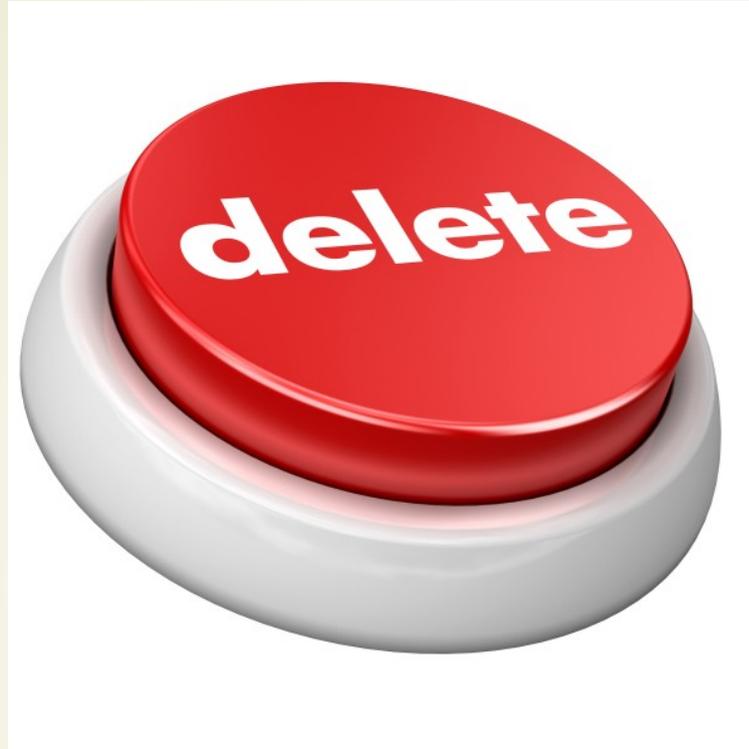


# Companion Services

57

► Services include:

- a. Supervising daily living activities, to include reminding client to bathe and take care of hygiene and personal grooming, reminding client to take medication, and overseeing planning and preparation of snacks and meals.
- b. Staying with client in the evening and at night to ensure security.
- c. Accompanying client into the community, such as shopping.
- d. Supervising/assisting with laundry, and performing light housekeeping duties that are essential to the care of the client.
- e. Following written instructions such as the care plan and documenting services provided.



# *Community Specialist Service*

# Specialized Medical Equipment

## Assistive Technology



## **SME/AT Federal Definition**

- ▶ “Assistive technology means an item, piece of equipment (including any equipment not covered by Medicaid State Plan Services), service animal or product system, whether acquired commercially, modified or customized that is used to increase, maintain, or improve functional capabilities of participants. Assistive technology services means a service that directly assist an individual in the selection, acquisition, or use of an assistive technology device that may includes:
- ▶ (A) the evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant;
- ▶ (B) services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants;
- ▶ (C) services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
- ▶ (D) coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the service plan;
- ▶ (E) training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and
- ▶ (F) training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants. Providers of this service must maintain documentation of items purchased for each individual .”

# Assistive Technology

- ▶ Can include any specialized medical equipment includes devices, controls, or appliances specified in the service plan of care, which enable recipients to increase their ability to perform activities of daily living or to perceive, control, or communicate with the environment in which they live. Included items are those necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. All items shall meet applicable standards of manufacture, design and installation.
- ▶ Providers of this service must maintain documentation of items purchased for each individual.

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# Specialized Medical Equipment

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- ▶ A prescription from the participant's physician is required for this service. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the recipient.
- ▶ Payment is for the cost of the item provided.
- ▶ There is a \$5,000 per year, per individual maximum cost.
- ▶ For children 21 years and younger, State Plan Services available through EPSDT are utilized prior to expending waiver funds.
- ▶ Self-Directed Specialized Medical Equipment/AT is only available to those participants who are self-directing personal care, companion and/or LPN/RN services.

