Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **Alabama** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:
Alabama Home and Community-Based Waiver for Persons with Intellectual Disabilities (ID Waiver)

C. Waiver Number:AL.0001
Original Base Waiver Number: AL.0001.

D. Amendment Number:AL.0001.R08.02

E. Proposed Effective Date: (mm/dd/yy)

10/01/19

Approved Effective Date: 10/01/19
Approved Effective Date of Waiver being Amended: 10/01/19

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

The purpose of this amendment is to add back services which were previously erroneously submitted in the 10/1/2019 Waiver Renewal without including a transition plan for ending the services. The services include Residential OLA/In-Home Residential Habilitation, Community Specialist, and Self-Directed Positive Behavior Support. Services will be added back to include a transition plan for ending the services. Because Residential OLA/In-Home Residential Habilitation was included with and integrated into the Residential Habilitation service section prior to removal, the Residential Habilitation section is added back as it was included in the 2/1/2018 amendment, prior to removal with the 10/1/2019 renewal. Because Self-Directed Positive Behavior Supports was included with and integrated into the Positive Behavior Support service section prior to removal, the Positive Behavior Support section is added back as it was included in the 2/1/2018 amendment, prior to removal with the 10/1/2019 renewal.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☒ Waiver Application	
☐ Appendix A Waiver Administration and Operation	
☐ Appendix B Participant Access and Eligibility	
☒ Appendix C Participant Services	
☐ Appendix D Participant Centered Service Planning and Delivery	
☐ Appendix E Participant Direction of Services	
☐ Appendix F Participant Rights	
☐ Appendix G Participant Safeguards	
☐ Appendix H	
☐ Appendix I Financial Accountability	
☒ Appendix J Cost-Neutrality Demonstration	

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

☐ **Modify target group(s)**

☐ **Modify Medicaid eligibility**

☐ **Add/delete services**

☐ **Revise service specifications**

☐ **Revise provider qualifications**

☐ **Increase/decrease number of participants**

☐ **Revise cost neutrality demonstration**

☐ **Add participant-direction of services**

☒ **Other**

Specify:

The purpose of this amendment is to add back services which were previously erroneously submitted in the 10/1/2019 Waiver Renewal without including a transition plan for ending the services. The services include Residential OLA/In-Home Residential Habilitation, Community Specialist, and Self-Directed Positive Behavior Support. Services will be added back to include a transition plan for ending the services. Because Residential OLA/In-Home Residential Habilitation was included with and integrated into the Residential Habilitation service section prior to removal, the Residential Habilitation section is added back as it was included in the 2/1/2018 amendment, prior to removal with the 10/1/2019 renewal. Because Self-Directed Positive Behavior Supports was included with and integrated into the Positive Behavior Support service section prior to removal, the Positive Behavior Support section is added back as it was included in the 2/1/2018 amendment, prior to removal with the 10/1/2019 renewal.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Alabama** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

Alabama Home and Community-Based Waiver for Persons with Intellectual Disabilities (ID Waiver)

C. Type of Request: amendment

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Original Base Waiver Number: AL.0001
Waiver Number:AL.0001.R08.02
Draft ID: AL.006.08.02

D. Type of Waiver *(select only one):*

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 10/01/19
Approved Effective Date of Waiver being Amended: 10/01/19

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☒ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

☒ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

This waiver supports individuals in Alabama who have a diagnosis of Intellectual Disabilities and who would otherwise require the level of care offered in an ICF/IID to be integrated fully into their communities. The waiver is operated by the Alabama Department of Mental Health Division of Developmental Disabilities (ADMH/DDD) under an agreement with, and supervision by, the Alabama Medicaid Agency. ADMH/DDD operates five regional offices and contracts with local public agencies known as 310 Boards from enabling legislation. The 310 Boards provide support coordination and are points of access for waiver applications. Eligibility is determined and due process notification administered by the regional DDD offices, which also approve plans of care, prior authorize funding, and monitor both support coordination and waiver services.

This waiver is a comprehensive service waiver, including residential service, supported living option, day services and in-home supports. The maximum cost is maintained in the aggregate and has always remained well under the average ICF/IID cost. This waiver has deeming options by which it can reach children at home with their families and adults with unearned income of up to 300% of the SSI maximum.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the state provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ○ **Not Applicable**
- ◉ **No**
- ○ **Yes**

C. Statewideness. Indicate whether the state requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- ◉ **No**
- ○ **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.
Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the state provides the following assurances to CMS:

A. Health & Welfare: The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least

annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. 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.

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except

when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

The Public Comment period for the second posting of the Division of Developmental Disabilities' Alabama Home and Community-Based Waiver for Persons with Intellectual Disabilities (ID Waiver) Waiver Renewal opened on May 23 and closed on June 24, 2019. The Division received public comments forwarded from the Alabama Medicaid Agency. The public comment period was announced on both the Department of Mental Health and the Alabama Medicaid Agency websites along with a notice in the Birmingham News newspaper (the largest circulated newspaper in Alabama) and its affiliate, AL.com that includes other newspaper sponsors such as the Huntsville Times, Mobile Press-Register, and Montgomery Independent. Also, ADMH/DD Division established a workgroup whose members included providers of services, support coordination, consumer advocacy and a departmental Regional Community Services Director. ADMH/DD Division also held six (6) stakeholder meetings regarding waiver services to glean information regarding the types of services persons with Intellectual Disabilities and families need. Based on a review of all the comments the following categories will be summarized and addressed for CMS (the division intends to respond to comment not addressed in this summary as time permits and make these responses public to stakeholders): 1) Service Rates; 2) Developmental Disabilities Eligibility; 3) Person-Centered Planning 4) Choice; 5) Service Definitions; and Provider Qualifications and 6) Other comments. ADMH/DD Division will respond to all other comments and questions not pertaining to the waiver renewal individually. A summary of the comments will be sent in a separate email because the characters entered was 24115 which is greater than the allowable maximum of 6000.

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Wettingfeld

First Name: Ginger

Title: Director, LTC Healthcare Reform

Agency: Alabama Medicaid Agency

Address: 501 Dexter Avenue

Address 2: P. O. Box 5624

City: Montgomery

State: **Alabama**

Zip: 36103-5624

Phone: (334) 242-5018 **Ext:** ☐ **TTY**

Fax: (334) 353-4182

E-mail: ginger.wettingfeld@medicaid.alabama.gov

B. If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Wingard

First Name: Rita

Title: Director of Systems Management

Agency: Alabama Department of Mental Health, Division of Developmental Disabilities

Address: 100 North Union St.

Address 2: P. O. Box 301410

City: Montgomery

State: **Alabama**

Zip: 36130-1410

Phone: (334) 242-3719 **Ext:** ☐ **TTY**

Fax: (334) 242-0542

E-mail: Rita.Wingard@mh.Alabama.gov

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature: Annie Scalet

State Medicaid Director or Designee

Submission Date: Apr 9, 2020

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name: Azar

First Name: Stephanie

Title: Commissioner

Agency: Alabama Medicaid Agency

Address: 501 Dexter Ave

Address 2: PO Box 5624

City:

Montgomery

State: **Alabama**

Zip: 36104

Phone: (334) 242-5600 **Ext:** ☐ **TTY**

Fax: (334) 242-5097

E-mail: stephanie.azar@medicaid.alabama.gov

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☒ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

The ID Waiver services of Residential OLA/In-Home Residential Habilitation, Community Specialist, and Self-Directed Positive Behavior Support will be phased out during the FY20 waiver year, which ends on September 30, 2020. Each current recipient of these services will be offered alternative services, as specified below. As part of that process, those service recipients will receive correspondence from the applicable Regional Community Services office which includes identification of the alternative service(s) as well as procedural information for a fair hearing request.

- Persons currently receiving Residential OLA/In-Home Residential Habilitation will be offered Supported Living Services, which was introduced in the 10/1/2019 ID Waiver renewal to replace Residential OLA/In-Home Residential Habilitation.
- The Community Specialist service had very little utilization for fiscal years 2018 – 2020. The service has been authorized for only seven (7) persons during this time period, and only two (2) claims for this service have been submitted for the time period of 2/1/2019 through 2/24/2020. This service has been utilized for only interpreter services, which may otherwise accessed through the Alabama Department of Mental Health, and linkage to services in the community, which may be accessed through Targeted Case Management services available through the Alabama Department of Mental Health. The health and welfare of individuals will be assured by the transition from the scant use of the Community Specialist service to provision of additional Targeted Case Management services and/or interpreter services, as needed, by 9/30/2020.
- Persons currently receiving Self-Directed Positive Behavior Support will be offered Positive Behavior Support through traditional waiver services.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of

milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The state assures that this renewal will be subject to any provisions or requirements included in the state's most recent and approved home and community based setting Statewide Transition Plan. The state will implement any CMCS required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan."

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

○ **The waiver is operated by the state Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

○ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

○ **Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

◉ **The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

The Alabama Department of Mental Health, Division of Developmental Disabilities

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

As the administering agency the Alabama Medicaid Agency ensures that the:
*Operating agency adheres to all federal guidelines described in the approved waiver document
*Health and safety of the client is protected
*Client has been given freedom of choice between institutional care and community care
*Direct service providers meet the qualifications as outlined in the approved waiver document; and signs all subcontracts of qualified direct service providers enrolled with the operating agency.
*Individuals served are aware of their rights to express concerns regarding service provision and/or direct service providers.

The Medicaid Agency provides ongoing oversight of this waiver program by assuring level of care determinations, plans of care, and other necessary documentation is correctly submitted and reviewed. This is accomplished by a direct review of a random sample of application and renewal documents per month.

In addition, the Medicaid Agency maintains ongoing oversight and authority over the program by:
*Conducting joint training with direct service providers enrolled to provide services through the ID waiver program.
*Participating in training provided periodically by the operating agency to discuss policies and procedures in an effort to consistently interpret and apply policies related to the ID waiver program.
*Conducting annual training for all operating agency staff to disseminate policies, rules and regulations regarding the home and community based waiver programs.
*Performing annual reviews conducted by LTC Quality Assurance Unit to assure the provisions of the interagency agreements are executed and all the assurances in the waiver are being met. The reviews include, but are not limited to provider's records, plans of care, staff qualifications and training, and case management services and monitoring.
*Annual reviews of Quality Enhancement Plan and Activities, quarterly review of complaints made to the Office of Advocacy, including the resolution of same, and participation in stakeholder task forces to assure that proposed improvements meet Medicaid requirements.
*Establishing policies and procedures for operating agency, direct service providers and targeted case managers to ensure services are provided as specified in the approved waiver document.
*Conducting desk reviews of all provider agencies serving sampled ID Waiver participants.

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

In order to implement self directed services, two types of contracted entities is being utilized. The first is a Financial Management Services Agency (FMSA) which will provide fiscal intermediary and other services to participants who choose to self-direct their services. The FMSA was selected by a competitive RFP process, and this FMSA is being utilized by the Alabama Medicaid Agency and another state agencies currently. The services of the FMSA are described in detail in Appendix E, which will include assuring "Qualified Provider Enrollment" and "Execution of Medicaid Provider Agreements."

The second type of contracted entity will consist of Self-directed Liaison who will be trained by the Operating Agency and the FMSA to provide detailed information about self-direction, its set-up, implementation, benefits and responsibilities. This function may take place before the person is actually enrolled in the waiver, therefore making it impossible for the self-directed consultant to be reimbursed under the waiver.

Self-directed Liaison have knowledge and experience in the field of Intellectual and Developmental Disabilities, who have no conflict of interest, and who are willing to be trained and provide detailed information and material to families and participants who indicate an interest in possibly using this service option. Due to the temporary nature of this position, the Operating Agency will not be acting in this capacity, but instead will work with the FMSA to develop the training and program implementation. Support Coordinators will be expected to gain knowledge and experience in self direction and will ultimately take over this function.

○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

○ **Not applicable**

◉ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.
Check each that applies:

☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

☒ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Public Corporations established under Act 310 of the Alabama Code provide support coordination to persons enrolled in the ID Waiver and serve as the local point of access for persons wishing to apply for the ID Waiver. The support coordinator assist the person/family in gathering and preparing the necessary documentation to submit to the Division of Developmental Disabilities Regional Offices.

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

Support Coordinator activities are subject to annual certification survey and quarterly regional office monitoring by the Division of Developmental Disabilities, on site. Also, the Alabama Medicaid Agency Waiver Quality Assurance Staff monitor all case management (and waiver) agencies annually.

The contracted entities which will be used to implement self-directed personal care are discussed at length in Appendix E.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

The Division of DD uses the Assessment Tool for Basic Assurances ®, a tool developed with CQL that has established 13 Basic Assurances ® that must be met in order for the program to be certified as a waiver provider.

Assessment Tool for Basic Assurances®
This section is divided into thirteen Basic Assurances® factors:

Factor One: Rights Protection and Promotion
Factor Two: Dignity and Respect
Factor Three: Natural Support Networks
Factor Four: Protection from Abuse, Neglect, Mistreatment and Exploitation
Factor Five: Best Possible Health
Factor Six: Safe Environments
Factor Seven: Staff Resources and Supports
Factor Eight: Positive Services and Supports
Factor Nine: Continuity and Personal Security
Factor Ten: Basic Assurances® System
Factor Eleven: Other Requirements Supporting Protection, Health and Safety
Factor Twelve: Personal Care, Companion, Respite and Crisis Intervention Services, and Supported Employment Services at an Integrated Worksite (non-congregate services)
Factor Thirteen: Case Management Standards

There are two methods involved in assessing whether an organization meets the Basic Assurance® standards:

Factors Four, Five and Six
The expectation is that the organization has strong systems and practices in place to promote protection, health and safety. Therefore, the criteria for Factors Four, Five and Six-- Protection from Abuse, Neglect, Mistreatment and Exploitation, Best Possible Health, and Safe Environments-- is set at 100%. The system and the practice for all Indicators in each Factor must be present to meet the 100% mark. Additional requirements in these areas (Protection, Best Possible Health, and Safe Environments) are captured in Factor Eleven, which is scored differently, as described below.

Factors One, Two, Three, Seven, Eight, Nine, Ten, Eleven, Twelve and Thirteen
Each Factor is composed of several indicators. Each of the Indicators in Factors One through Three and Seven through Thirteen are assessed and a rating made on one of the following criteria:
Action Required (AR)--Incomplete planning and action.
Progress Noted (PN)--Planning and action has occurred with evidence of partial results.
Effective Results (ER) --Actions are demonstrating the desired results.

When available, the reviewer will identify the evidence source that resulted in a requirement not met/not in compliance finding. This reference may identify a location, a record, specific observation or information disclosed during an interview. The evidence identified in this report is not intended to be inclusive of all instances where standards are not met; but rather a reflection of findings during the site visit. It is the obligation of the organization to ensure that all sites, services and documentation are in compliance with the certification standards.

Information Gathering
Probes, correlating with the requirements in Chapter 580-5-33, Administrative and Support Requirements for Community Providers of Developmental Disability Services, are included in this Assessment Tool as a means of discovering information about the Indicators and making rating decisions. They are not scored separately but are used to gather information to support the decision about whether the Indicator is being met satisfactorily.

The reviewer will make a decision about each Indicator based on the information gathered through conversation, spending time with people and review of documents. The reviewer will evaluate compliance with requirements within the Indicator and then make a final determination about the Indicator based on a preponderance of the information gathered. The reviewer will note Supporting Information for all Indicators rated “Action Required” (AR) and for those individual standards within Indicators rated “Progress Noted” (PN).

Scoring and Certification

Each organization will be subject to the requirements in Factors and Indicators based on the types of services provided (see chart following this discussion). The total number of the Indicators applicable for that organization is multiplied by 80% to determine the required number of met Indicators for a One Year Certification and 90% for a Two Year Certification. Rounding is applied to the nearest whole number, with .5 being rounded up. Individual Indicators determined by the reviewer to be not applicable for a particular situation will be deleted from the total Indicators required for that organization and this will be factored into the scoring.

The organization's Indicator rankings are added together to obtain the total number of Indicators meeting the "Progress Noted" (PN) and/or "Effective Results" (ER) status.

- If the organization does not meet the 100% criteria for Factors Four, Five and Six, AND/OR does not meet the minimum of 80% on other applicable Indicators, the organization will be determined not in substantial compliance with standards and will not be certified. The organization may be placed on Provisional Certification Status for up to sixty (60) days, and a Plan of Action to address Indicators rated "Action Required" and "Progress Noted" must be submitted to the Office of Certification Administration within thirty (30) days from receipt of the letter from that Office. Timeframes to come into full compliance with the indicators must be included in the Plan of Action. Failure to submit the Plan of Action within the time period specified may result in the immediate decertification of the organization's programs. Prior to the expiration of Provisional Certification status, the programs will undergo a follow-up site certification review to determine future certification status.

- If the organization meets the 100% criteria for Factors Four, Five and Six, AND receives either PN or ER on a minimum of 80% of the other applicable Indicators, the organization is certified for one year and a Plan of Action to address Indicators rated "Action Required" and "Progress Noted" must be submitted to the Office of Certification Administration within thirty (30) days from receipt of the letter from that Office.

- If the organization meets the 100% criteria for Factors Four, Five and Six, AND receives either PN or ER on a minimum of 90% of the other applicable Indicators, the organization is certified for two years.