# Environmental Accessibility Adaptations

- ▶ Those physical adaptations to the home, required by the recipient's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and without which, the recipient would require institutionalization. \
- ▶ Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the recipient,
- ▶ but shall exclude those adaptations or improvements to the home which are of general utility and not of direct medical or remedial benefit to the waiver client, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are excluded from this benefit.
- ▶ An evaluation by a Physical Therapist may be necessary to assist in the determination of structural requirements and need for the EAA service.
- ▶ All services shall be provided in accordance with applicable State or local building codes as well as ADA Standards.

# Environmental Accessibility Adaptations

- ▶ The individual's home may be a house or an apartment that is owned, rented or leased.
- ▶ Adaptations to the work environment covered by the Americans with Disabilities Act, or those that are the responsibility of other agencies, are not covered.
- ▶ Covered adaptations of rented or leased homes should be those extraordinary alterations that are uniquely needed by the individual and for which the property owner would not ordinarily be responsible.
- ▶ Payment is for the cost of material and labor.
- ▶ The unit of service would be the job.
- ▶ Total costs of environmental accessibility adaptations shall not exceed \$5,000 per year, per individual.
- ▶ This service does not require a prescription from the participant's physician.

# Specialized Medical Supplies

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- Specialized medical supplies are those which are specified in the plan of care and are necessary to maintain the individual's health, safety and welfare, prevent further deterioration of a condition, or increase an individual's ability to perform activities of daily living.
- Specialized medical supplies are supplies that address the participant's physical health and any ancillary supplies.
- All items shall meet applicable standards of manufacture and design.
- Providers of this service must maintain documentation of items purchased for each individual.
- State plan services must be utilized prior to the expenditure of waiver funds for medical supplies.

# Specialized Medical Supplies

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- ▶ Supplies reimbursed under this service shall not include common over-the-counter personal care items and items which are not of direct medical or remedial benefit to the recipient and does not include items such as soap, cotton swabs, toothpaste, deodorant, shampoo or sanitary items or supplies otherwise furnished under the Medicaid State plan,
- ▶ Costs for medical supplies are limited to \$1800 per year, per individual and must be prescribed by the participant's physician.
- ▶ This service is not available to participants under the age of 21 years as medical supplies are covered through EPSDT for this age group.
- ▶ Self-Directed Specialized Medical Supplies service is only available to those participants who are self-directing personal care, companion and/or LPN/RN services.

# Individual Goods and Services (SD Only)

- ▶ Individual Directed Goods and Services are services are available to only those participants self directing services who are able to save funds through negotiation of worker's employment wages
- ▶ Individual goods and services include equipment or supplies not otherwise provided through this waiver or through the Medicaid State Plan that address an identified need in the service plan (including improving and maintaining the participant's opportunities for full membership in the community) and meet the following requirements: the item or service would decrease the need for other Medicaid services; and/or promote inclusion in the community; and/or increase the participant's safety in the home environment; the item or service is not illegal or otherwise prohibited by Federal and State statutes and regulations, and the participant does not have the funds to purchase the item or service or the item or service is not available through another source.

## Services (SD Only)

are services are available to only  
who are able to save funds  
through negotiation of worker's  
employment wages

Equipment or supplies not otherwise  
provided through this waiver or  
through the Medicaid State Plan that  
address an identified need in the  
service plan (including improving and  
maintaining the participant's  
opportunities for full membership in  
the community) and meet the  
following requirements: the item or  
service would decrease the need for  
other Medicaid services; and/or  
promote inclusion in the community;  
and/or increase the participant's  
safety in the home environment;  
the item or service is not illegal or  
otherwise prohibited by Federal and  
State statutes and regulations, and  
the participant does not have the  
funds to purchase the item or  
service or the item or service is not  
available through another source.

# Individual Goods and Services

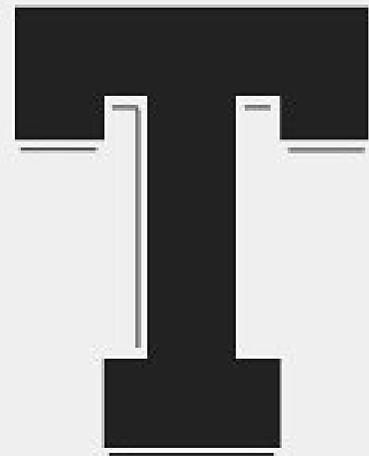
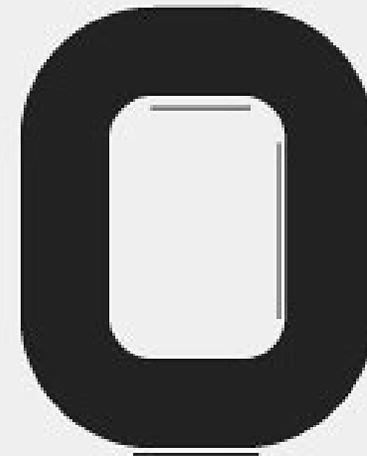
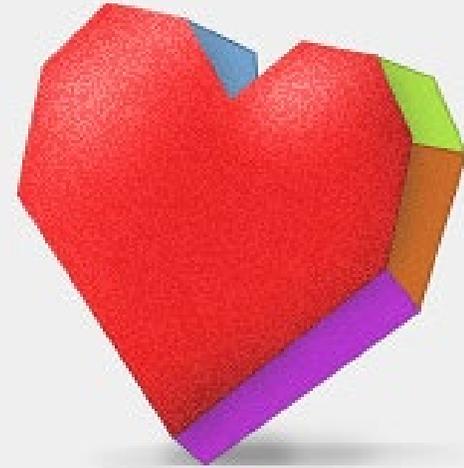
- ▶ If an individual returns to traditional waiver services the ability to access any dollars from the savings account and utilize this service will be terminated.
- ▶ Dollars not utilized will be refunded to the Division of Developmental Disabilities.
- ▶ Dollars can be accumulated past the fiscal year, however, cannot exceed \$10,000.00 at any give time. The case manager/liaison will be responsible for monitoring the balances of the savings to ensure proper utilization.
- ▶ Items, goods or services that are not for the primary benefit of the participant are prohibited.
- ▶ Items, goods and/or services unrelated to the person's assessed long-term support needs and outcomes related to those needs are prohibited.
- ▶ State plan services and waiver service funds should be expended prior to the utilizing the Individual Goods and Services.
- ▶ The case manager has oversight of expenditures of Individual Goods and Services and must document the need of any item or service in the case record.
- ▶ Individual Goods and Services can be utilized prior to expenditure of waiver funds in the event her are no providers accessible in the participant's area to provide the service. This must be documented in the case record.

# Personal Emergency Response Service

- Installation (\$500.00 for install and testing)
- Monthly Monitoring (Estimated \$83.00 per month)
- Total costs per participant per year is limited to \$1,500.00-\$3,000.00
- ***Not available to persons receiving Residential services***
- Appropriate for those who can operate responsibly.
- CMS restricts the use of camera for surveillance

# Occupational Therapy Service

- ▶ Occupational therapy is the application of occupation-oriented or goal-oriented activity to achieve optimum functioning, to prevent dysfunction, and to promote health.
- ▶ The term "occupation" as used in occupational therapy refers to any activity engaged in for evaluation, specifying, and treating problems interfering with functional performances.
- ▶ Services include assisting in the evaluation of an individual to determine level of functioning by applying diagnostic and prognostic tasks and guiding and treating individuals in the prescribed therapy to secure and/or obtain necessary functioning.
- ▶ Provision of this service will prevent institutional placement.
- ▶ Therapist may also provide consultation and training to staff or caregivers (such as client's family and /or foster family). Consultation/Training Services to direct caregivers will be allowed when the service to caregivers is for the direct benefit of the recipient and is necessary to enable the recipient to be cared for outside of an institution.



# Occupational Therapy Service

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- ▶ Occupational Therapy requires a physician's prescription and documentation in the form of an initial assessment and development of a treatment plan with established goals that must be present in the case record and must justify the need for service.
- ▶ Services must be listed on the care plan and be provided and billed in 15-minute units of service.
- ▶ Occupational therapy is limited to no more than 50 hours or 200 units for the initial plan. If it appears that more therapy is needed, the OT will re-evaluate and submit another treatment plan that includes goals and outcomes, to the case manager who will complete a request for action to the CSD to approve.
- ▶ No more than an additional 50 hours, or 200 units will be allowed per occurrence per individual.
- ▶ The OT should teach the primary caregiver how to continue needed exercises for the participant.
- ▶ Occupational therapy under the waiver is not available to children under the age of 21 when provided as the result of an EPSDT screening, because that service is covered under the State Plan.
- ▶ Group therapy is not allowed.
  