The following chart indicates how the Factors and Indicators are applied per organization based on the services provided:

Total Indicators Applied to the Organization	Minimum Number of PN+ER Required for 80% Criteria	Minimum Number of PN+ER Required for 90% Criteria
30	24	27
31	25	28
32	26	29
33	26	30
34	27	31
35	28	32
36	29	32
37	30	33
38	30	34
39	31	35
40	32	36
41	33	37
42	34	38
43	34	39
44	35	40
45	36	41
46	37	41
47	38	42
48	38	43

Examples:

- An organization providing Case Management only is subject to meeting the requirements in 33 Indicators. The organization will need to rate PN or ER on 26 Indicators for a One Year Certification (80% of 33 Indicators = 26.4, rounded to 26). The organization will need to rate PN or ER on 30 Indicators for a Two Year Certification (90% of 33 Indicators = 29.7, rounded to 30).

• An organization providing Case Management services as well as one or more of the Non-Congregate services is subject to meeting the requirements in 36 Indicators (33 for Case Management, and an additional 3 Indicators in Factor Thirteen). A One Year Certification will require a rating of PN or ER on 29 (28.8) Indicators, and a Two Year Certification will require a rating of PN or ER on 32 (32.4) Indicators.

Contracted entities which will be used to implement self-directed services:

Division of Developmental Disabilities staff pulls a scientifically calculated random sample of recipients and reviews the pertinent records for these individuals. Alabama Medicaid Agency Waiver Quality Assurance staff also pulls a random sample in order to review the required records.

The contracted entities which will be used to implement self directed services, and the methods, personnel and frequency of assessing their performance are discussed at length in Appendix E.

The Self-directed Liaisons will be trained by state staff and by the FMSA, in order to have the detailed knowledge with which to assist participants and their families. All training material, employment forms, information packets, brochures and manuals will have the approval of the Alabama Medicaid Agency prior to implementation. The Self-directed Liaisons will be reporting to the regional offices of the Operating Agency, and the regional offices will approved their work or not, based on a variety of feedback. Feedback from the FMSA, case managers, and families will inform the Operating Agency of the effectiveness or lack of effectiveness of any individual consultant. If necessary, retraining will be implemented for ineffective consultants, replacement of a consultant could be required if families are not receiving the necessary support. Communication between the regional offices and the consultants will be frequent, weekly or even daily, as the process for training and implementation of self-directed services will be detailed therefore evaluation frequency is ongoing.

The Operating Agency, contracted self-directed liaison (SDL) and the contracted financial management agency (FMA) work together to ensure the ministration of self-directed services are in accordance with waiver requirements. The self-directed liaison and the regional fiscal manager both ensure that time cards are accurate and claims are submitted based on the accuracy of the time cards processed by the financial management agency. After the SDL has assisted the participant/family/representative for a few months to ensure understanding of SDS and responsibilities, the case manager and/or a community specialist will assume this role. The SDL remains available for consult as needed for each participant self-directing services. The contracted self-directed liaison has constant and direct contact with the FMA due to the pre-employment work that is necessary for the employment process to begin its process. Any issues or concerns that the SDL has is directly brought to the attention of the Operating Agency and addressed in a timely manner. The SDL works directly with each regional office and with the case management agency responsible for the waiver participant's planning. It is the responsibility of the regional offices of the Operating Agency to report any instances in which the SDL is not functioning in accordance with waiver requirements.

The oversight methods that encompass each function that is performed by contracted entities or local/regional non-state entities as specified in item A-7 include the FMA is required to submit time cards that have been processed, training documentation, license documentation, and a complete employee packet to the Operating Agency for review. The frequency for this review is quarterly. The SDL submits documentation of activities completed as part of the contract process on a monthly basis. Additionally, there is a RFP process every two years for the FMA to ensure all required tasks set forth by the Operating Agency can be fully implemented. The SDL's contract is also reviewed every two years and the job scope is listed as requirements for extending the contract.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the*

function.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	☒	☒	☐	☒
Waiver enrollment managed against approved limits	☒	☒	☐	☐
Waiver expenditures managed against approved levels	☒	☒	☐	☐
Level of care evaluation	☒	☒	☐	☐
Review of Participant service plans	☒	☒	☐	☐
Prior authorization of waiver services	☒	☒	☐	☐
Utilization management	☒	☒	☐	☐
Qualified provider enrollment	☒	☒	☒	☐
Execution of Medicaid provider agreements	☒	☒	☒	☐
Establishment of a statewide rate methodology	☒	☒	☐	☐
Rules, policies, procedures and information development governing the waiver program	☒	☒	☐	☐
Quality assurance and quality improvement activities	☒	☒	☐	☐

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- 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
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of data reports specified in the agreements, policies and procedures with the Medicaid Agency that were submitted on time and in the correct format. Numerator:

Numerator: Number of data reports provided timely and in the correct format.
Denominator: Number of data reports due.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Data reports submitted to Medicaid

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of total reported performance measures that were below 86%. Numerator: Number of performance measures that were below 86%. Denominator: Total number of reported performance measures

Data Source (Select one):
Other
If 'Other' is selected, specify:
Performance Measures reporting

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
The number and percent of requested reports submitted by the OA reviewed and validated by AMA Program Manager for compliance. Numerator: OA submitted reports reviewed and validated by AMA Program Manager for waiver compliance. Denominator: Number of reports submitted by the OA.

Data Source (Select one):
Reports to State Medicaid Agency on delegated
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100%**

		Review
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The Alabama Medicaid Agency has an established methodology for aggregating data from multiple sources and weighting it to rate performance within a specific domain. The methodology was designed by the University of Alabama at Birmingham, from that institution's analysis of the original CMS protocol specifications, and the methodology is used for quality assurance reviews of all the Alabama Medicaid Home and Community-Based Waivers. Measure number three is an example of this methodology.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The first measure, should non-enrolled/non-trained self-directed providers be found, the money paid will be recouped. The Operating Agency will ensure that all non-certified self-directed employees have been verified and approved through the FMSA employment process via the FMSA packet reviews and time-card submission process, as well as case manager quarterly follow-up and self-directed liaison review. If this is not the case then the immediate response by the Operating Agency will be to ensure the health and safety of the person being served while a more thorough investigation is conducted. If it is determined that the safety of the person is at risk then the Operating Agency will look for alternative means of service provision. This could mean placing the person into the traditional personal care service, where the Operating Agency certifies the personal care provider, until the self-directed employee is either established through the FMSA employment process or replaced.

The second measure is based on the AL Medicaid Agency's Annual Quality Assurance review. It is during this review, which spans two fiscal years, AMA pulls the provider's site visit review to ensure full remediation. DMH/DDD will gather pertinent information that supports certification findings and AMA will review all the documentation to the point of resolution. If there is an issue with documentation or a failure to remediate the AMA will include details in their findings report. DDD will correct any area of non-compliance and AMA will review the following year.

All measures are shared with the operating agency in quarterly reports, and are presented with reference to baseline data from previous periods. The goal is to improve the scores, but if they stay the same or decrease slightly, it does not require corrective action. Significant drops from baseline, as determined by the Medicaid Agency, will require follow-up, and a plan of correction.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☒ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☒	**Intellectual Disability**	3		☒
☐ **Mental Illness**					
	☐	**Mental Illness**			☐
	☐	**Serious Emotional Disturbance**			

b. Additional Criteria. The state further specifies its target group(s) as follows:

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

- (●) **Not applicable. There is no maximum age limit**
- ( ) **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- (●) **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ( ) **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

  The limit specified by the state is *(select one)*

  - ( ) **A level higher than 100% of the institutional average.**

    Specify the percentage:

  - ( ) **Other**

    Specify:

- ( ) **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ( ) **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

  Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the state is *(select one)*:

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

○ **Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the formula:

○ **May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.**

○ **The following percentage that is less than 100% of the institutional average:**

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	5260
Year 2	5260
Year 3	5260
Year 4	5260
Year 5	5260

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)*:

◉ **The state does not limit the number of participants that it serves at any point in time during a waiver year.**

○ **The state limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

○ **Not applicable. The state does not reserve capacity.**

◉ **The state reserves capacity for the following purpose(s).**

Purpose(s) the state reserves capacity for:

Purposes	
Children in State Care and Custody	
Transition to Integrated, Competitive Paying Employment	
Participants Transferring from the Living at Home Waiver	
Emergency Placements	
Outplacements from Nursing Homes	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Children in State Care and Custody

Purpose *(describe):*

Children with intellectual disabilities come into the State's care and custody due to family inability to cope, usually with behavior, in addition to the other pressures that tend to overwhelm families with special needs children. The State's Children Service Agency (The Alabama Department of Human Resources, or DHR) ordinarily finds foster homes for such children, but sometimes the behavior and other conditions are more than a foster home can manage and the child must either be placed in an institution by court order, or in the home and community-based waiver as a court-accepted alternative.

Describe how the amount of reserved capacity was determined:

The number of children entering from this source has averaged 25 per year for several years. This figure fluctuates, so we may have to submit amendments each year to keep the number correct.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved	
Year 1	25	
Year 2	25	
Year 3	25	
Year 4	25	
Year 5	25	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Transition to Integrated, Competitive Paying Employment

Purpose *(describe):*

The Department of Mental Health, Division of Developmental Disabilities has been focused on supported employment as it relates to young adults transitioning out of the education system. Last year, the Division implemented two Project Search sites within the state. This year an additional three sites were added to the original two. This project is about employment emersion with a focus on training and transitioning senior year students into competitive and integrated employment upon completion of the program. The project involves various state agencies. For our part, the division would like to assist with long term services to the extent a student is eligible for the waiver. It is anticipated that most of the school transitions will be served appropriately on the Living at Home Waiver, however there may be some individuals whose needs exceed the cap. The Division would like to reserve 15 slots to accommodate those that wish to work and need the long term supports of the waiver to assist them in accomplishing this goal.

Describe how the amount of reserved capacity was determined:

The numbers for students exiting the Project Search program with jobs has been very good. Most of the graduates that leave with jobs can be served under the supports waiver. The Division's intent is to grow employment in Alabama and make these services more readily available as we practice the Employment First philosophy when providing supports for waiver participants.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	15
Year 2	15
Year 3	15
Year 4	15
Year 5	15

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Participants Transferring from the Living at Home Waiver

Purpose *(describe):*

The Alabama Living at Home Waiver (waiver control number 0391) serves nearly the same population, but is a "supports" waiver that excludes residential habilitation and has a maximum expenditure cap. The State must assure it has sufficient slots in this waiver to transfer any Living at Home Waiver participant,whose cost of supports, exceeds that waiver's maximum cost or whose needs change and now include residential habilitation.

Describe how the amount of reserved capacity was determined:

Data for several years has indicated an average of 25 transfers per year from the Living at Home Waiver to this Waiver. With programming changes at the Medicaid Fiscal Agent and a waiver amendment, Disabled Adult Children (DACs) are now able to remain on the Living at Home Waiver as are 300% above of the SSI FBR. This has significantly reduced the number of individuals who have to transfer. The reserved capacity for years 1 through 5 is has been reduced accordingly (approximately 15).

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	15
Year 2	15
Year 3	15
Year 4	15
Year 5	15

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Emergency Placements

Purpose *(describe):*

New admissions to the waiver who would otherwise be homeless or subject to abuse or neglect, or in significant danger of harm from other sources and require immediate intervention.

Describe how the amount of reserved capacity was determined:

ADMH/DDD continues to encounter emergency situations, however, based on the average number over the last 4 years, the number has been decreased based on utlilization. Since this time we have made updates in our process to serve people in a high risk situation through attrition slots. Due to this adjustment the State requests to reserve 35 open "slots" per year for individuals in this category which is a reduction from the previous waiver years.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	50
Year 2	50
Year 3	50

Waiver Year	Capacity Reserved
Year 4	50
Year 5	50

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Outplacements from Nursing Homes

Purpose *(describe):*

Institutionalized individuals have a right, with some limitations, to be placed in the community, in accordance with the Olmstead Decision. This reserve capacity is to ensure we have sufficient "slots" to serve people who wish to move to the community. Additionally, this Waiver is included in the states Money Follows the Person grant as part of a mechanism to move people from the Skilled Nursing Facility into the community. These reserved slots would serve this purpose as well.

Describe how the amount of reserved capacity was determined:

Because the State has eliminated state run institutions for individuals with intellectual disabilities, the demand for outplacement is currently solely based on Skilled Nursing Facilities. The State projects it will reserve 15 each year for the years of the proposed renewal. This number may be reduced once the Division develops a SNF transition waiver for IID as mentioned in the MFP plan.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	15
Year 2	15
Year 3	15
Year 4	15
Year 5	15

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- ◉ **The waiver is not subject to a phase-in or a phase-out schedule.**
- ○ **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

Applicants are determined eligible for the Waiver and placed on a waiting list, ranked by criticality and length of time waiting. Applicants are selected from the waiting list basically in rank order. Selection criteria is defined in the Administrative Code.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. 1. State Classification. The state is a *(select one)*:

- (●) **§1634 State**
- ( ) **SSI Criteria State**
- ( ) **209(b) State**

2. Miller Trust State.
Indicate whether the state is a Miller Trust State *(select one)*:

- ( ) **No**
- (●) **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- [ ] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [ ] **Optional state supplement recipients**
- [ ] **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

- ( ) **100% of the Federal poverty level (FPL)**
- ( ) **% of FPL, which is lower than 100% of FPL.**

Specify percentage:

☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**

☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**

☐ **Medically needy in 209(b) States (42 CFR §435.330)**

☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

☒ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

435.110- Parents and Other Caretaker Relatives- MAGI pdf S25
435.116- Pregnant Women- MAGI pdf S28
435.118- Infants and Children under Age 19 – MAGI pdf S30
435.227- Children with Non IV-E Adoption Assistance (Over age 21)- MAGI pdf S53
435.150- Former Foster Care pdf S33
435.110 Attachment 2.2A pg 1
435.145 Attachment 2.2A pg 14
435.222 Reasonable Classification of Individuals under Age 21- pdf S52, S11
435.228 Children with Non IV-E Adoption Assistance pdf S53
“individuals deemed eligible for SSI under”;
435.122
435.134
435.135
435.137
435.138

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

○ **No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*

◉ **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

◉ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

☒ **A special income level equal to:**

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

○ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the state elects to (*select one*):

○ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

◉ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

The state uses the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

◉ **The following standard included under the state plan**

Select one:

○ **SSI standard**
○ **Optional state supplement standard**
○ **Medically needy income standard**
○ **The special income level for institutionalized persons**

(*select one*):

○ **300% of the SSI Federal Benefit Rate (FBR)**
○ **A percentage of the FBR, which is less than 300%**

Specify the percentage:

○ **A dollar amount which is less than 300%.**

Specify dollar amount:

○ **A percentage of the Federal poverty level**

Specify percentage:

◉ **Other standard included under the state Plan**

Specify:

The maintenance needs allowance is equal to the individual's total income as determined under the post-eligibility process which includes income that is placed in a miller trust.

○ **The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The following formula is used to determine the needs allowance:**

Specify:

○ **Other**

Specify:

ii. Allowance for the spouse only (*select one*):

◉ **Not Applicable (see instructions)**
○ **SSI standard**
○ **Optional state supplement standard**
○ **Medically needy income standard**
○ **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

◉ **Not Applicable (see instructions)**
○ **AFDC need standard**
○ **Medically needy income standard**
○ **The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

○ **Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified

in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

- (●) **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ( ) **The state does not establish reasonable limits.**
- ( ) **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

The state uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

◉ **The following standard included under the state plan**

Select one:

○ **SSI standard**
○ **Optional state supplement standard**
○ **Medically needy income standard**
○ **The special income level for institutionalized persons**

(*select one*):

○ **300% of the SSI Federal Benefit Rate (FBR)**
○ **A percentage of the FBR, which is less than 300%**

Specify the percentage:

○ **A dollar amount which is less than 300%.**

Specify dollar amount:

○ **A percentage of the Federal poverty level**

Specify percentage:

◉ **Other standard included under the state Plan**

Specify:

The state is using post-eligibility rules for the period Jan 1st 2014 through Dec 31 2018 as per part 2404 of the ACA. Alabama is using the same allowance for waiver participants and amounts for medical and remedial care under spousal impoverishment post eligibility rules as it uses under regular post eligibility rules.

○ **The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The following formula is used to determine the needs allowance:**

Specify:

○ **Other**

Specify:

ii. Allowance for the spouse only (*select one*):

○ **Not Applicable**

◉ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

The state is using post-eligibility rules for the period Jan 1st 2014 through Dec 31 2018 as per part 2404 of the ACA. Alabama is using the same allowance for waiver participants and amounts for medical and remedial care under spousal impoverishment post eligibility rules as it uses under regular post eligibility rules.

Specify the amount of the allowance (*select one*):

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ○ **The following dollar amount:**

Specify dollar amount: [ ] If this amount changes, this item will be revised.

- ◉ **The amount is determined using the following formula:**

Specify:

The state is using post-eligibility rules for the period Jan 1st 2014 through Dec 31 2018 as per part 2404 of the ACA. Alabama is using the same allowance for waiver participants and amounts for medical and remedial care under spousal impoverishment post eligibility rules as it uses under regular post eligibility rules.

iii. Allowance for the family (*select one*):

- ◉ **Not Applicable (see instructions)**
- ○ **AFDC need standard**
- ○ **Medically needy income standard**
- ○ **The following dollar amount:**

Specify dollar amount: [ ] The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

- ○ **The amount is determined using the following formula:**

Specify:

- ○ **Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's

Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

- (●) **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ( ) **The state does not establish reasonable limits.**
- ( ) **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ( ) **SSI standard**
- ( ) **Optional state supplement standard**
- ( ) **Medically needy income standard**
- ( ) **The special income level for institutionalized persons**
- ( ) **A percentage of the Federal poverty level**

  Specify percentage:

- ( ) **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised

- ( ) **The following formula is used to determine the needs allowance:**

  Specify formula:

◉ **Other**

Specify:

The maintenance needs allowance is equal to the individual's total income as determined under the post-eligibility process which includes income that is placed in a miller trust.

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

◉ **Allowance is the same**

○ **Allowance is different.**

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

◉ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

○ **The state does not establish reasonable limits.**

○ **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to

need waiver services is: 1

ii. Frequency of services. The state requires (select one):

- (●) **The provision of waiver services at least monthly**
- ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- ( ) **Directly by the Medicaid agency**
- (●) **By the operating agency specified in Appendix A**
- ( ) **By a government agency under contract with the Medicaid agency.**

Specify the entity:

- ( ) **Other**

Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Support coordinators employed by local public agencies collect, develop and submit evaluation materials and assessment information to a QIDP in the Operating Agency's Regional Office, who makes the eligibility determination. The support coordinator is, at minimum, a person who has a Bachelor of Arts or a Bachelor of Science degree, preferably in a human services related field or social work program with specialized training and a four year college degree. The QIDP in the Operating Agency's Regional Office makes the determination based, at minimum, on the information from a psychologist (psychological evaluation) and the support coordinator.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

Level of Care requires documentation of a full scale IQ below 70; a diagnosis of Intellectual Disabilities with an age of onset prior to age 18, and significant functional limitations in three (3) of six areas (6) of life activities (Self Care; Receptive and Expressive Language; Learning; Mobility; Self Direction; Capacity for Independent Living). The full scale IQ is obtained from a psychological evaluation, and the age of onset is obtained, if not from the evaluation, from ancillary documentation such as a previous psychological or school record. The limitations in adaptive functioning are determined from the ICAP (Inventory for Client and Agency Planning, Riverside Press). If necessary to support a conclusive determination, an ABS will be required, but only when maladaptive behavior appears to be the only factor causing the ICAP to qualify an otherwise borderline individual. Although persons as young as three years of age can be admitted to the waiver, available state plan and EPSDT services must be utilized for all participants who are under 21 years of age.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

○ **The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**

◉ **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

The same level of care evaluation form was used for both institutional and waiver services, but the information from which adaptive functioning scores were obtained differed. Adaptive functioning level for institutional (ICF/IID) eligibility was determined using the ABS. The ICAP domain scores were specifically modified by one of the authors of the ICAP to meet the requirements of Alabama's definition and to match the outcomes of the ABS. The only difference between the two instruments is that the ABS does not use maladaptive behavior as a factor, and the ICAP does. The ICAP is used in determining some of the rates for waiver services, so for efficiency of administration, the State recognizes the ICAP for determining adaptive limitations unless there is a doubt that the person would be eligible in an ICF/IID due to the predominance of maladaptive behavior in a qualifying, but borderline, ICAP service score. Currently, the Department of Mental Health does not operate state funded ICF/IID.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

Local public planning authorities, known as designated 310 agencies after the legislation authorizing their creation, officially represent each county of the State of Alabama. These local authorities are the designated points of application to the Department of Mental Health. The 310 agencies coordinate and submit applications for enrollment in the Medicaid HCBS Waiver for Persons with Intellectual Disabilities to one of the five regional community services offices of the DMH (Operating Agency).

A QIDP in the RCS office reviews the results of all test and assessment information provided with the application and determines the eligibility of all individuals seeking waiver services.

The information needed to determine a person's eligibility for the waiver includes the Level of Care Evaluation (based on full scale IQ, the age of onset, and an ICAP functional assessment). In addition, medical information is submitted, and a criticality assessment is submitted and entered into a data base which ranks the individual on a waiting list. If the submitted test/assessment information is not complete or is inconclusive regarding the type or level of disabilities of the individual, the RCS office QIDP will request additional tests/assessments. Notification of need for additional tests, assessments or other information stops the level of care determination process until the additional information has been received.

Applicants who are determined eligible are placed on a waiting list, ranked by criticality of need and length of time waiting. When the person can be served from the waiting list, additional, different information must be submitted, including a individualized Plan of Care, a Summary of Habilitation and a signed Dissatisfaction of Services form to notify the applicant of his or her right to due process, the Choice Form, Resolution Process form and the Individual and Family History. Additional forms are required if the applicant is not already Medicaid eligible and is applying for a special income level or institutional deeming.

Annual re-determinations must include, along with the Person Centered Plan of Care and a Summary of Habilitation for the next year, information to re-determine the level of care:
a. Written reference to and update of the original psychological evaluation which documented the applicant's intellectual disabilities or of a more recent full assessment, all documents to be kept on file and produced if requested.
b. ICAPs will not need to be re-administered if nothing about the functioning level has changed, but an updated ICAP may be requested as warranted by a change in the individual's functional capabilities or behaviors.
c. An annual medical report must be on file.
d. A Individual and Family History updated within 90 days of re-determination.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**
  Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- ◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ○ **The qualifications are different.**
  Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care *(specify):*

The RCS office of the Operating Agency, once appropriate documentation is approved, submits the Waiver eligibility decision and enrollment information to Central Office. Central Office submits the information electronically to the AL Medicaid's fiscal intermediary to register the person in the long-term care system as a recipient of Waiver services and retrieves the enrollment dates. This eligibility enrollment is good for 12 full months, but then has to be resubmitted. Without the electronic resubmission and registration, claims for subsequent service dates will fail. Likewise the Plan of Care is effective for 12 months, and Support Coordinators know when they have to submit redetermination packets and assist individuals to remain eligible for the waiver.

In order to assist the Support Coordinators, the Division has design several prompts in the information system that will remind he/she of a pending redetermination due. First, the information system is designed to electronically prompts the Support Coordinator, this "tickler", when there is a redetermination due. The tickler system is set up to generate a redetermination notification, which launches 330 days after the previous redetermination or initial application. Additionally, there are two reports that the Support Coordinator, his/her supervisor, and the RCS office staff can run, filtered by enrollment start and end dates, which will list all the individuals that should be redetermined during the specified dates and will also identify individuals whose redetermination are overdue. The first report, Redeterminations Due, will list all individuals that need to be redetermined within the report dates based on the Waiver enrollment dates. Support Coordinators are encouraged to run this report 90, 60, or 45 days in advance and to begin the redetermination paperwork within 60 days of the individual's eligibility expiration date. The second report, Redeterminations Overdue, works the same way but presents a list of individuals that have not been redetermined, but should have been based on enrollment dates. This report will give the Division the ability to track overdue re-determinations in a more efficient manner and follow-up as needed. There are times when redeterminations are delayed for documentation purposes but in the event that someone failed to complete a redetermination on time this report will capture that information.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Records are maintained by the case management agencies and also by the Operating Agency's Regional Offices.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are

identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of eligible applicants who received a level of care evaluation completed prior to entry into the waiver. Numerator: Number of eligible applicants who received a level of care completed prior to entry into the waiver. Denominator: Number of eligible applicants.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = Random Sample Confidence Interval +/-5% Confidence Level 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of initial LOC determinations where the instrument and process were accurately applied. Numerator: Number of initial LOC determinations where the instrument and process were accurately applied. Denominator: Number of initial LOC determinations reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
Level of care documentation

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Problems regarding individual participants' initial Level of Care are currently handled on an individual basis by RCS office staff of the operating agency. Resolution of these problems requires manual intervention. There is no Medicaid funding paid for someone not in active status with the Medicaid Fiscal Agent as of the date of service and no individual will be enrolled without a LOC, so there is never an issue of payments made incorrectly.

The RCS office has designated staff trained to review all supporting documentation that feeds into the Level of Care form. An assessment in the information system will capture review results. A report will aggregate the data results to reveal patterns where success is less than 86%. Intervention, in general, will consist of:

a. Bringing the data to the attention of those responsible for the discovered areas of weakness.

b. When data shows consistent problems over two consecutive quarters, technical assistance / training will be provided to those at the point of weakness.

c. If no improvement is seen in the next quarter after the intervention, a plan of correction will be required.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

1. Freedom of Choice: being informed of feasible alternatives under the waiver.

As part of assessment and service coordination, participants and/or responsible parties are provided with adequate information to make an informed decision regarding community based care and the option to receive those services in non-disability specific setting based on the individual's choice. This process frequently includes visits to programs and meetings with multiple providers in the area. Service coordination addresses problems and presents feasible solutions. Service coordination also includes an exploration of all resources currently utilized by the individual both formal and informal, as well as those waiver services that may be provided to meet the individual's needs. If any needs cannot be met, these also are discussed with the individual and his family to fully inform them of the alternatives. All individuals are provided choice among service providers available.

2. Freedom of Choice: being given the choice of either institutional or home and community based services.

Each person served through the waiver must make a written choice of institutional or community-based care, which will remain in effect until such time as the client changes his/her choice. The only exception to making a written choice would occur when the person is not capable of signing the Plan of Care form and has no legal or responsible party who can sign. In such a case, the support coordinator must document the reason(s) for absence of a signed choice and efforts made to locate a responsible party who could have signed for the person.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Records are maintained by the case management agencies and also by the Operating Agency's Regional Offices.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

Accommodations made for Limited English Proficiency (LEP) persons include a language line as well as several publications in Spanish on the Medicaid Website such as the Covered Services Handbook, and basic eligibility documents. The language translation line offers numerous languages and meaningful access through the Medicaid toll free telephone number. Through the translators the LEP person can request and receive any available Medicaid assistance and apply for available Medicaid services. Hispanic is the only significant Limited English Proficiency population in the State of Alabama at an estimated 4.1%.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service		
Statutory Service	**Day Habilitation**		
Statutory Service	**Employment Support**		
Statutory Service	**Personal Care**		
Statutory Service	**Prevocational Services**		
Statutory Service	**Residential Habilitation**		
Statutory Service	**Respite**		
Other Service	**Adult Companion Services**		
Other Service	**Assistive Technology Services**		
Other Service	**Benefits and Career Counseling**		

Service Type	Service		
Other Service	Community Experience		
Other Service	Community Specialist		
Other Service	Crisis Intervention		
Other Service	Environmental Accessibility Adaptations		
Other Service	Housing Stabilization Service		
Other Service	Individual Directed Goods and Services		
Other Service	Occupational Therapy		
Other Service	Personal Emergency Response System		
Other Service	Physical Therapy		
Other Service	Positive Behavior Support		
Other Service	Skilled Nursing		
Other Service	Specialized Medical Supplies		
Other Service	Speech and Language Therapy		
Other Service	Supported Employment Transportation		
Other Service	Supported Living Service		

Appendix C: Participant Services

C-1/C-3: Service Specification

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: 04 Day Services

Sub-Category 2: 04070 community integration

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

Day Habilitation services are services which involve the provision of regularly scheduled activities in non-residential settings, separate from the member's residence or other residential living arrangement. Activities focus on assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that enhance social integration and outcomes. The service also provides assistance that supports community participation including achievement of valued social roles that reflect a member's individualized interests and desires with regard to type(s) of community involvement and community contributions the member prefers. Activities build on the strengths and gifts that each member has to offer to the wider community, identified through individualized strengths-based assessment, and enable the member to broaden horizons and develop/pursue adult learning and personal enrichment goals.

Activities are designed to foster the acquisition of positive social skills and interpersonal competence, greater independence and ability to exercise and communicate personal choices and preferences.

Day Habilitation services shall support and enhance, rather than supplant, an individual's involvement in public education, post-secondary education/training and competitive integrated employment (or services designed to lead to competitive integrated employment).

Day habilitation services focus on enabling the member to attain and maintain his or her maximum potential and shall be coordinated with any needed therapies in the member's person-centered services and support plan, such as physical, occupational, or speech therapy. For members with documented degenerative medical conditions, day habilitation activities in both facility and integrated community settings may include training, supports and community involvement opportunities that are designed to maintain skills and functioning and to prevent or slow regression, rather than acquiring new skills or improving existing skills.

Day habilitation services may also be used to provide retirement activities. As some members get older, they may no longer desire to work and may need supports to assist them in meaningful retirement activities in their communities.

Day habilitation services are expected to be furnished in a variety of settings in the community, except for the member's residence, that may utilize a provider-owned or controlled setting as a hub or base. Day Habilitation settings must comply fully with the HCBS Settings Rule, therefore ensuring each member's Day Habilitation service plan includes opportunities to participate a variety of community-based activities that are consistent with the purpose and intended outcome of the service and that facilitate the member's interactions with people from the broader community. This includes opportunities for career exploration and career planning activities specific to pursuing competitive integrated employment for working-age members not already engaged in competitive integrated employment.

When Day Habilitation is authorized, four levels of Day Habilitation can be used for authorization, based on participant characteristics:
Level one day habilitation is for consumers whose ICAP service score is 61 to 99. Minimum staffing ratio for Facility-Based is 1:15; minimum staffing ratio for Community-Based is 1:4
Level two day habilitation is for consumers whose ICAP service score is 36 to 60. Minimum staffing ratio for Facility-Based is 1:12; minimum staffing ratio for Community-Based is 1:3
Level three day habilitation is for consumers whose ICAP service score is 1 to 35. Minimum staffing ratio for Facility-Based is 1:8; minimum staffing ratio for Community-Based is 1:2
Level four day habilitation is for consumers who need one to one support. Minimum staffing ratio for Facility-Based is 1:1; minimum staffing ratio for Community-Based is 1:1.

Reimbursement rates are associated with each level, based on the associated minimum staffing ratios needed to support persons with different ICAP scores and whether the service is delivered in a facility-based (provider controlled) setting or an integrated community setting, taking account of the more intensive staffing ratios and different costs that are applicable for services delivered in integrated community settings.

Transportation between the Day Habilitation facility and one or more integrated community sites for integrated service delivery time is always included in the service and accounted for in the rate for the service. Transportation between the member's place of residence and the Day Habilitation facility, or site where the member starts and ends Day Habilitation services each day, shall either be included as a component part of Day Habilitation or arranged for the member in another way. If this transportation is provided by the Day Habilitation provider, the cost of this transportation shall be included and accounted for in the rate paid to the provider. All providers of transportation

shall ensure that the provider qualifications for specialized (community) transportation are met.

Meals provided as part of these services shall not constitute a “full nutritional regimen” (3 meals per day).

A member’s care plan may include two or more types of non-residential services; however, different types of face-to-face non-residential services may not be billed for the same unit of time. Members who receive Day Habilitation services may also receive supported employment individual, group, assessment/discovery, job development, PT, oT or any combination of these services

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

- Day Habilitation may not provide for the payment of services that are vocational in nature (i.e., for the primary purpose of producing goods or performing services).
- Day Habilitation services may not be used to provide activities involving paid work, including any situation where work done by a member is required to be paid under state and federal labor laws.
- Volunteering cannot involve volunteering for the provider of the service or volunteering in situations where a member must be paid under existing state and federal labor laws

* Day habilitation services cannot exceed 5 hours per day.

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 Title
Agency	Certified Day Habilitation Program

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:

Agency

Provider Type:

Certified Day Habilitation Program

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

Day Habilitation providers must demonstrate:
- Ability and capacity to offer members regular (daily) opportunities to access the broader community.
- Use of an individualized service planning process that ensures individual member goals are identified and used to guide service delivery and opportunities offered both in the facility and in the broader community.
- Understanding and use of community mapping strategies to identify opportunities for community involvement and participation that align with each member's individualized interests and desires with regard to type(s) of community involvement and community contributions they prefer.

Day Habilitation training services will be delivered by a habilitation aide in coordination with the individual's person centered plan.
The Aide will work under supervision and direction of a QIDP and/or Supervisor having experience working with people with ID, but a QIDP must ensure individual plans are implemented as prescribed. Documentation of the supervision received, training provided, and evaluation of Aide must be present in the personnel record. Supervision must assist the Aide as necessary as they provide individual Habilitation services as outlined by the person centered plan.

Minimum Qualifications of the Day Habilitation Aide:

a) Must have at least two references from work and/or school, and one personal, which have been verified by the provider agency
b) Must have background checks required by law and regulation
c) Must be at least 18 years of age
d) Must be able to read and write and follow instructions
e) Must be able to follow the plan of care with minimal supervision unless there is a change in the person's condition
f) Must have no physical or mental impairment that would prevent providing the needed assistance to the person
g) If providing transportation, must have valid driver's license and insurance as required by State Law

Training Requirements:

Prior to assignment, each Habilitation Aide will be required to be certified by the provider agency as having completed a course of instruction provided or approved by the DMH which will minimally include:

1. Recipient rights and grievance procedures.
2. Overview of intellectual and developmental disabilities.
3. Concepts of human development.
4. CPR, first aid, medical emergencies.
5. Management of challenging behavior.
6. Physical management techniques.
7. Health observation, including hygiene, medication control/ universal precautions.
8. Recipient abuse, neglect and mistreatment.
9. Habilitation training programs.