- ▶ Documentation

Providers of service must maintain a service log that documents specific days on which physical therapy services were delivered. Occupational therapist must document each therapy session in a treatment note and must sign each note denoting whether or not progress is made.

# Physical Therapy Service

- ▶ Physical therapy is treatment of an individual by the employment of effective properties of physical measures and the use of therapeutic exercises and rehabilitative procedures with or without assistive devices, for the purpose of preventing, correcting, or alleviating a physical or mental disability.
- ▶ Services must begin with the PT evaluation that, if necessary, results in the development of a treatment plan.
- ▶ The treatment plan should outline the frequency of service, goals of therapy, and outcomes or milestones to be reached by the participant. The PT may recommend exercises to the participant/family that will be completed at home that will help to ensure maximum potential is reached.
- ▶ The evaluation of an individual to determine level of functioning by applying diagnostic and prognostic tasks and providing treatment training programs that are designed to: preserve and improve abilities for independent function, such as range of motion, strength, tolerance, coordination and facility performing activities of daily living; and prevent irreducible progressive disabilities through means such as the use of orthotic and prosthetic appliances, assistive and adaptive devices, positioning, behavior adaptations and sensory stimulation.
- ▶ Therapist may also provide consultation and training to staff or caregivers (such as client's family and/or other caregiver). Services to direct caregivers will be allowed when the service to caregivers is for the direct benefit of the recipient and is necessary to enable the recipient to be cared for outside of an institution.



# Physical Therapy Service

- Physical Therapy requires a physician's prescription
- an initial assessment
- development of a treatment plan with established goals that must be present in the case record and must justify the need for service.
- Services must be listed on the care plan and be provided and billed in 15-minute units of service.
- Physical therapy is limited to no more than 50 hours or 200 units for the initial plan.
- If it appears that more therapy is needed, the PT will re-evaluate and submit another treatment plan that includes goals and outcomes, to the case manager who will complete a request for action to the CSD to approve.
- No more than an additional 50 hours, or 200 units will be allowed per occurrence per individual. The PT should teach the primary caregiver how to continue ROM exercises for the participant.
- Physical therapy under the waiver is not available to children under the age of 21 when provided as the result of an EPSDT screening, because that service is covered under the State Plan. Group therapy is not allowed.

## Documentation

- Providers of service must maintain a service log that documents specific days on which physical therapy services were delivered. Physical therapist must document each treatment note and must sign each note denoting whether or not progress is made.

# Positive Behavioral Service

- ▶ Positive Behavior Support (PBS) is a set of researched-based strategies that combine behavioral and biomedical science with person-centered, valued outcomes and systems change to increase quality of life and decrease problem behaviors by teaching new skills and making changes in a person's environment. The strategies take into consideration all aspects of the person's life and are intended to enhance positive social interactions across work, academic, recreational, and community settings while reducing actions that are not safe or that lead to social isolation, loneliness or fearfulness. PBS provides framework for approaches that emphasize understanding the person, strengthening environment that build on individual strengths and interests, and decreasing interventions that focus on controlling problematic behavior in order to fit the person's environment. Some of the billable tasks include, but are not limited to: conducting functional behavior assessments, behavior support plan (BSP) development, training to implement the BSP, data entry/analysis/graphing, monitoring effectiveness of BSP, writing progress notes/reports, etc. BSP may include consultation provided to families, other caretakers, and habilitation services providers. BSP shall place primary emphasis on the development of desirable adaptive behavior rather than merely the elimination or suppression of undesirable behavior. A behavior support plan may only be implemented after positive behavioral approaches have been tried, and its continued use must be reviewed every thirty days with reports due quarterly.