Retraining will be conducted as needed, but at least annually for training requirements 1, 5, 6, 7 & 8 above.

Verification of Provider Qualifications

Entity Responsible for Verification:

DMH Certification Surveyors

Frequency of Verification:

Prior to Contract Approval, Annually or Biennially for already approved providers (based on previous survey score), or more often as needed based on service monitoring concerns.

Appendix C: Participant Services

C-1/C-3: Service Specification

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:

Supported Employment

Alternate Service Title (if any):

Employment Support

HCBS Taxonomy:

Category	Sub-Category
Category 1: 03 Supported Employment	**Sub-Category 1:** 03022 ongoing supported employment, group
Category 2: 03 Supported Employment	**Sub-Category 2:** 03021 ongoing supported employment, individual
Category 3: 03 Supported Employment	**Sub-Category 3:** 03010 job development
Category 4: 17 Other Services	**Sub-Category 4:** 17990 other

Service Definition *(Scope):*

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 POC. 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 person centered plan and the plan of care describes all the supports and services necessary to support the person to achieve their desired outcomes and attain or maintain a quality life as defined by them, including services that may be provided through natural supports, the Medicaid State Plan or any other applicable plans and should include a choice of non-disability specific options.

There are three variations of Supported Employment covered within this waiver: 1) Individual Assessment/Discovery, 2) Small Group and 3) Individual.
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.
The second,Employment Small Group, most often consists of groups of individuals being supported in enclave or mobile work crew activities. This is reimbursed per 15 minutes unit of service. There are two level of staffing for Employment Small Group. Each level has its own individual to staff ratio. Employment Small Group are services and training activities provided in regular business, industry, and community settings for groups. Group size 1:2-3 and 1:4 have a ratio of one provider staff for each and reimbursement is made based on the group size. Examples of Small Group Employment include mobile crews and other business-based workgroups employing small groups of workers. Employment Small Group services must be provided in a manner that promotes integration into the workplace and interaction between participants and people without disabilities in those workplaces. The outcome of this service is sustained paid employment and work experience leading to further career development and community-based individual employment for which the compensation is 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.

The third is Employment Individual. Employment Individual includes two distinct levels of services: 1)Job Developer and 2)Job Coach and is reimbursed per 15 minutes unit of service. Both Job Development and Job Coaching services must be provided in integrated settings where the participant is paid at minimum wage (or better).Employment Individual services are the ongoing supports to participants who, because of their disabilities, need intensive on-going support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce 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. The outcome of this service is sustained paid employment at or above minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals. Two procedure codes under this heading are specifically intended to support the provision of supported employment at competitive wages in an integrated worksite: Job Coach and Job Developer. These are different roles and are performed, normally, by different staff. However, some providers may choose to utilize one staff to perform the two distinct services so long as documentation supports the differing activities. The provider agency must also have a QIDP. Supported Employment (both group and individual) services do not include facility based, or other similar types of vocational services furnished in specialized facilities that are not part of the general workplace.

Transportation accommodations to the worksite or supported employment provider's home-base should be a component of the planning process and integrated into the person centered plan. While developing the plan which will reflect employment goals; transportation issues, concerns, and access should be addressed. All avenues of

possible sources of transportation should be considered including public transportation and natural supports such as family. If training is needed in order for a person to access transportation then that training should be outlined in the plan.

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

The following limitation (A) applies to both (Supported) Employment Small Group and Individual services. Additional limitations regarding (Supported) Employment Individual are listed in (B) below.

(A) Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

2. Payments that are passed through to users of supported employment programs; or

3. Payments for vocational training that is not directly related to an individual's supported employment program.

Supported Employment, individual and group, does not include facility based or other similar types of vocational services furnished in specialized facilities not a part of the general workplace. Supported Employment, individual and group does not include volunteer work. Such volunteer learning and training activities that prepare a person for entry into the paid workforce are addressed through prevocational services.The Individualized Job Coach and Employment Small Group cannot overlap traditional services; these services cannot be provided during the same hours of the day as Day Habilitation or Prevocational Habilitation.It is expected that the job coach will fade his or her support as the individual becomes more integrated into the employer's workforce. Also, personal care on worksite can be used to supplant some of the job coach's faded hours. Thus, the maximum hours for an individual will be presumed to be 836 or 3344 units per year. The optimal support for waiver participants is natural supports in the work environment. However, for those participants who require on-going paid support after the 836 hours are exhausted, a request can be made to the RO Employment Specialists for increased time. Request should justify the need for an extension. The Employment Coordinator will forward the approval to the CSD for approval and addition onto the POC.The Individualized Job Developer can overlap traditional services, up to the maximum 40 hours per year. An employment plan is required initially, and subsequent updates can request modifications to the above limitations based on the observations of the professionals involved and approved by the RO Employment Specialist/Coordinator. The Employment Specialist/Coordinator will forward his approval to the CSD for approval and addition onto the POC. Detailed explanation and rationale will be required.

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

Expectations and Outcomes:
Once an Assessment/Discovery is complete, the job development should begin with job placement as the expected outcome. Providers must expect to submit reports requested and designed by the DMH/DDD (and the Alabama Medicaid Agency and CMS, should the requests be made). Reports will support the measurement of outcomes.

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 Title
Agency	Certified Day Habilitation Program
Agency	Certified Waiver Hourly Services Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Employment Support

Provider Category:
Agency
Provider Type:

Certified Day Habilitation Program

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

(Supported) Employment Small Group providers must meet the same standards as the Day Habilitation provider. The Department of Mental Health, Division of Developmental Disabilities requires certification of programs delivering Supported Employment services. Standards are in Alabama Code, Chapters 580-3-23 and 580-5-33. There are base standards for the traditional, day habilitation model listed at (A) below; additional or modified requirements apply for the Individualized Employment model (Job Coach and Job Developer) and are listed under the Provider Type Certified Hourly Supports Program.

(A) 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 Developmental Disabilities.

When the application, supporting data, and site visit prove the program or service is in full compliance with certification requirements, a certification certificate will be issued by the Division of Developmental Disabilities.

Subsequent site inspections shall be scheduled in accordance with policy and procedures of the Department's Division of Technical Services. Programmatic re-surveys are conducted at one or two year intervals depending on the previous survey outcome.

Programs delivering Supported Employment services shall have written mission statements for dissemination to prospective clients and their families. The mission statement shall address:

Program philosophy and purpose;
Geographical area served;
Range of services provided; and
Population served, including criteria for service eligibility, program admission and program discharge.

The staffing pattern shall be appropriate to the type and scope of program services and shall include staff members who meet the experiential and educational qualifications set forth in the approved job descriptions. The program shall develop and maintain appropriate, up-to-date staffing schedules. Staff to client daily ratio shall not be more than specified in the service description. No client shall ever be left unsupervised unless the activity is part of a structured activity or plan of care.

In addition to certification, the following requirements apply to the providers staff.

Employment Small Group personnel will meet the same requirements as basic direct care staff:
Qualifications:
High School diploma or equivalent
Minimum 1 year experience working with persons with ID
Background check; drug testing.
Training in career development planning and vocational assessment, in addition to what the DMH/DDD standards require.sessment Discovery: ADMH/DDD approved Employment Training completion is necessary for the provision of this service.

Supported Employment Individual: Job Coach
The minimal requirement for this position is graduation from high school or its equivalent and two years of work experience. A Bachelor's Degree, preferable with a major concentration in rehabilitation, industrial arts, vocational education, psychology or a related field is preferred. Work experience of a supervisory or training nature as well as knowledge of persons with disabilities would be particularly desirable.

The Job Developer, in addition to the Job Coach Qualifications, will complete a minimum of one certificate based job development and placement curriculum. The Supported Employment Coordinator for the Division of Developmental Disabilities will provide an approved listing of such curriculums.

Benefits and Limitations

Job Coach hours must be flexible in order to meet needs as they arise.

Individuals who are more capable may need less support over the long term, while individuals who are less capable may need more support, therefore the number of units authorized should be based on the person centered plan and placed on the individual plan of care.
Furthermore, it is expected that the job coach will fade his or her support as the individual becomes more integrated into the workplace.
Thus, the maximum hours for an individual will be presumed to be 836 or 3344 units per year.
An employment addendum is required as part of the person centered plan, and any updates can request modifications to the above limitations. All changes should be reflected on the individual plan of care. Detailed explanation and rationale will be required.

Job Specification:
The Job Coach is responsible to the Program Director for the training and associated support services necessary to ensure the successful employment of individuals involved in Supported Employment. The Job Coach works under the direction of a QIDP/program manager. The provider must have a QIDP to ensure the plan is implemented as prescribed.

The specific duties of the Job Coach include:
a. Training of individuals in supported work to perform specific jobs consistent with their abilities;
b. Working with employers to modify or adapt job duties or work stations so individuals in supported work can have the maximum opportunity for job success. This may involve job and task analysis, employer interviews, and actual job performance to insure a thorough understanding of the specific job and general job rules prior to placement of the client;
c. Teaching individuals associated work skills, responsibilities and behaviors not related to the specific job being performed, such as how to complete a time card, when and where to take bathroom and lunch breaks, safety precautions, etc.;
d. Assisting each individual placed in a job-training program to become an integrated member of the work force. This may happen in the general course of the job but could require activity such as encouragement of the individual worker or other employees to communicate with each other, or the provision of disability awareness training to workers of the company;
e. Working with individual to be placed in employment and/or with family or service provider to insure that the individual has reliable transportation to and from work, adequate housing, and emotional support for his or her job efforts;
f. Making every effort to insure that the individual in supported work and the job are appropriately matched through comprehensive vocational assessment (Situational Assessment and/or Discovery) prior to job placement. Part of the assessment may include reviewing current progress notes in individual's present placement, studying referral information, and working with the individual to assess work skills;
g. Communicating through written and oral reports on progress of individual's in supported work to Program Director and other program staff; follow oral or written instructions (such as the care plan or rehabilitation plan);
h. Providing continued ongoing support to individual's in supported work;
i. Performing other job duties necessary to ensure the success of individual's in supported work as well as any additional tasks assigned by the Program Director that will be of benefit to other individuals in the program.

Individualized Job Coach:
a. Performing a vocational assessment such as Situational Assessment or Discovery (prior to job development) which will be utilized for job development and placement.
b. Development of plan for employment as part of the person centered planning process but with distinct employment outcomes.
c. On the job training and skill development
d. Facilitating job accommodations and use of assistive technology
e. Job site analysis (matching job site needs with needs of the person), job carving
f. Educating the person and others on the job site regarding rights and responsibilities, accommodations needed, natural supports and the role of self-advocacy in the work place.
g. Participation with the interdisciplinary team to support the person to achieve chosen employment

outcomes.
h. Facilitate transportation arrangements with team.
i. Documentation: progress on training goals and documentation of training; progress notes on a per day basis rather than a per unit basis.

Individualized Job Developer:
a. Marketing the service and person's skills
b. Employer Negotiation
c. Job Structuring (negotiating hours or location to meet the abilities of the person)
d. Job Carving
e. Placement: once placement is arranged, the job coach enters, and when a need is obvious and documented to transition the individua,there may be a cross-over (transfer) period to total no more than 5 hours for the two services

The supported employment provider agency should also have a QIDP.

Training Requirements:
The training program for Supported Employment personnel will reinforce the responsibility to insure successful employment of recipients involved in supported employment. The personnel must be certified by a QIDP as having completed training approved by DMH/DDD. This certification must be documented and is subject to review by DMH/DDD and Alabama Medicaid. Minimum training requirements shall include the following areas:
a. Overview of intellectual and developmental disabilities
b. Skills to identify recipient abuse, neglect and mistreatment and reporting procedures
c. Recipient rights and grievance procedures
d. Ability to read, write and follow the individualized plan of care.
e. Planning and conducting appropriate activities to support the person in finding and maintaining employment.

Ongoing training will be conducted as needed but at least annually for training requirements b and c above.

Verification of Provider Qualifications

Entity Responsible for Verification:

DMH Certification Surveyors

Frequency of Verification:

Prior to Contract Approval, Annually or Biennielly for already approved providers (based on previous survey score), or more often as needed based on service monitoring concerns.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Employment Support

Provider Category:

Agency

Provider Type:

Certified Waiver Hourly Services Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Al. Administrative Code Chapters 580-3-23 and 580-5-33 Supported Employment (Individual) Service Provider Qualifications
Job Coach and Job Developer workers may be employed by, or under contract with, any agency that qualifies to provide hourly services under the waiver. Any agency or individual undertaking the provider on this service must employ or contract with a QIDP to provide the required supervision and must meet the other requirements in this addendum related to training, plans of care, documentation, and reporting. The primary requirements for the provider agency are to:
a) Handle all payroll taxes required by law
b) Provide training and supervision as required by this scope of services
c) Maintain records to assure the worker was qualified, the service was provided, and provided in accordance with the plan of care
d) Implement a plan and method for providing backup at any time it is needed
e) Implement and assure the person and his or her family are and remain satisfied with the service

Other Standard *(specify):*

Assessment Discovery: ADMH/DDD approved Employment Training completion is necessary for the provision of this service.

Supported Employment Individual: Job Coach
The minimal requirement for this position is graduation from high school or its equivalent and two years of work experience. A Bachelor's Degree, preferable with a major concentration in rehabilitation, industrial arts, vocational education, psychology or a related field is preferred. Work experience of a supervisory or training nature as well as knowledge of persons with disabilities would be particularly desirable.

The Job Developer, in addition to the Job Coach Qualifications, will complete a minimum of one certificate based job development and placement curriculum. The Supported Employment Coordinator for the Division of Developmental Disabilities will provide an approved listing of such curriculums.

Benefits and Limitations
Job Coach hours must be flexible in order to meet needs as they arise.

Individuals who are more capable may need less support over the long term, while individuals who are less capable may need more support, therefore the number of units authorized should be based on the person centered plan and placed on the individual plan of care.
Furthermore, it is expected that the job coach will fade his or her support as the individual becomes more integrated into the workplace.
Thus, the maximum hours for an individual will be presumed to be 836 or 3344 units per year.
An employment addendum is required as part of the person centered plan, and any updates can request modifications to the above limitations. All changes should be reflected on the individual plan of care. Detailed explanation and rationale will be required.

Job Specification:
The Job Coach is responsible to the Program Director for the training and associated support services necessary to ensure the successful employment of individuals involved in Supported Employment. The Job Coach works under the direction of a QDDP/program manager. The provider must have a QIDP to ensure the plan is implemented as prescribed.

The specific duties of the Job Coach include:
a. Training of individuals in supported work to perform specific jobs consistent with their abilities;
b. Working with employers to modify or adapt job duties or work stations so individuals in supported work can have the maximum opportunity for job success. This may involve job and task analysis, employer interviews, and actual job performance to insure a thorough understanding of the specific job and general job rules prior to placement of the client;
c. Teaching individuals associated work skills, responsibilities and behaviors not related to the specific job being performed, such as how to complete a time card, when and where to take bathroom and lunch breaks, safety precautions, etc.;
d. Assisting each individual placed in a job-training program to become an integrated member of the work force. This may happen in the general course of the job but could require activity such as encouragement of the individual worker or other employees to communicate with each other, or the provision of disability awareness training to workers of the company;
e. Working with individual to be placed in employment and/or with family or service provider to insure that the individual has reliable transportation to and from work, adequate housing, and emotional support for his or her job efforts;
f. Making every effort to insure that the individual in supported work and the job are appropriately matched through comprehensive vocational assessment (Situational Assessment and/or Discovery) prior to job placement. Part of the assessment may include reviewing current progress notes in individual's present placement, studying referral information, and working with the individual to assess work skills;
g. Communicating through written and oral reports on progress of individual's in supported work to Program Director and other program staff; follow oral or written instructions (such as the care plan or rehabilitation plan);
h. Providing continued ongoing support to individual's in supported work;

i. Performing other job duties necessary to ensure the success of individual's in supported work as well as any additional tasks assigned by the Program Director that will be of benefit to other individuals in the program.

Individualized Job Coach:
a. Performing a vocational assessment such as Situational Assessment or Discovery (prior to job development) which will be utilized for job development and placement.
b. Development of plan for employment as part of the person centered planning process but with distinct employment outcomes.
c. On the job training and skill development
d. Facilitating job accommodations and use of assistive technology
e. Job site analysis (matching job site needs with needs of the person), job carving
f. Educating the person and others on the job site regarding rights and responsibilities, accommodations needed, natural supports and the role of self-advocacy in the work place.
g. Participation with the interdisciplinary team to support the person to achieve chosen employment outcomes.
h. Facilitate transportation arrangements with team.
i. Documentation: progress on training goals and documentation of training; progress notes on a per day basis rather than a per unit basis.

Individualized Job Developer:
a. Marketing the service and person's skills
b. Employer Negotiation
c. Job Structuring (negotiating hours or location to meet the abilities of the person)
d. Job Carving
e. Placement: once placement is arranged, the job coach enters, and when a need is obvious and documented to transition the individua,there may be a cross-over (transfer) period to total no more than 5 hours for the two services

The supported employment provider agency should also have a QIDP.