# Positive Behavioral Services

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- ▶ Positive Behavior Support (PBS) waiver service is comprised of two general categories of service tasks. These are (1) development of a Behavior Support Plan (BSP) and (2) implementation of a BSP. In addition, this waiver service has three service levels: two professional and one technical, each with its own procedure code and rate of payment. The service levels are distinguished by the qualifications of the service provider and by supervision requirements. Both professional and technical level service providers may perform tasks within both service categories, adhering to supervision requirements that are described under provider qualifications.
- ▶ The two professional service provider levels are distinguished by the qualifications of the person providing the service. Both require advanced degrees and specialization, but the top level also requires board certification in behavior analysis. The third service provider level is technical and requires that the person providing the service be under supervision to perform PBS tasks.

# Positive Behavior Service

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- ▶ The maximum units per year of both professional and technician level units in combination cannot exceed 1200 and the maximum units of any combination of professional level one (1) or two (2) cannot exceed 800.
- ▶ Maximum units of Technician level service are the balance between billed professional level one (1) and two (2) units and the combined maximum per year.
- ▶ Professional level providers may provide more than the 800 unit limit, but these additional units will be paid at the Technician level up to the 1200 max on total units.
- ▶ Providers of service must document which tasks are provided by date performed in addition to their clinical notes. There will be no accommodation for exceeding the overall cap of 1200 units for all three levels.
- ▶ The following do not qualify for billing under this waiver service: 1) individual or group therapy, 2) group counseling, 3) behavioral procedures not listed in a formal BSP or that do not comply with the current Behavioral Services Procedural Guidelines and Community Certification Standards, 4) non-traditional therapies, such as music therapy, massage therapy, etc., 5) supervision.
- ▶ **Self-Directed PBS was removed as an option of service delivery in the 2019 renewal. Those persons receiving that service currently continue to receive.**

# Crisis Intervention Services

Specific crisis intervention service components may include the following:

- ▶ Analyzing the psychological, social and ecological components of extreme dysfunctional behavior or other factors contributing to the crisis;
- ▶ Assessing which components are the most effective targets of intervention for the short term amelioration of the crisis;
- ▶ Developing and writing an intervention plan;
- ▶ Consulting with those connected to the crisis in order to implement planned interventions, and following-up to ensure positive outcomes from interventions or to make adjustments to interventions; and
- ▶ Providing intensive direct supervision when a consumer is physically aggressive or there is concern that the consumer may take actions that threaten the health and safety of self and others.

Crisis intervention services are expected to be of brief duration (10 weeks, maximum). When services of a greater duration are required, the individual shall be transitioned to a more appropriate service program or setting.

# Crisis Intervention

- ▶ Crisis Intervention provides immediate therapeutic intervention, available to an individual on a 24-hour basis, to address personal, social, and/or behavioral problems which otherwise are likely to threaten the health and safety of the individual or of others and/or to result in the individual's removal from his current living arrangement.
- ▶ Crisis intervention may be provided in any setting in which the consumer resides or participates in a program. The service includes consultation with family members, providers and other caretakers to design and implement individualized crisis treatment plans and provide additional direct services as needed to stabilize the situation.
- ▶ When the need for this service arises, the service will be added to the plan of care for the person. A separate crisis intervention plan will be developed to define in detail the activities and supports that will be provided.
- ▶ All crisis intervention services shall be approved, at least by phone followed up in writing, by the regional community service office of the DMH prior to the service being initiated.
- ▶ Crisis intervention services are expected to be of brief duration (10 weeks, maximum). When services of a greater duration are required, the individual shall be transitioned to a more appropriate service program or setting.

# 80 Speech Therapy Service

- ▶ Speech and language therapy include diagnostic, screening, preventive, corrective services provided on an individual basis, when referred by a physician (M.D., D.O.).
- ▶ These services may include: Screening and evaluation of individuals' speech and hearing functions and comprehensive speech and language evaluation; participation and may include swallowing therapy in the continuing interdisciplinary evaluation of individuals for purposes of implementing, monitoring and following up on individuals' rehabilitation programs;
- ▶ and treatment services as an extension of the evaluation process that include: consulting with others working with the individual for speech education and improvement, designing specialized programs for developing an individual's communication skills comprehension and expression. Provision of this service in the community is an alternative to an institutional level of care.
- ▶ Therapist may also provide training to staff and caregivers (such as a client's family and/or foster family). Services to direct caregivers will be allowed when the service to caregivers is for the direct benefit of the recipient and is necessary to enable the recipient to be cared for outside of an institution.
- ▶ Speech Therapy is expected to be therapeutic with outcomes and goals based on the therapist evaluation.

## What is a CH and LANG Pathologist?



# Speech Therapy Service

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- ▶ Services must be listed on the care plan and prescribed by the participant's physician and related to a participant's particular diagnosis.
- ▶ An evaluation is required by the speech therapist to determine the need for service.
- ▶ If there is a need for service, the Speech Therapist must develop the treatment plan outlining the frequency of service and length of time expected to meet outlined goals and expected outcomes. The need for service must be documented in the case record and the outcome is expected improvement for the waiver participant.
- ▶ Speech and Language Therapy is limited 30 visits in any one planned therapy program.
- ▶ The service is expected to terminate when the goals of the developed treatment plan are met or when no further progress is anticipated. However, a request for an extension of therapy, up to an additional 30 visits, complete with proper justification showing the progress toward the goal(s) must be submitted by the case manager to the CSD for approval following the regular RFA established process.
- ▶ Services shall be provided and billed as an encounter unit of service and with only one encounter daily. Documentation of service provided by the Speech Therapist is required for each encounter and each note must be signed by the therapist. Notes must be maintained in the client file.
- ▶ Speech/Language Therapy must be due to an acute episode and should terminate once therapy becomes maintenance in nature. Speech/language therapy under the waiver is not available to children under the age of 21 when provided as the result of an EPSDT screening, because that service is covered under the State Plan. Group therapy will not be reimbursed.
- ▶ Providers of service must maintain a service log that documents specific days on which speech and language therapy services were delivered and detailed documentation of what the service entailed.
- ▶ Therapist must keep notes and document participant progress toward the planned goals. Documentation of progress toward specific goals are required.

# Nursing Services

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- ▶ Services listed in the service plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.
- ▶ The RN completes an in-home assessment to determine if the services may be safely and effectively administered in the home. This assessment also will identify the need for service and the amount of time needed. Services consist of nursing procedures that meet the person's health needs as ordered by a physician. There is no restriction on the place of service.
- ▶ LPN services may provide skilled care for the recipient if a licensed physician prescribes the service. The LPN works under the supervision of the RN. The RN evaluates the participant and establishes the Nursing Plan of care prior to assigning services to the LPN. There is no restriction on the place of service.
- ▶ This service may also, when provided to a participant or family which is self-directing personal care services, include training and supervision related to medical care and/or assistance with ordinarily self-administered medications to be provided by the personal care worker. This training and supervising component of nursing is only available to people who receive personal care at home, either agency-based or self directed. It is not available to agencies providing residential and day programs, because payment for the nurse supervision is already included in the rate paid for those services.