Training Requirements:
The training program for Supported Employment personnel will reinforce the responsibility to insure successful employment of recipients involved in supported employment. The personnel must be certified by a QIDP as having completed training approved by DMH/DDD. This certification must be documented and is subject to review by DMH/DDD and Alabama Medicaid. Minimum training requirements shall include the following areas:
a. Overview of intellectual and developmental disabilities
b. Skills to identify recipient abuse, neglect and mistreatment and reporting procedures
c. Recipient rights and grievance procedures
d. Ability to read, write and follow the individualized plan of care.
e. Planning and conducting appropriate activities to support the person in finding and maintaining employment.

Ongoing training will be conducted as needed but at least annually for training requirements b and c above.

Verification of Provider Qualifications

Entity Responsible for Verification:

DMH Certification Surveyors

Frequency of Verification:

Prior to Contract Approval, Annually or Biennially for already approved providers (based on previous survey score), or more often as needed based on service monitoring concerns.

Appendix C: Participant Services

C-1/C-3: Service Specification

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:

Personal Care

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Personal Care Services include assistance with any activity of daily living (ADL) or instrumental activity of daily living (IADL). Assistance for ADLs includes bathing, toileting, transfer and ambulation, skin care, grooming, dressing, extension of therapies and exercise, routine care of adaptive equipment primarily involving cleaning as needed, meal preparation, assistance with eating, and incidental household cleaning and laundry. IADLs include assistance with shopping, budgeting, using public transportation, social interaction, recreation, and leisure activities. Assistance with IADLs includes accompaniment, coaching and minor problem-solving necessary to achieve the objectives of increased independence, productivity and inclusion in the community.

Personal Care can also include supporting a person at an integrated worksite where the individual is paid a competitive wage. There is a separate code for this service, to distinguish it from other personal care activities.

Personal care attendants may transport consumers in their own (the attendant's) vehicles as an incidental component of this service. For this component to be reimbursed, the personal care attendant must be needed to support the consumer in accessing the community, and not merely to provide transportation. 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 is in-serviced on safety procedures when transporting a consumer. This service will provide transportation into the community to shop, attend recreational and civic events, go to work and participate in People First and other community building activities. It shall not replace transportation that is already reimbursable under day or residential habilitation nor the Medicaid non-emergency medical transportation program. The planning team must also assure the most cost effective means of transportation, which would include public transport where available. Transportation by a personal care attendant is not intended to replace generic transportation or to be used merely for convenience.
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 support coordinator) 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.

Self-Directed Personal Care Services

This definition of Personal Care Services is intended to allow participants and their families to recruit, hire, train, supervise, and if necessary to discharge, their own personal care workers. The workers will be paid by a fiscal intermediary, also known as a FMSA (Financial Management Service Agency).

The definition of Self-Directed Personal Care Services includes assistance with any activity of daily living (ADL) or instrumental activity of daily living (IADL). Assistance for ADLs includes bathing, toileting, transfer and ambulation, skin care, grooming, dressing, extension of therapies and exercise, routine care of adaptive equipment primarily involving cleaning as needed, meal preparation, assistance with eating, and incidental household cleaning and laundry. IADLs include shopping, banking, budgeting, using public transportation, social interaction, recreation, and leisure activities. Assistance with IADLs includes accompaniment, coaching and minor problem-solving necessary to achieve the objectives of increased independence, productivity and inclusion in the community.

Self-Directed Personal Care may also include general supervision and protective oversight reasonable to ensure the health, safety and inclusion of the client. 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.

Self-Directed Personal Care may include supporting the participant at an integrated worksite where the participant is paid a competitive wage. There is not a separate rate or service code for this support when it is self directed.

Self-Directed personal care attendants may transport consumers in their own (the attendant's) vehicles as an incidental component of this service. For this component to be reimbursed, the personal care attendant must be needed to support the consumer in accessing the community, and not merely to provide transportation. Additional payment will be made to the worker for mileage. The attendant must have a valid Alabama driver's license and insurance coverage as required by State law. This service may provide transportation into the community to shop,

attend recreational and civic events, go to work and participate in People First and other community building activities. It shall not replace transportation that is already reimbursable under day or residential habilitation nor the Medicaid non-emergency transportation program. Transportation by a personal care attendant is not intended to replace generic transportation or to be used merely for convenience.

The plan of care or an addendum shall specify any special requirements for training, more than basic training, which may be needed to support the individual. Consumers and their families shall be key informers on the matter of special training, and will be responsible for providing such training to their workers.

There is no restriction on the place of service as long as the person is eligible for the waiver in that setting and no duplication of payment occurs. Payment is for a 15-minute unit of service delivered to the individual, and does not include the worker's time of travel to and from the place of work.

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

Personal care is limited to no more than 12 hours/48 units each day for individuals living in the home with relatives or caregivers. The number of hours provided may exceed 12 hours/48 per day for those individuals who live independently and assessed needs indicate the need for additional support and/or for participant whose hours need to exceed the 12 hours can be provided, but the approval should be based on the emergent need (i.e. illness or death of the primary caregiver). The plan of care or an addendum shall specify any special requirements for training, more than the basic training, which may be needed to support the individual. Parents and other caretakers shall be key informers on the matter of special training, and will be encouraged to participate in the training and supervision of the worker.

When this service is provided to participants living with their parents or guardians, it shall not supplant the cost and provision of support ordinarily provided by parents to children without disabilities, nor shall it supplant educationally related services and support that is the responsibility of local education authorities. The number of hours/units provided to the individual documents assessed need for the service as an alternative to institutional care and the reasonable cost effectiveness of his or her plan.

There is no restriction on the place of service so long as the person is eligible for the waiver in that setting and no duplication of payment occurs. Payment is for a 15-minute unit of service delivered to the individual, not including worker's time of travel to and from the place of work.

Agency provided Personal Care Workers shall not be members of the immediate family (parents, spouses, children) of the person being supported, nor may they be legally obligated in any other way to provide the service. Any other relatives, or friends, who are employed to provide services shall meet the qualifications for providers of care and, as for all other personal care workers, payment shall only be made for services actually rendered. Employment of a relative or friend shall be noted and justified in the consumer's record by the provider agency. While in general personal care will not be approved for a person living in a group home or other residential setting, the Division of Developmental Disabilities may approve it for specific purposes that are not duplicative.

Self-Directed Personal Care may not be provided to participant's who lack the necessary support systems to ensure the responsibilities of employing staff are carried out and that the participant's security and well-being is maintained. Thus, this service would typically be provided to participants who live in their own homes with family members or other responsible relatives who can assist with the responsibilities of administering a self-directed services program. Self-Directed Personal Care may also be provided in settings where the individual lives in his own house or apartment alone or with others, with the assistance of family or a circle of support, but the Regional Community Service Office must review and approve this arrangement before it can be reimbursed. The purpose of this review is to assure the support is near and frequent enough to carry out the needed tasks and also to assure there is no conflict of interest.

When this service is provided to individuals living with their family/guardians, it shall not supplant the cost and provision of support ordinarily provided by family/guardians without disabilities, nor shall it supplant educationally related services and support that is the responsibility of local education authorities. Otherwise, the only limitation on hours provided is the individual's documented need for the service as an alternative to institutional care and the reasonable cost effectiveness of his or her plan.

Personal care services are not available for persons under the age of 21 as this service is covered through EPSDT.

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 Title
Agency	Certified Waiver Hourly Services Provider
Individual	Self Directed Personal Care Employee

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:

Agency

Provider Type:

Certified Waiver Hourly Services Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

Personal Care Services Provider Qualifications

Personal care workers may be employed by, or under contract with, any agency qualified to provide services under the waiver, and by home health and other home care agencies, and individuals that may not otherwise be waiver providers. Any agency or individual undertaking the provision of this service must employ or contract with a QIDP to provide the required supervision and must meet the other requirements of this addendum related to training, plans of care, documentation and reporting. The primary requirements for the provider agency are to:

a) Handle all payroll taxes required by law
b) Provide training and supervision as required by this scope of services
c) Maintain records to assure the worker was qualified, the service was provided and provided in accordance with the plan of care
e) Implement a plan and method for providing backup at any time it is needed
f) Implement and assure the person and his or her family are and remain satisfied with the service
g) Exclusion lists are checked monthly by the employer. Employer documentation of verification is required.

Personal Care Workers:

a) Must have at least two references from work and/or school, and one personal, which have been verified by the provider agency
b) Must have background checks required by law and regulation
c) Must be at least 18 years of age
d) Must be able to read and write and follow instructions
e) Must be able to follow the plan of care with minimal supervision unless there is a change in the person's condition
f) Must have no physical or mental impairment that would prevent providing the needed assistance to the person
g) If providing transportation, must have valid driver's license and insurance as required by State Law

Personal Care Workers shall not be members of the immediate family (parents, spouses, children) of the person being supported, nor shall they be in any other way legally obligated for the individual. Any other relatives, or friends, who are employed to provide services shall meet the qualifications for providers of care and, as for all other personal care workers, payment shall only be made for services actually rendered. Employment of a relative or friend shall be noted and justified in the individual's record by the provider agency.

Training Requirements

This service is intended to promote self-determination of waiver participants. To the extent practical, safe and cost effective, the individual and his family are encouraged to exert choice in planning, and in the selection and hiring of staff, and are encouraged to provide training and supervision to the worker(s). Agencies are encouraged to partner with individuals and families in this endeavor, while providing a safe and effective backup system to meet contingencies.

Training shall be provided prior to the worker delivering services and includes:

Procedures and expectations related to the personal care worker including following the Personal Care Plan of Care, the rights and responsibilities of the provider and the consumer, reporting and record keeping requirements, procedures for arranging backup when needed, and who to contact within the provider agency or regional office.

a) Information about the specific condition and needs of the person to be served, including his or her physical, psychological or behavioral challenges, his or her capabilities, and his or her support needs and preferences related to that support.
b) Training in CPR and first aid and, if administration of ordinarily self-administered medication is

required by the consumer, training in medication administration. As needed due to challenging behavior by the consumer, the worker will also be trained in behavioral intervention techniques appropriate to the consumer. Training in medication administration and behavior intervention techniques may be waived if not required to support the person.
c) Training in communication skills; in understanding and respecting consumer choice and direction; in respecting the consumer's confidentiality, cultural and ethnic diversity, personal property and familial and social relationships; in handling conflict and complaints and in responding to emergencies.
d) Training in assisting with activities of daily living and instrumental activities of daily living, as needed by the individual
e) The provider will maintain a record of training.

Supervision

A QIDP must visit the person, in person, at least every 60 days and must complete a supervisory visit to ensure the personal care worker is performing the job as expected. The visiting QIDP shall make an assessment of the effectiveness of the service, the consumer satisfaction with the service, and of any changes that may need to be made, including additional training or a change in the plan of care. The form must contain the original signature of the family member/legal guardian or individual and is dated the day the visit is made to the home. Payment for personal care that delivered after 60 days where no supervisory visit has been completed will not be made. This record must be sent to the Support Coordinator for placement into the individual file. The dates of the supervisory visits must be entered into the EVVM system by the due date or the worker's times cannot be billed. An exception to the 60 day requirement is when an attempted visit occurs. A attempted visit is when the QIDP has a visit scheduled and upon arriving at the home, the individual is not at home. The provider agency has 5 working days from the attempted visit to complete the 60 day supervisory visit.

Documentation

The direct service provider and/or billing provider must maintain documentation of the dates and hours of service provided, and of the service activities provided within each span of work, showing that services delivered are consistent with the recipient's plan of care. Daily or weekly logs are signed by the worker and by the consumer or family member, which identify the consumer and the consumer's Medicaid number, the worker providing the service, the date(s) of service, the time service began and the time service ended, and the specific activities provided within each span of work, will be acceptable as a minimum. The use of an Electronic Visit Verification Management system may alter the method in which service delivery is recorded and/or eliminate some of the above mentioned requirements for client/family signatures. Payment for the 60 day required supervisory visit may be electronically captured as well. .

Verification of Provider Qualifications

Entity Responsible for Verification:

DMH/DD Certification

Frequency of Verification:

Prior to Contract Approval, Annually or biennially for already approved providers (based on previous survey score), or more often as needed based on service monitoring concerns.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:

Individual

Provider Type:

Self Directed Personal Care Employee

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Self Directed Personal Care Workers:

* Must have at least two references, one from work and/or school, and one personal, which have been verified by the consumer or family (with or without the support of a consultant).
* Must have background checks required by law and regulation
* Must be at least 18 years of age
* Must be able to read and write and understand instructions, as verified by the individual or family.
* If providing transportation, must have valid driver's license and insurance as required by State Law

Training Requirements

This service is intended to promote self-determination of waiver participants. The individual and/or his family are to select and hire staff, and to provide training and supervision to the worker(s). The family must be trained on the types of incidents to report, who to report to and the timeframes to report any incidents.

Basic elements of training shall be provided prior to the worker delivering services and includes:

Procedures and expectations related to the personal care worker including following the Plan of Care, the rights and responsibilities of the worker and the individual, reporting and record keeping requirements, procedures for arranging backup when needed, and who to contact within the FMSA, the case management agency and regional office. In addition and as needed, training in the following areas will be provided by the family or others and recorded.

a) Information about the specific condition and needs of the person to be served, including his or her physical, psychological or behavioral challenges, his or her capabilities, and his or her support needs and preferences related to that support.
b) If administration of ordinarily self-administered medication is required by the consumer, training and ongoing supervision in medication administration.
c) Training as needed in communication skills; in understanding and respecting individual choice and direction; in respecting the individual's confidentiality, cultural and ethnic diversity, personal property and familial and social relationships; in handling conflict and complaints and in responding to emergencies.
d). Training in assisting with activities of daily living and instrumental activities of daily living, as needed by the individual and identified by the plan of care.
e). Training on the types of incidents and incident reporting is required.

Supervision

Supervision of the self-directed personal care workers is the responsibility of the family and/or the consumer.

Documentation

The family and consumer must maintain documentation of the dates and hours of service provided and provide this to the FMSA bi-weekly. These records are necessary for audits performed by CMS, Medicaid, and/or ADMH/DDD monitors and auditors. Daily or weekly logs, signed by the worker and by the consumer or family member, which identify the consumer, the worker providing the service, the date(s) of service, the time service began and the time service ended, and the activities provided within each span of work, will be required. A form will be provided by the FMSA or may be collected by an electronic visit verification system as required by federal law.

Verification of Provider Qualifications

Entity Responsible for Verification:

Self Directed Personal Care Services Financial Management Services

The self-directed personal care workers will be employed by the family and participant, who will be employers of record. The family and consumer will be supported by a Financial Management Service Agency (FMSA). The FMSA will pay the personal care workers employed by the family and participant, on a bi-weekly basis. Payment will be made on the basis of receipt of one time card per personal care worker, which will document the hours the worker has worked during the bi-weekly pay period with an indication of the service rendered for that time period (i.e. adult companion, personal care).

The FMSA will withhold the necessary tax amounts, including employer's share, and pay these amounts to the proper authorities on a quarterly basis. In addition to withholding FICA and Unemployment, the Fiscal Agent will withhold and submit income taxes for the workers. The primary requirements for the FMSA are to:

a) Handle all payroll taxes required by law
b) Assist with the documentation of training and other qualifications of workers as required by the waiver, including verification of citizenship.
c) Maintain records to assure the worker was qualified, the service was provided in accordance with the plan of care
d) Furnish background checks on prospective employees
e) Provide the person and family with easy access to resolve problems with payroll and provide a notification route for any other issues that may arise. This means that the FMSA, if it hears that a change may be needed or that a backup plan needs to start, will notify the operating agency, the self directed liaison and the case manager. The objective is to provide a network within which, no matter which contact the person or family makes, the information is shared and the reaction is comprehensive.
f) Also, the FMSA will help to assure the person and his or her family are and remain satisfied with the service

Frequency of Verification:

Workers employed by consumers and families will have their qualifications verified initially by the FMSA, and no further verification is necessary unless a situation or qualification changes and the participant or family reports it to the FMSA. Exclusion lists are checked monthly by the FMSA.

Appendix C: Participant Services

C-1/C-3: Service Specification

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:

Prevocational Services

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04010 prevocational services

Category 2:

04 Day Services

Sub-Category 2:

04070 community integration

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

Prevocational services are designed to create a path to competitive integrated employment, which includes competitive integrated self-employment and customized employment or customized self-employment that otherwise meets the criteria for being competitive and integrated. Competitive integrated employment is employment that meets all of the following criteria: (1) ensures compensation is at least the locally established minimum wage where the member works; (2) occurs in a location typically found in the community; (3) enables the member to interact with co-workers and customers to the same extent as a person without a disability filling a similar position; (4) for wage employment, ensures the employer of record is the business or organization benefitting from the work done by the member; and (5) offers the member an individualized position.
Prevocational services involve the provision of learning and skill-building experiences, including community-based volunteering for an organization other than the service provider, where a member can develop general, non-job-task-specific strengths and skills that contribute to employability in competitive integrated employment. Services are intended to develop and teach general skills for competitive integrated employment, including but not limited to: ability to communicate effectively with supervisors, coworkers and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; general workplace safety and mobility training. Services are expected to specifically involve strategies that enhance a member's desire for, and employability in, competitive integrated employment.
Prevocational services, regardless of how and where they are delivered, are expected to help members make reasonable and continued progress toward participation in at least part-time competitive integrated employment.