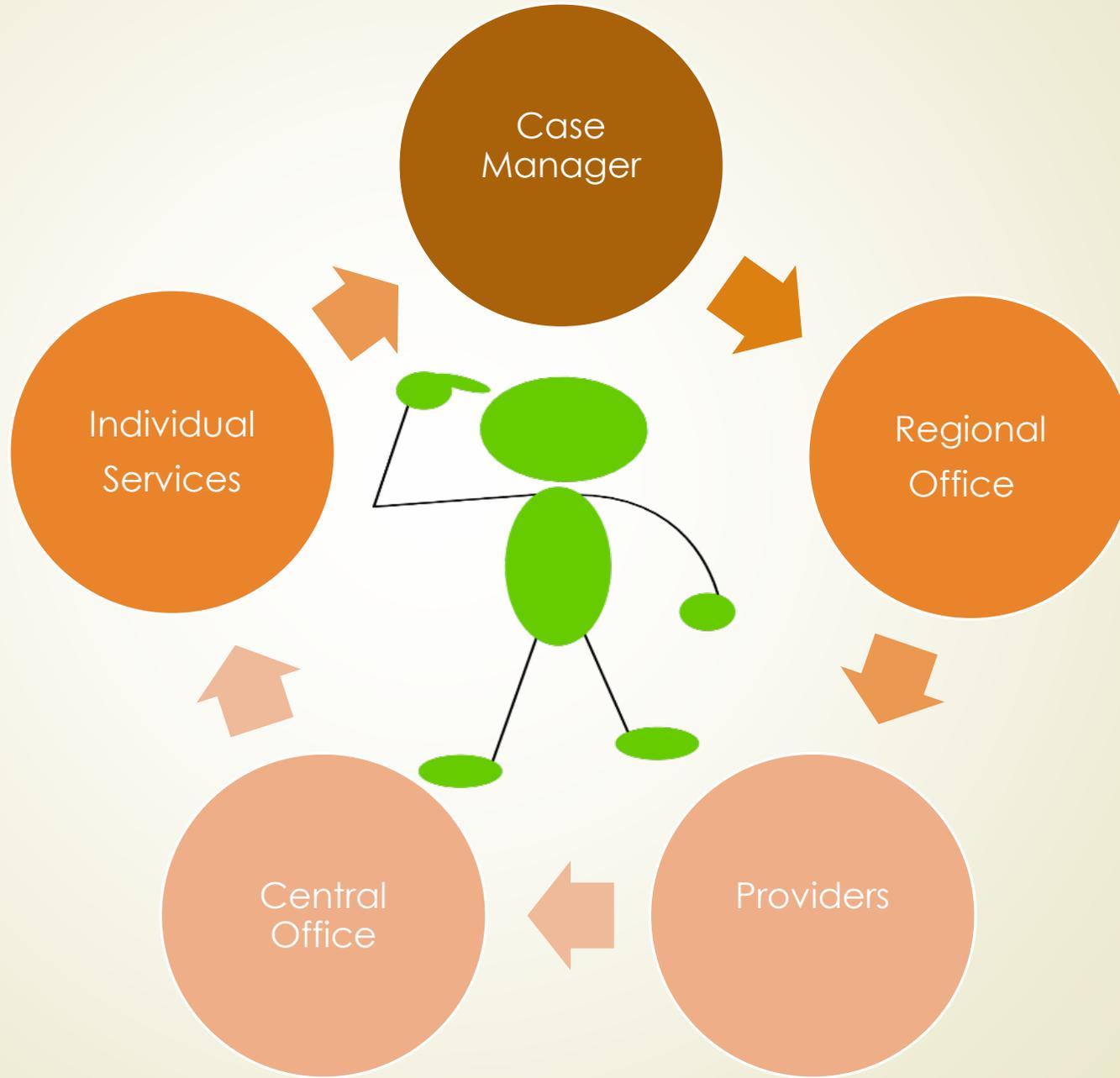
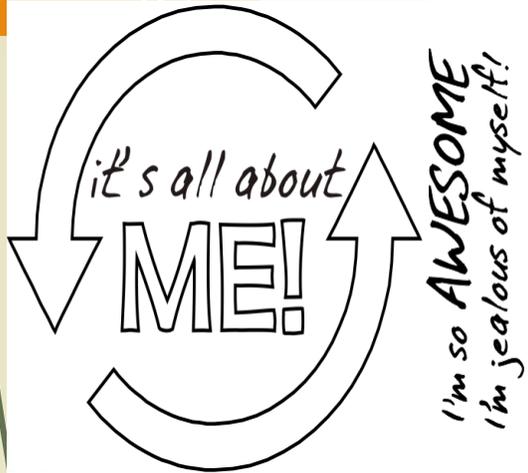
# Nursing Service

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- ▶ RN/LPN Services must be prescribed by a physician and is based upon the individual's assessed need.
- ▶ When Nursing is provided to self-directing participants and families, it is intended to focus on training and supervision of the personal care worker and is not intended as a private duty nursing service.
- ▶ Skilled nursing service under the waiver is not available to children under the age of 21, including self-directed RN/LPN, when provided as the result of an EPSDT screening, because that service is covered under the State Plan. A record of the RN/LPN visit will be captured by an Electronic Visit Verification Monitoring system.