Individuals receiving prevocational services must have a competitive integrated employment goals in their person-centered plan and prevocational services must be designed to support such employment goals.

Prevocational services are expected to be furnished in a variety of settings in the community, except for the member’s residence or other waiver-funded residential settings. While a provider may utilize a provider-owned or controlled setting as a hub or base for service delivery, and that setting may include individuals without disabilities who are not receiving HCBS, prevocational services must be delivered consistent with all of the requirements of the HCBS Settings Rule, therefore ensuring each individual’s Prevocational service plan includes opportunities to participate a variety of community-based activities that are consistent with the purpose and intended outcome of the service and that facilitate the individual’s access to the broader community and interactions, in the broader community, with people not receiving HCBS. This includes opportunities for career exploration specific to pursuing competitive integrated employment.
Participation in prevocational services is not a required pre-requisite for individual or small group supported employment services under the waiver. Prevocational services differ from vocational services(actual employment) in that prevocational services, regardless of setting, are delivered for furthering habilitation goals that will lead to greater opportunities for competitive and integrated employment and career advancement at or above minimum wage.
Individuals receiving prevocational services may pursue competitive integrated employment opportunities while receiving prevocational services.at any time to enter the general workforce.
An individual’s care plan may include two or more types of day and employment services; however, different types of day and employment services may not be billed for the same unit of time. Prevocational services may be provided to supplement, but may not duplicate, services available and provided to the individual as part of an approved Individualized Plan for Employment (IPE) funded by ADRS or under an approved Individualized Education Plan (IEP) funded under the Individuals with Disabilities Education Act (IDEA).

Individuals participating in prevocational services that involve work shall be compensated in accordance with applicable Federal and State laws and regulations. Compensation at sub-minimum wage shall comply with the Fair Labor Standards Act and the Workforce Investment and Opportunity Act (WIOA) including WIOA provision for youth with disabilities under age 26.
Reimbursement rates are associated with the minimum staffing ratios needed to support persons based on whether the service is delivered in a facility-based (provider controlled) setting or an integrated community setting, taking account of the different staffing ratios and different costs that are applicable for services delivered in integrated community settings. There are four reimbursement rate levels based on four acuity tiers. An individual’s acuity tier is based on his/her ICAP score. Staffing ratios for both facility-based and community-based service provision vary based on acuity tier. For facility, the staffing ratios vary from a low of 1:15 to a high of 1:1. For community, the staffing ratios vary from a low of 1:3 to a high of 1:1.

Transportation between the individual's place of residence and the provider facility, or site where the individual starts and ends Prevocational services each day, is included as a component part of the service or arranged for the

individual in another way. Transportation during the service is always a component part of the service.

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

This service cannot be authorized or reauthorized for an individual who does not desire and document an outcome of competitive integrated employment in his/her individual plan.

To ensure effectiveness of service delivery models, reimbursable service models shall be those that do not limited weekly service delivery only to participation in paid facility-based work. This activity alone is not sufficient to constitute a prevocational service consistent with the approved definition.

If authorized for an individual already working in competitive integrated employment, the service must be focused on goals related to ensuring the individual's success in, and ability to sustain, competitive integrated employment, and the individual's competitive integrated employment must be sufficient enough to warrant the authorization of this service as a support for sustaining successful participation in competitive integrated employment (i.e. at least twelve (12) hours per week).

Waiver funding is not available for the provision of vocational services delivered in facility based or sheltered work settings, where individuals are supervised for the primary purpose of producing goods or performing services.

Prior to authorizing this service, the member's record documents this service is not otherwise available to the member, in a timeframe that is otherwise typical, through a program funded by ADRS under the section 110 of the Rehabilitation Act of 1973 or, for individuals ages 18-22, through a program funded under the Individuals with Disabilities Education Act (IDEA) (20 U.S.C.1401 et seq).
Prevocational services are limited to a total 2470 hours. The hours of service cannot exceed over 5 hours per day and are usually provided during the time the day facility is operational. Authorization of units beyond this limit may only be approved if the individual is actively engaged in obtaining competitive integrated employment either through ADRS services, waiver supported employment-individual services or another verifiable funding source.

The expectation is that, before the 2470 unit limit is exhausted, a referral will be made to the AL Department of Rehabilitation Services to begin the Milestone program for job placement and short term follow up or the individual would utilize the individual supported employment job development services under the waiver, if ADRS services are not timely available to the individual. If units beyond the 2470 hour limit are needed, and a person is not actively engaged in obtaining competitive integrated employment, the support coordinator must submit a justification for continuing this service to the Central Office Supported Employment Coordinator or the Employment Specialist working in the RO. The Employment Coordinator/Specialists will notify the Support Coordinator of the approval who will begin the RFA process to the Regional Office.

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 Title
Agency	Certified Prevocational Program

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:

Agency

Provider Type:

Certified Prevocational Program

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

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 Developmental Disabilities.

When the application, supporting data, and site visit prove the program or service is in full compliance with certification requirements, a certificate will be issued by the Division of Developmental Disabilities.

Subsequent site inspections shall be scheduled in accordance with policy and procedures of the Division of Technical Services. Programmatic re-surveys are conducted at one or two year intervals depending on the previous survey outcome.

Programs delivering Prevocational services shall have written mission statements for dissemination to prospective clients and their families. The mission statement shall address:

Program philosophy and purpose;
Geographical area served;
Range of services provided; and
Population served, including criteria for service eligibility, program admission and program discharge.

The staffing pattern shall be appropriate to the type and scope of program services and shall include staff members who meet the experiential and educational qualifications set forth in the approved job descriptions. The program shall develop and maintain appropriate, up-to-date staffing schedules. Staff to client daily ratio shall not be more than 1:15 in facility based prevocational. The ratio for community based prevocational service is 1:3 No client shall ever be left unsupervised unless the activity is part of a structured activity or plan of care.
Day Habilitation providers must also demonstrate:
• Ability and capacity to offer members regular (daily) opportunities to access the broader community.
• Use of an individualized service planning process that ensures individual member goals are identified and used to guide service delivery and opportunities offered both in the facility and in the broader community.
• Understanding and use of community mapping strategies to identify opportunities for community involvement and participation that align with each member’s individualized interests and desires with regard to type(s) of community involvement and community contributions they prefer.
In addition to certification, the following requirements apply to the provider's staff:
Activity Program Aide: Job Specifications
a) Must have at least two references from work and/or school, and one personal, which have been verified by the provider agency
b) Must have background checks required by law and regulation
c) Must be at least 18 years of age
d) Must be able to read and write and follow instructions
e) Must be able to follow the plan of care with minimal supervision unless there is a change in the person's condition
f) Must have no physical or mental impairment that would prevent providing the needed assistance to the person
g) If providing transportation, must have valid driver's license and insurance as required by State Law

Training Requirements:

Prior to assignment, each Habilitation Aide will be required to be certified by the provider agency as having completed a course of instruction provided or approved by the DMH which will minimally include:

1. Recipient rights and grievance procedures.
2. Overview of intellectual and developmental disabilities.
3. Concepts of human development.

4. CPR, first aid, medical emergencies.
5. Management of challenging behavior.
6. Physical management techniques.
7. Health observation, including hygiene, medication control/ universal precautions.
8. Recipient abuse, neglect and mistreatment.
9. Habilitation training programs.

Retraining will be conducted as needed, but at least annually for training requirements 1, 5, 6, 7 & 8 above.Specific Duties:
The Job Coach is responsible to the Program Director for the training and associated support services necessary to ensure the successful employment of individuals involved in Supported Employment. The Job Coach works under the direction of a QDDP/program manager. The provider must have a QDDP to ensure the plan is implemented as prescribed.
The duties of the Activity Program Aide (Pre-Vocational) include:
1. Instructs/demonstrates/interacts with clients concerning a variety of education, personal care, pre-vocational training, job safety, and social behaviors, in accordance with the individual's assessed needs and plan requirements. Uses sound judgment and abides by supervisor's instructions, minimum standards and other applicable regulatory standards in order to foster client self-sufficiency and independence.
2. Converses with/listens to clients concerning personal needs, responsibilities, expectations, aspirations, privileges, and personal/behavioral problems in a supportive and understanding manner.
3. Participates in developing, modifying, and adapting instruction and training to individual client needs.
4. Interacts often and appropriately with clients using both verbal and nonverbal methods (gestures, modeling, sign language, etc.) to provide information to clients about expected behavior, duties, and activities.
5. Observes the quality of production and integrates efficiency concepts in the work process.
6. Provides/receives information to/from peers, supervisors, other professional staff, support personnel, and clients pertaining to care plan, schedules, programs, and progress using personal contacts, meetings, memorandums, reports, records and filing systems in accordance with established schedules in order to facilitate client training, record maintenance and the exchange of other pertinent information.
7. Assists in computing data for programs such as behavior management, speech, token reinforcement, vocational, and social in order to assess client progress.

Training Requirements
The Activity Program Aide (Pre-Vocational) training should demonstrate interaction with recipients concerning education, personal care, pre-vocational training, job safety and social behaviors, in accordance with the recipient's habilitation plan and care plan. The minimum training requirements:
1. Planning and coordinating all activities according to the individual habilitation and care plan.
2. Leadership with recipients doing therapeutic or rehabilitative activities programs.
3. Conferring with other professional personnel concerning the progress and needs of the recipients.
4. Providing individual instruction when needed.
5. Health observation including hygiene medication control/universal precautions.
6. Recipient abuse, neglect and mistreatment.
7. Knowledge of equipment and supplies needed for assigned activities.
8. Recipients rights and grievance procedures.
9. CPR first aid, medical emergencies.
10. Training on how to read and comprehend written materials, such as the care plan, habilitation plans and policy and procedures manuals.

Ongoing training will be conducted as needed but at least annually for above training requirements 6 and 8.
Additional Provider Requirements
The provider of service
a) Must have required training prior to providing service;
b) Must keep record of required training in the personnel folder; and
c) Must maintain a service log that documents specific days on which services were delivered

consistent with the recipient's individual plan of care.

Verification of Provider Qualifications

Entity Responsible for Verification:

DMH Certification Surveyors

Frequency of Verification:

Prior to Contract Approval, Annually or Biennially for already approved providers (based on previous survey score), or more often as needed based on service monitoring concerns.

Appendix C: Participant Services

C-1/C-3: Service Specification

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:

Residential Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02011 group living, residential habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Residential Habilitation service is a type of residential service selected by the person supported, offering individualized services and supports that enable the person supported to acquire, retain, or improve skills necessary to reside in a community-based setting and which supports each resident's independence and full integration into the community, and ensures each resident's choice and rights. Residential Habilitation services shall be provided in a dwelling which may be rented, leased, or owned by the Residential Habilitation provider, and shall comport fully with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, and set forth in the person-centered plan and plan of care. Participants receiving residential services should have enforceable leases agreed upon and signed by the individual and he/she is entitled to file an appeal, as needed and are regarded similarly as those without disabilities in respect to signed lease/rental agreements. 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, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS. The individual has the right to a rental agreement that is fully enforceable.

1) Residential habilitation services provide care, supervision, and skills training in activities of daily living, home management and community integration. All settings that are so required must have appropriate site and programmatic certification from the Operating Agency.

Residential habilitation activities must relate to identified, planned goals. Training and supervision of staff by a QIDP shall assure the staff is prepared to carry out the necessary training and support functions to achieve these goals. Initial training requirements must be met prior to the staff beginning work. For recipients living in certified residences, staff must be trained regarding the individual's person centered plan prior to beginning work with the recipient.

The service includes the following:

a) Habilitation training and intervention in the areas of self-care, sensory/motor development, interpersonal skills, communication, behavior shaping and supports, community living skills, mobility, health care, socialization, community inclusion, money management, pursuit of leisure and recreational activities and household responsibilities. Training and intervention may consist of incidental learning in addition to formal training plans, and will also encompass modification of the physical and/or social environment. This may mean changing factors that impede progress (i.e. moving a chair, substituting Velcro closures for buttons or shoe laces, helping to shift attitudes toward the individual being supported, opening a door for someone, etc.) and provision of direct support, as alternatives to formal habilitative training.

Habilitation supplies and equipment that are not considered as a waiver service (specialized medical supplies and specialized medical equipment) are not considered in the daily rate for residential services and should be included as room and board; transportation costs to transport individuals to day programs, social events or community activities when public transportation and/or transportation covered under the Medicaid state plan are not available will be included in payments made to providers of residential habilitation. Residential Habilitation service workers may transport individuals in their own vehicles as an incidental component of Residential rates.

Providers of Residential Habilitation must present proof certification of training and qualifications of staff delivering services in Specialized Medical Homes and/or in Specialized Behavioral homes to Certification and when staffing changes occur, must present proof to the CSD in the Regional Office. The provider of residential service is responsible for checking both AMA and the OIG exclusion lists each month to ensure employee have not been debarred from providing Medicaid services. Documentation of the monthly checks is required.

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

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. The DDD shall not certify programs or settings where there exists a cluster of such settings. Clusters shall be defined as multiple program or residential settings located on the same street, court, etc. where these type settings constitutes more than twenty five percent (25%) of all settings. The DDD shall not certify programs or settings where two or more are directly next to one another or share a property line, regardless of whether these settings result in less that twenty-five (25%) percent of the total settings on a street , court, etc.

The service excludes the following:
Services, directly or indirectly, provided by a member of the individuals 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.

Home accessibility modifications, when covered as a distinct service under the waiver may not be furnished to a individual in a provider setting. Residential Services shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for individuals with Intellectual Disabilities (ICFs/IID).

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 Title
Agency	Community Residential Facility

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:
Agency
Provider Type:

Community Residential Facility

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

Documentation:

Providers must have documented record of having completed training prior to providing services. Providers of service must maintain a service log that documents specific dates on which services were delivered, consistent with the consumer's person centered plan.

Residential Habilitation Provider Qualifications

The Department of Mental Health, Division of Developmental Disabilities requires certification of programs delivering Residential Habilitation services. Standards are in Al. Administrative Code Chapters 580-3-23 and 580-5-33.
An applicant wishing to provide Residential Habilitation Services must provide written statements of certification of the facility's compliance with fire and health standards where applicable and submit these and other documentation to the Division of Developmental Disabilities.
When the application, supporting data, and site visit prove the program or service is in full compliance with certification requirements, a certificate will be issued by the Division of Developmental Disabilities.

Subsequent site inspections shall be scheduled in accordance with policy and procedures of the Department's Division of Technical Services. Programmatic re-surveys are conducted at one or two year intervals depending on the previous survey outcome.

Programs delivering Residential Habilitation services shall have a written mission statement for dissemination to prospective clients and their families. This mission statement shall address:

Program philosophy and purpose;
Geographical area served;
Range of services provided; and
Population served, including criteria for service eligibility, program admission and program discharge.

Each Residential Habilitation program must develop and maintain appropriate, up-to-date staffing schedules for each facility. Program staff ratios and staff work schedules shall be maintained to meet the needs of clients. An emergency, on-call staff person, in addition to those normally required to maintain appropriate staffing patterns, shall be available. Staff scheduling and work place assignments shall be so arranged as to provide continuous on-site response capability in the event of individual needs. The staffing pattern shall be appropriate to the type and scope of programmed services and shall include staff members who meet qualifications set forth in the approved job descriptions. If a program is contracted to serve clients who require considerable guidance and supervision (i.e., moderately and severely physically disabled individuals, individuals who are aggressive, assaultive or are security risks, or clients who exhibit severely hyperactive or psychotic behavior), the daily ratio of training staff to clients may vary from 1:1 to 1:8, depending on programmatic and support need. This ratio shall be justified and documented. If a program is contracted to serve individuals requiring training or assistance in basic independent living skills, the training staff-to-client daily ratio shall not exceed 1:10.
Residential Aides must possess a high school diploma or its equivalency, must be able to perform the essential functions of the job and be able to follow plans of care.
Residential Habilitation services will be delivered/supervised by a Qualified Intellectual Disabilities Professional in coordination with the individual's person centered plan.
Residential providers must also demonstrate:

- Ability and capacity to offer members regular (daily) opportunities to access the broader community.
- Use of an individualized service planning process that ensures individual member goals are identified and used to guide service delivery and opportunities offered both in the facility and in the broader community.
- Understanding and use of community mapping strategies to identify opportunities for community involvement and participation that align with each member’s individualized interests and desires with regard to type(s) of community involvement and community contributions they prefer.

SPECIALIZED MEDICAL RESIDENTIAL SERVICES PROVIDER

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.

SPECIALIZED BEHAVIORAL SERVICES PROVIDER

REQUIREMENTS
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 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.

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.

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.

SPECIALIZED BEHAVIORAL SERVICES PROVIDER

REQUIREMENTS
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 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.

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

DMH Certification Surveyors

Frequency of Verification:

Prior to Contract Approval, Annually or Biennially for already approved providers (based on previous survey score), or more often as needed based on service monitoring concerns.

Appendix C: Participant Services

C-1/C-3: Service Specification

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:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09011 respite, out-of-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09012 respite, in-home
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

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 is intended for participants whose primary caregivers typically are the same persons day after day (e.g. family members and/or adult family foster care providers), and is provided during those portions of the day when the caregivers typically provide care. Relief needs of hourly or shift staff workers will be accommodated by staffing substitutions, plan adjustments, or location changes, and not by respite care. Respite care typically is scheduled in advance, but it can also serve as relief in a crisis situation. As crisis relief, out of home respite can also allow time and opportunity for assessment, planning and intervention to try to re-establish the person in his home, or if necessary, to locate another home for him.

Some consumers are institutionalized because their community supports become exhausted, or because they don't know how to cope with an increasingly challenging behavior, or due to the loss/incapacitation of a caregiver. The scope of out of home respite will allow quick response to place the person in an alternate setting and provide intensive evaluation and planning for return, with or without additional intervention and supports. Planning will be made for alternate residential supports if return is not possible. The goal is to avoid institutionalization.

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

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.

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 Title
Agency	Certified Waiver Hourly Services Provider (for In-Home Respite)
Agency	Community Residential Facility

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:

Certified Waiver Hourly Services Provider (for In-Home Respite)

Provider Qualifications
License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DMH Certification Surveyors

Frequency of Verification:

Prior to Contract Approval, Annually or Bi-Annually for already approved providers (based on previous survey score), or more often as needed based on service monitoring concerns.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Community Residential Facility

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

Documentation

The billing provider must maintain documentation of the services provided each day. Logs signed by the worker and cosigned by the consumer or family member are acceptable.

Respite Care Provider Qualifications

Respite care workers may be employed by any agency qualified to provide services under the waiver, and by home health and other home care agencies, and individuals that may not otherwise be waiver providers. Any agency or individual undertaking the provision of this service must employ or contract with a QIDP to provide the required supervision and must meet the other requirements of this addendum related to training, plans of care, documentation and reporting.

The primary requirements for the provider agency are to:

*Handle all payroll taxes required by law
*Provide training and supervision as required by this scope of services
*Maintain records to assure the worker was qualified, the service was provided and provided in accordance with the plan of care
*Implement a plan and method for providing backup at any time it is needed
*Implement and assure the person and his or her family are and remain satisfied with the service

Respite Care Workers:

*Must have background checks required by law and regulation.
*Must be at least 18 years of age.
*Must be able to read and write and follow instructions.
*Must have at least completed tenth grade.
*Must be able to follow the plan of care with minimal supervision unless there is a change in the person's condition.
*Must have no physical or mental impairment that would prevent providing the needed oversight and care to the person.

Verification of Provider Qualifications

Entity Responsible for Verification:

DMH Certification Surveyors

Frequency of Verification:

Prior to Contract Approval, Annually or Bi-Annually for already approved providers (based on previous survey score), or more often as needed based on service monitoring concerns.

Appendix C: Participant Services

C-1/C-3: Service Specification

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:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Adult Companion Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
08 Home-Based Services	08040 companion
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Non-medical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not include hands-on nursing care. Providers may perform light housekeeping tasks that are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the plan of care, and not purely diversional in nature. This service is needed to prevent institutionalization.

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.

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

The QIDP will provide and document in the case record on-site supervision of the companion worker every 60 days. The supervisor will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performance by the worker.

Objective: Companion Services are to provide support and supervision that is focused on safety, non-medical care and socialization for clients participating in the ID waiver. Medicaid will not reimburse for activities performed which are not within the scope of services.

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 Title
Individual	Self Directed Adult Companion Employee
Agency	Certified Waiver Hourly Services Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Companion Services

Provider Category:

Individual

Provider Type:

Self Directed Adult Companion Employee

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Requirements:

a. Services must be on the service plan of care with documentation in the case record of need for service. The service is 15-minutes of direct companion services provided to the client.
b. The provision of the service, and the number of units of service provided to each client, is dependent upon the individual's needs as set forth in the service plan of care.
c. Companion service is not available to group home residents.
d. No payment will be made for companion services furnished by a member of the participant's family (parent, child, spouse or legally obligated individual).
e. Companion services are limited to functionally impaired adults (age 21 and over).
f. Companion service is non-medical and does not include hands-on care.

Adult Companion Services Provider Qualifications

1. Ability to read and write.
2. Ability to establish and to maintain effective working relationships with clients.
3. Ability to demonstrate emotional maturity and to show the proper attitude toward clients.
4. Ability to understand and to follow simple oral and written instructions.
5. Must have a background check required by law and regulations.

Training and Documentation Requirements:
This service is intended to promote self-determination of waiver participants. The individual and/or his family are to select and hire staff, and to provide training and supervision to the worker(s).

Basic elements of training shall be provided prior to the worker delivering services and includes:

Procedures and expectations related to the companion care worker including following the person centered plan, the rights and responsibilities of the worker and the consumer, reporting and record keeping requirements, procedures for arranging backup when needed, and who to contact within the FMSA, the case management agency and regional office. In addition and as needed, training in the following areas will be provided by the family or others and recorded.

a) Information about the specific condition and needs of the person to be served, including his or her physical, psychological or behavioral challenges, his or her capabilities, and his or her support needs and preferences related to that support.
b) Reminding the individual of medications.
c) Training as needed in communication skills; in understanding and respecting consumer choice and direction; in respecting the consumer's confidentiality, cultural and ethnic diversity, personal property and familial and social relationships; in handling conflict and complaints and in responding to emergencies.
d) Training in assisting with activities of daily living and instrumental activities of daily living, as needed by the individual and identified by the person centered plan.

Supervision

Supervision of the self-directed adult companion workers is the responsibility of the family and/or the consumer.

Documentation

The family and consumer must maintain documentation of the dates and hours of service provided and provide this to the FMSA bi-weekly for processing billing to Medicaid and payment to the workers. Daily or weekly logs, signed by the worker and by the consumer or family member, which identify the consumer, the worker providing the service, the date(s) of service, the time service began and the time service ended, and the activities provided within each span of work, will be required. A form will be provided by the FMSA.

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Services

The self-directed adult companion workers will be employed by the family and consumer, who will be employers of record. The family and consumer will be supported by a Financial Management Service Agency (FMSA). The FMSA will pay the workers employed by the family and participant, on a bi-weekly basis. Payment will be made on the basis of receipt of one time card per worker, which will document the hours the worker has worked during the bi-weekly pay period with an indication of the service rendered for that time period (i.e. adult companion, personal care).

The FMSA will withhold the necessary tax amounts, including employer's share, and pay these amounts to the proper authorities on a quarterly basis. In addition to withholding FICA and Unemployment, the Fiscal Agent will withhold and submit income taxes for the workers. The primary requirements for the FMSA are to:

a) Handle all payroll taxes required by law
b) Assist with the documentation of training and other qualifications of workers as required by the waiver, including verification of citizenship.
c) Maintain records to assure the worker was qualified, the service was provided in accordance with the plan of care
d) Furnish background checks on prospective employees
e) Provide the person and family with easy access to resolve problems with payroll and provide a notification route for any other issues that may arise. This means that the FMSA, if it hears that a change may be needed or that a backup plan needs to start, will notify the operating agency, the self directed liaison and the case manager. The objective is to provide a network within which, no matter which contact the person or family makes, the information is shared and the reaction is comprehensive.
f) Also, the FMSA will help to assure the person and his or her family are and remain satisfied with the service

Frequency of Verification:

Workers employed by consumers and families will have their qualifications verified initially by the FMSA, and no further verification is necessary unless a situation or qualification changes and the participant or family reports it to the FMSA. Exclusion lists are checked monthly.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Companion Services

Provider Category:

Agency

Provider Type:

Certified Waiver Hourly Services Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

Requirements:

a. Services must be on the service plan of care with documentation in the case record of need for service. The service is 15-minutes of direct companion services provided to the client.
b. The provision of the service, and the number of units of service provided to each client, is dependent upon the individual's needs as set forth in the service plan of care.
c. Companion service is not available to group home residents.
d. No payment will be made for companion services furnished by a member of the participant's family (parent, child, spouse or legally obligated individual).
e. Companion services are limited to functionally impaired adults (age 21 and over).
f. Companion service is non-medical and does not include hands-on care.

Adult Companion Services Provider Qualifications

All individuals providing this service must meet the following qualifications:
2. Ability to read and write.
3. Ability to establish and to maintain effective working relationships with clients.
4. Ability to demonstrate emotional maturity and to show the proper attitude toward clients.
5. Ability to understand and to follow simple oral and written instructions.

Training and Documentation Requirements:

Prior to assignment, each companion worker must be certified by the provider agency as having completed a course of instruction provided or approved by DMH. The course of instruction must be documented in writing and is subject to review by DMH and Medicaid. Minimally this instruction will include:

1. Overview of intellectual disabilities,
2. Appropriate skills required for managing various behaviors,
3. Physical management techniques,
4. Health observation including medication control/universal precautions,
5. Recipient abuse, neglect and mistreatment policies,
6. Recipient rights and grievances procedures,
7. Written materials such as the care plan, habilitation plan and policy and procedures manuals, and
8. CPR, first aid, medical emergencies.

A copy of the required training documentation should be in the companion worker folder. Ongoing training to be provided as needed, but at least annually for above training requirements 2, 3, 4, 5 & 6.

The direct service provider and/or billing provider must maintain documentation of the dates and hours of service provided, and of the service activities provided within each span of work, showing that services delivered are consistent with the service plan of care. Daily or weekly logs, signed by the worker and by the consumer or family member, which identify the consumer and the participant's Medicaid number, the worker providing the service, the date(s) of service, the time service began and the time service ended, and the specific activities provided within each span of work, will be acceptable as a minimum. In addition, there must be evidence of a quarterly review of the services provided and of the continued appropriateness of those services by a QIDP.

Verification of Provider Qualifications

Entity Responsible for Verification:

DMH Certification Surveyors

Frequency of Verification:

Prior to Contract Approval, Annually or Bi-Annually for already approved providers (based on previous survey score), or more often as needed based on service monitoring concerns.

Appendix C: Participant Services

C-1/C-3: Service Specification

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:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Assistive Technology Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

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 .

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

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 Assistive Technology is only available to those participants who are self-directing personal care, companion and/or LPN/RN services.

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 Title
Agency	Home Medical Equipment and Services Providers
Agency	Self Directed Home Medical Equipment Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology Services

Provider Category:
Agency
Provider Type:

Home Medical Equipment and Services Providers

Provider Qualifications
License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

Providers of this service must meet the same standards required for the providers under the Alabama State Plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Licensure is by the Alabama Board of Home Medical Equipment Services Providers

Frequency of Verification:

Annually.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology Services

Provider Category:

Agency

Provider Type:

Self Directed Home Medical Equipment Agency

Provider Qualifications

License *(specify):*

Licensure is by the Alabama Board of Home Medical Equipment Services Providers.

Certificate *(specify):*

Other Standard *(specify):*

Providers of this service must meet the same standards required for the providers under the Alabama State Plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

FMSA

Frequency of Verification:

Upon purchase.

Appendix C: Participant Services

C-1/C-3: Service Specification

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:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Benefits and Career Counseling

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03030 career planning
Category 2:	**Sub-Category 2:**
17 Other Services	17990 other
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Benefits and Career Counseling is two distinct services: Benefits Reporting Assistance and Benefits Counseling

The Benefits Reporting Service (BRS) 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 BRA will receive referrals from a variety of sources, including Support Coordinators, 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.

The second service is Benefits Counseling is a more intensive service provided by a Community Work Incentives Coordinator (CWIC) who will receive referrals from the BRA, 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. The CWIC will work in conjunction with the BRA to develop trainings and webinars based on SSA information provided and may assist or provide trainings and education as needed. The CWIC will be available to work with waiver participants to provide information on waiver benefits and employment and may also 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 .
BRA services and CWIC services must be documented and billed in 15 minute increments.

These positions require proactive, well organized professionals who work well independently and as effective team members. They must have the ability to manage multiple high priority tasks, possess and use excellent time management skills and have good verbal and written communication skills.

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

Both services are billed in 15 minute increments. BRS is limited to 12 units/3 hours per month per waiver participant per year (144 units or 36 hours per year). CWIC service is limited to 60 units/15 hours per year per waiver participant. Documentation of service provided is required.

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 Title
Agency	Supported Employment Provider
Agency	DMH or DVRS Certified Work Incentives Counselor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Benefits and Career Counseling

Provider Category:
Agency
Provider Type:

Supported Employment Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Providers must meet ADMH standards and requirements as outlined in the service description to provide supported employment Services. BRA must meet the same requirements as a job coach and must be certified through completion of approved specialized SSA training program (ADRS SSA Boot Camp).

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH/DD Certification Surveyors

Frequency of Verification:

Initially and biennially or more frequently based on certification review scores

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Benefits and Career Counseling

Provider Category:

Agency

Provider Type:

DMH or DVRS Certified Work Incentives Counselor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

The individual(s) must be a Certified Work Incentives Counselor (CWIC) through a recognized training by the Social Security Administration for the delivery of service. This may includes a Level 5 security clearance from Social Security Administration/Department of Homeland Security due to Personally Identifiable Information (PII).

Other Standard *(specify):*

CWICS must be organized and able to communicate effectively with families, providers, case managers, and participants

Verification of Provider Qualifications

Entity Responsible for Verification:

AL Department of Mental Health

AL Department of Rehabilitation Services

Frequency of Verification:

As needed to remain certified per the Social Security Administration.

Appendix C: Participant Services

C-1/C-3: Service Specification

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:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Experience

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04070 community integration
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Community Experience has two distinct categories: Individual and Group Community Experience services are non-work related activities that are customized to the individual(s) desires to access and experience community participation. Community Experience is provided outside of the person's residence and can be provided during the day, evening, or weekends. The intent of this service is to engage in activities that will allow the person to either acquire new adaptive skills or support the person in utilizing adaptive skills in order to become actively involved in their community.

Community Experience Individual services are provided to an individual participant, with a one-to-one staff to participant ratio which is determined necessary through functional and health risk assessments (ICAP and HRST) prior to approval and include only those receiving Day Hab level 4. Additionally, a behavioral assessment will need to support this specialized staffing if related to behavioral challenges prior to approval. Community Experience Group services are provided to groups of participants, with a staff to participant ratio of one to two or more, but no greater than four (4) participants.

CEI and CEG services are directly linked to goals and expectations identified in the person centered plan. The intended outcome of these services is to improve access to the community through increased skills, increased natural supports, and/or less paid supports. CEI and CEG services are designed to be teaching and coaching in nature. These services assist the participant in acquiring, retaining, or improving socialization and networking, independent use of community resources and community participation outside the place of residence. CEI and CEG services are not facility-based.

Transportation to and from activities and settings is a component of this service. Transportation is provided by the agency responsible for the service or by staff/family/or other natural support. Transportation provided through Community Experience Services is included in the cost of doing business and incorporated in the rate.

All Community Experience Services do not include educational services otherwise available through a program funded under 20 USC Chapter 3, section 1400 of the Individuals with Disabilities Education Act (IDEA). Community Access services must not duplicate or be provided at the same period of the day as Prevocational Service, Day Habilitation, Employment Small Group, or Job Coach and cannot be utilized at the same time a person is receiving Residential Habilitation services.

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

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. Community Experience is designed to be provided for individuals involved in day services as long as it is specified in the person centered plan. Additionally, Community Experience cannot overlap other Day Services including Pre-vocation, Day Habilitation, Personal Care, Employment Small Group, or Job Coach. 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.

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 Title
Agency	Certified Day Habilitation Program

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Experience

Provider Category:

Agency

Provider Type:

Certified Day Habilitation Program

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Alabama Administrative Code Chapters 580-3-23, 580-5-33

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

ADHM/DDD Certification Surveyors

Frequency of Verification:

Prior to contract approval, annually or biennially based on survey score.

Appendix C: Participant Services

C-1/C-3: Service Specification

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:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Specialist

HCBS Taxonomy:

Category 1: 17 Other Services

Sub-Category 1: 17990 other

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

Community Specialist Services is a time limited, task specific services that may include professional observation and assessment, facilitation of person centered plan development and continuance, individualized program design and implementation, training of consumers and family members, consultation with caregivers and other agencies, and monitoring and evaluation of planning and service outcomes as needed to facilitate and implement the person centered plan. The service may also, at the choice of the consumer or family, include advocating for the consumer and assisting him or her in locating and accessing services and supports. The community specialist will serve as both a qualified planner and, at the consumer's or family's request, a broker.

The community specialist must meet QIDP qualifications and be free of any conflict of interest with other providers serving the consumer. The services of the community specialist will assist the consumer and his caregivers to design and implement specialized programs to enhance self-direction, independent living skills, community integration, social, leisure and recreational skills, and behavior support.

These functions differ from case management in the skill level and independence of the specialist, as well as the focus on self-determination and advocacy for the individual. Targeted case managers will continue to perform traditional duties of intake, completion of paperwork regarding eligibility, serving in the capacity of referral and resource locating, monitoring and assessment.

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

The planning team shall first ensure that provision of this service does not duplicate the provision of any other services, including Targeted Case Management provided outside the scope of the waiver. The community specialist will be involved for only a short time (30 to 60 days) and designed not to duplicate case management services. If the consumer or family chooses to have the community specialist remain involved for a longer period of time, it must be agreed upon by the team and extended on the plan of care. The need to extend the service must be fully justified in writing by the case manager. Community Specialist Service is limited to a 90 day period per participant per waiver year. The community specialist will share information with the case manager at quarterly, more frequently if necessary, in an effort to remain abreast of the client’s needs and condition. A community specialist who facilitates the planning meeting for a person shall not have any conflict of interest with any provider who may wish to serve the person.