# Remember!!!

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# Early Periodic Screening Diagnostic Testing (EPSDT)

- ▶ Must be used for children under the age of 21 years for Personal Care, Medical Supplies, Positive Behavior Supports, Crisis Intervention, Assistive Technology, Nursing Services
- ▶ Personal Care Transportation is not covered under EPSDT
- ▶ Participants whose match is paid by DHR or LEA are exempt from the EPSDT program.

# MSIQ Checks

- Done electronically and is updated in ADIDIS Fund Eligibility Page Monthly
- Mainframe
- Provider Portal

The screenshot shows a web application interface for "Alabama Live". The user is logged in as Christopher Harris, with the role of MR Admin. The page displays the "Fund Eligibility" section for a client named Harris, Christopher Na'juan (376698). The interface includes a search bar with filters for "Participating" and "Last Name". Below the search bar are tabs for "MY ADIDIS", "CLIENTS", "PROVIDERS", "CLAIMS", "UTILITIES", and "REPORTS". The "Fund Eligibility" tab is active, showing a list of records. A filter box is visible, set to "Subject Code" equal to "4400". The table below shows 15 records of fund eligibility, all for "Medicaid" in "Region1" with "Federal Funds - TCM" as the description. The records include start and end dates, status, source, last updated times, and active status.

Payer Name	Index Code	Subobject Code	Subobject Description	Start Date	End Date	Status	Source	Last Updated	Active
Medicaid	Region1	4400	Federal Funds - TCM	10/01/2019	10/31/2019	1	MC	10/3/2019 6:23:53 PM	True
Medicaid	Region1	4400	Federal Funds - TCM	09/01/2019	09/30/2019	1	MC	10/3/2019 6:23:53 PM	True
Medicaid	Region1	4400	Federal Funds - TCM	08/01/2019	08/31/2019	1	MC	10/3/2019 6:23:53 PM	True
Medicaid	Region1	4400	Federal Funds - TCM	07/01/2019	07/31/2019	1	MC	10/3/2019 6:23:53 PM	True
Medicaid	Region1	4400	Federal Funds - TCM	06/01/2019	06/30/2019	1	MC	9/5/2019 12:08:11 PM	True
Medicaid	Region1	4400	Federal Funds - TCM	05/01/2019	05/31/2019	1	MC	8/7/2019 5:32:50 PM	True
Medicaid	Region1	4400	Federal Funds - TCM	04/01/2019	04/30/2019	1	MC	7/4/2019 1:06:06 PM	True
Medicaid	Region1	4400	Federal Funds - TCM	03/01/2019	03/31/2019	1	MC	6/6/2019 3:50:34 PM	True
Medicaid	Region1	4400	Federal Funds - TCM	02/01/2019	02/28/2019	1	MC	5/23/2019 9:17:12 AM	True
Medicaid	Region1	4400	Federal Funds - TCM	01/01/2019	01/31/2019	1	MC	4/4/2019 3:51:10 PM	True
Medicaid	Region1	4400	Federal Funds - TCM	12/01/2018	12/31/2018	1	MC	3/7/2019 1:08:08 PM	True
Medicaid	Region1	4400	Federal Funds - TCM	11/01/2018	11/30/2018	1	MC	2/7/2019 2:39:01 PM	True
Medicaid	Region1	4400	Federal Funds - TCM	10/01/2018	10/31/2018	1	MC	1/3/2019 12:39:40 PM	True
Medicaid	Region1	4400	Federal Funds - TCM	09/01/2018	09/30/2018	1	MC	12/6/2018 1:09:07 PM	True
Medicaid	Region1	4400	Federal Funds - TCM	08/01/2018	08/31/2018	1	MC	11/7/2018 7:53:46 AM	True

# Redeterminations

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- ▶ Support Coordinators can begin the redetermination paperwork **60 days** prior to the participant's eligibility decision ends
- ▶ Paperwork should not be held at the Regional Office for "lack of a signature"
- ▶ Paperwork should not be held at the Regional office for "missing prescriptions for services"
- ▶ Redeterminations are expected to be processed by the last working day in the month
- ▶ Central office is process **400-500 Redeterminations** each month, so it is imperative to process them timely

# Questions or Comments

Central Office  
334-242-3701