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 Title
Individual	Self Directed Community Specialist employee
Agency	Case management agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Specialist

Provider Category:

Individual

Provider Type:

Self Directed Community Specialist employee

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

The individual must meet federally defined QIDP qualifications (42 CFR 483.430) and be free of any conflict of interest. This means he or she cannot work for any provider agency from which a person receives a waiver service.
Note that a person may qualify as a community specialist and work for an agency, and also work for a participant or family who is self-directing, as long as there is no conflict of interest.

Verification of Provider Qualifications

Entity Responsible for Verification:

The FMSA (Financial Management Service Agency) will verify the qualifications prior to enrolling the community specialist. This verification need only be made initially. If the community specialist is also employed by an agency, and thus certified by the Operating Agency, the FMSA may accept the Operating Agency's verification of qualifications, but will need to verify the absence of conflict of interest itself.

Frequency of Verification:

Initial verification is all that is required unless the participant or family reports a change which might call the initial verification into question. Exclusion lists will be checked monthly.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Specialist

Provider Category:

Agency

Provider Type:

Case management agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

The individual must meet federally defined QIDP qualifications (42 CFR 483.430) and be free of any conflict of interest from other service providers. This means he or she cannot work for any provider agency from which a person receives a waiver service.

In addition, the provider must have experience, verified by the DMH, in person centered planning and if assisting with SDS, training in that component as well. This will consist of both training and actual practice.

Verification of Provider Qualifications

Entity Responsible for Verification:

DMH Certification Surveyors

Frequency of Verification:

Prior to Contract Approval, Annually or Biennially for already approved providers (based on previous survey score), or more often as needed based on service monitoring concerns.

Appendix C: Participant Services

C-1/C-3: Service Specification

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:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Crisis Intervention

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

10 Other Mental Health and Behavioral Services	10030 crisis intervention

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

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.

Individuals with intellectual disabilities are occasionally at risk of being moved from their residences to institutional settings because the person, or his family members or other caretakers, are unable to cope with short term, intense crisis situations. Crisis intervention can respond intensively to resolve the crisis and prevent the dislocation of the person at risk. The consultation which is provided to caregivers also helps to avoid or lessen future crises.

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.

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.

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

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.

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 Title
Agency	Certified Waiver Provider or DMH (State Agency) Regional Team

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Crisis Intervention

Provider Category:

Agency

Provider Type:

Certified Waiver Provider or DMH (State Agency) Regional Team

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

Providers of crisis intervention shall consist of a team under the direction and supervision of a psychologist, counselor or social worker licensed by the State of Alabama and meeting the requirements of a QIDP (as defined at 42 CFR 483.430). All team members shall have at least one year of work experience in serving persons with developmental disabilities, and shall, either within their previous work experience or separately, have a minimum of 40 hours training in crisis intervention techniques prior to providing services. The team shall be mobile and prepared to provide direct staffing if that is necessary to implement the plan.
Crisis teams may be agency based (certified waiver residential and day habilitation providers, or DMH Regional Offices), or they may stand alone.

Verification of Provider Qualifications

Entity Responsible for Verification:

DMH Certification Surveyors

Frequency of Verification:

Prior to Contract Approval, Annually or Bi-Annually for already approved providers (based on previous survey score), or more often as needed based on service monitoring concerns.

Appendix C: Participant Services

C-1/C-3: Service Specification

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:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental Accessibility Adaptations

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Those physical adaptations to the home, required by the individual 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.

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

Rental and leased property are excluded from modifications as it the landlord's responsibility for ensuring property is accessible, however, in the event that costs prohibits adaptations, some modification could be considered , such as, modular ramps or any that could be moved if the individual changes residents. 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. All other community resources should be explored and exhausted prior to expending waiver funding.

Self-Directed Environmental Accessibility Adaptations are only available to those participants who are self-directing personal care, companion and/or LPN/RN services.

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 Title
Agency	Self Directed Contractor
Agency	Contractor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Agency

Provider Type:

Self Directed Contractor

Provider Qualifications

License *(specify)*:

Meets all applicable State (Alabama Code 230-X-1) and Local Licensure requirements.

Certificate *(specify)*:

Other Standard *(specify)*:

All construction, wiring, plumbing meets applicable building codes.

Verification of Provider Qualifications

Entity Responsible for Verification:

Alabama Licensing Board for General Contractors.

Frequency of Verification:

Annual

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Environmental Accessibility Adaptations

Provider Category:

Agency

Provider Type:

Contractor

Provider Qualifications

License *(specify):*

Meets all applicable State (Alabama Code 230-X-1) and Local Licensure requirements.

Certificate *(specify):*

Other Standard *(specify):*

All construction, wiring, plumbing meets applicable building codes.

Verification of Provider Qualifications

Entity Responsible for Verification:

Alabama Licensing Board for General Contractors

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Housing Stabilization Service

HCBS Taxonomy:

Category 1:	Sub-Category 1:
16 Community Transition Services	16010 community transition services
Category 2:	**Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

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).
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.

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

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

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 Title
Agency	DMH Transition Services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Housing Stabilization Service

Provider Category:

Agency

Provider Type:

DMH Transition Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Bachelor's degree in a Human Services field, Business Administration, or Public Administration with at least 24 months of experience in the identification and/or the accessing of housing resources. Human services fields includes the following disciplines: Social Work, Psychology, Criminal/Juvenile Justice, Special Education, Rehabilitation, Counseling, Speech Pathology, Audiology, Nursing, Physical or Occupational Therapy and any related academic disciplines associated with the study of human behavior, human skills development or basic human care needs. Duties require constant contact with officials in the state mental health system, other agencies, housing authorities/organizations and general public.

Verification of Provider Qualifications

Entity Responsible for Verification:

AL Department of Mental Health

Frequency of Verification:

Verification of qualifications will be conducted once. There is no need to re-evaluate.

Appendix C: Participant Services

C-1/C-3: Service Specification

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:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Individual Directed Goods and Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17010 goods and services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

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.

Goods and Services are required to meet the identified needs and outcomes in the individual's person centered plan, are the most cost effective to meeting the assessed need, assures health, safety, and welfare, and are directly beneficial to the individual in achieving at least one of the following outcomes: Improved cognitive, social, or behavioral functioning; maintain the individual's ability to remain in the community; enhance inclusion and family involvement; develop or help maintain personal, social, or physical skills; decrease dependency on formal supports services; increase independence.

Experimental or prohibited treatments are excluded, as well as room and board; items solely for entertainment of recreation; cigarettes and alcohol.

The process begins with the enrollment meeting between the person (and family if applicable) and the self directed liaison. The liaison will review all the employer of record paperwork and discuss the budgetary and employer authority and responsibility. During this meeting the person's budget will be discusses along with what is considered acceptable and not acceptable uses of this service and a spending plan is developed identifying items for purchase. A list will be provided to the person (and family) indicating items that are strictly prohibited. It is also during this time that the person may identify items of interest and the savings plan is developed. These items will be listed on the person's budget and submitted to the FMSA. A copy of the spending plan will be kept in the client record and maintained by the Case Manager. The FMSA will follow their process of working with the individual on procurement and reimbursement, as well as adjust the person's budget accordingly. The FMSA will notify the Regional Office, and the case manager or self-directed liaison of the actual amount spent on Individual Directed Goods and Services monthly.

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

Individual Goods and Services are limited to those individuals self-directing services. The limit on amount is determined individually based on the balance of the individual's savings account at the time of the request which is maintained by the Financial Management Services Agency. annually. The duration of this service is again based on the individual's savings account balance and the individual's participation in self-directed 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. Additionally, 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 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 are to provide the service. This must be documented in the case record.

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 Title
Agency	Home Health Care Agency or Other Merchants or Contractors
Individual	Self Directed Vendor of Goods or Services (Family, friend, neighbor, supportive home care worker)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Individual Directed Goods and Services

Provider Category:

Agency

Provider Type:

Home Health Care Agency or Other Merchants or Contractors

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Typical vendors in the community, according to the goods, services and supports needed. The person's experience/knowledge providing the good and/or service matches the good/service provided.

Frequency of Verification:

Annually or at the time of purchase.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Individual Directed Goods and Services

Provider Category:

Individual

Provider Type:

Self Directed Vendor of Goods or Services (Family, friend, neighbor, supportive home care worker)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Typical vendors in the community, according to the goods, services and supports needed. The person's experience/knowledge providing the good and/or service matches the good/service provided.

Verification of Provider Qualifications

Entity Responsible for Verification:

Self Directed Liaison
Financial Management Services Agency (FMSA)

Frequency of Verification:

Annually or at the time of purchase

Appendix C: Participant Services

C-1/C-3: Service Specification

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:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Occupational Therapy

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11080 occupational therapy
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

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 clients 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.

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

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 5O 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 occupational 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.

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 Title
Agency	Occupational Therapist employed or contracted by a certified agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Occupational Therapy

Provider Category:

Agency

Provider Type:

Occupational Therapist employed or contracted by a certified agency.

Provider Qualifications

License *(specify):*

Occupational Therapists are licensed under the Code of Alabama, 1975 Sec. 34-39-5

Certificate *(specify):*

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

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DMH Certification Surveyors

Frequency of Verification:

Prior to Contract Approval, Annually or Bi-Annually for already approved providers (based on previous survey score), or more often as needed based on service monitoring concerns.

Appendix C: Participant Services

C-1/C-3: Service Specification

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:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Personal Emergency Response System

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Personal emergency response system (PERS) is a service that provides a direct telephonic or other electronic communications link between someone living in the community and health professionals to secure immediate assistance in the event of a physical, emotional or environmental emergency. PERS may also include cellular telephone service used when a conventional PERS is less cost-effective or is not feasible. This service may include installation, monthly fee (if applicable), upkeep and maintenance of devices or systems as appropriate.

The use of these technologies requires assurance that safeguards are in place to protect privacy, provide informed consent, and that documented needs are addressed in the least restrictive manner. The person centered plan should identify options available to meet the need of the individual in terms of preference while also ensuring health, safety, and welfare. Personal risk factors should be discussed, information regarding data collection should be discussed, customized list of individuals/providers to be notified of alerts should be customized, who will be allowed access to data (service provider/staff), and choice should be afforded between providers both equipment and monitoring. The person centered plan should also include the purpose of the PERS, back-up system for PERS in times of electronic outages or failure, training of caregiver (paid and unpaid), provider/caregiver response time for different events, safeguards for protection of the person's privacy related to remote support and data collection. If remote support includes video (in person's bedroom), informed consent must be addressed (and documented) and privacy concerns should be addressed.

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

Emergency Response System installation and testing is approximated to cost $500.00; Emergency Response Monthly Service Fee (excludes installation and testing) is approximated to cost no more than $83.00/month; Emergency Response system purchase is approximated to cost $1,500.00. The maximum cost for all PERS per year is $3000.00

This service will not be authorized for person's receiving residential habilitation. PERS will not replace supervision and monitoring of activities of daily living which are provided to meet requirements of another service (i.e. personal care; day habilitation).

Self-Directed PERS are only available to those participants who are self-directing personal care, companion and/or LPN/RN services.

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 Title
Agency	Self Directed authorized PERS vendor
Agency	Service Provider Agency and authorized PERS vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System

Provider Category:

Agency

Provider Type:

Self Directed authorized PERS vendor

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:

The PERS provider should assure that these devices, where applicable, meet Federal Communication Commission standards or Underwriters Laboratory standards or the equivalent.

The installation of PERS systems should be done by qualified installers representing the health agency managing the personal emergency response system. In the event these installers are not available the agency should seek experienced technicians to complete necessary line adaptations.

PERS Minimum Requirements:
1) Provide an alert button or other mechanism that can be activated by the person to indicate the needs for emergency assistance and/or utilize technology to detect a possible adverse event indicating the need for immediate response.
2) Immediately transmit/communicate the alert to a central clearinghouse that maintains 24/7 immediate/real time recognition of and response to the alert and includes a "failsafe" procedure that assures that every alert for assistance is responded to in a timely manner as defined in the person's person centered plan or PERS parameters.
3) A call tree that reflects the person's needs and preferences.
4) Assurance that any agency or individual who creates, collects, records, maintains, stores, or discloses any individually identifiable participant data complies with the Health Insurance Portability and Accountability Act (HIPAA) and all other data privacy laws and requirements.
5) Address the documented risk factors and preferences of the person.

Verification of Provider Qualifications

Entity Responsible for Verification:

FMSA

Frequency of Verification:

At time of purchase.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System

Provider Category:

Agency

Provider Type:

Service Provider Agency and authorized PERS vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The PERS provider should assure that these devices, where applicable, meet Federal Communication Commission standards or Underwriters Laboratory standards or the equivalent.

The installation of PERS systems should be done by qualified installers representing the health agency managing the personal emergency response system. In the event these installers are not available the agency should seek experienced technicians to complete necessary line adaptations.

PERS Minimum Requirements:
1) Provide an alert button or other mechanism that can be activated by the person to indicate the needs for emergency assistance and/or utilize technology to detect a possible adverse event indicating the need for immediate response.
2) Immediately transmit/communicate the alert to a central clearinghouse that maintains 24/7 immediate/real time recognition of and response to the alert and includes a "failsafe" procedure that assures that every alert for assistance is responded to in a timely manner as defined in the person's person centered plan or PERS parameters.
3) A call tree that reflects the person's needs and preferences.
4) Assurance that any agency or individual who creates, collects, records, maintains, stores, or discloses any individually identifiable participant data complies with the Health Insurance Portability and Accountability Act (HIPAA) and all other data privacy laws and requirements.
5) Address the documented risk factors and preferences of the person.

Verification of Provider Qualifications

Entity Responsible for Verification:

DMH

Frequency of Verification:

At time of purchase.

Appendix C: Participant Services

C-1/C-3: Service Specification

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:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Physical Therapy

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11090 physical therapy

Category 2:	Sub-Category 2:

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

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.

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

Physical 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. Physical therapy is limited to no more than 5O 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.

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 Title
Agency	Physical Therapist employed or contracted by a certified agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Physical Therapy

Provider Category:

Agency

Provider Type:

Physical Therapist employed or contracted by a certified agency.

Provider Qualifications

License *(specify):*

Physical Therapists are licensed under the Code of Alabama, 1975 Sec.34-24-212

Certificate *(specify):*

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

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DMH Certification Surveyors

Frequency of Verification:

Prior to Contract Approval, Annually or Bi-Annually for already approved providers (based on previous survey score), or more often as needed based on service monitoring concerns.

Appendix C: Participant Services

C-1/C-3: Service Specification

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:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Positive Behavior Support

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
10 Other Mental Health and Behavioral Services	10040 behavior support
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

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.

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

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.

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 Title
Individual	Self Directed Board Certified Behavior Analyst or Assistant
Agency	Individual employed or contracted by a certified agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Positive Behavior Support

Provider Category:

Individual

Provider Type:

Self Directed Board Certified Behavior Analyst or Assistant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Board Certified Behavior Analyst or Assistant

Other Standard *(specify):*

Three levels of provider may provide Positive Behavior Support services. The qualifications are as follows:

Level 1: Providers must have either a Ph.D. or M.A. and be certified as a Behavior Analyst (BCBA) by the
Behavior Analysis Certification Board.

Behavior Analysis Certification Board
3323 Thomasville Rd. Suite B
Tallahassee, FL 32308
Phone (850) 386-4444; FAX (850) 386-2404; Web www.BACB.com

Level 2: Providers must have either a Doctoral or Master's level degree in the area of Behavior Analysis, Psychology, Special Education or a related field and three yearsÃ¢ÂÂ™ experience working with persons with Developmental Disabilities. Level 2 providers with a Doctorate do not require supervision.

Level 3: Providers must be either a QIDP (per the standard at 43 CFR 483.430) or be a Board Certified Assistant Behavior Analyst (BCABA). Level 3 providers require supervision averaging at a minimum of one hour per week by either a Level 1 provider or a Level 2 Doctoral provider.

All PBS service providers must complete an Orientation Training. This will consist of training to ensure providers are aware of the minimum standards of practice outlined in the Behavioral Services Procedural Guidelines adopted by the Department. Providers must also complete any additional orientation training refresher courses when BSP Guidelines have been updated. The orientation will be provided by DDD via Department of Mental Health's e-learning software. The DMH will maintain a registry of trained BPS providers and record of their orientation. The provider will maintain a record of who is supervising the Level 3 provider and will make available upon request/audit.

Verification of Provider Qualifications

Entity Responsible for Verification:

FMSA

Frequency of Verification:

Upon enrollment.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Positive Behavior Support

Provider Category:

Agency

Provider Type:

Individual employed or contracted by a certified agency.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Board Certified Behavior Analyst or Assistant

Other Standard *(specify):*

Three levels of provider may provide Positive Behavior Support services. The qualifications are as follows:

Level 1: Providers must have either a Ph.D. or M.A. and be certified as a Behavior Analyst (BCBA) by the
Behavior Analysis Certification Board.

Behavior Analysis Certification Board
3323 Thomasville Rd. Suite B
Tallahassee, FL 32308
Phone (850) 386-4444; FAX (850) 386-2404; Web www.BACB.com

Level 2: Providers must have either a Doctoral or Master's level degree in the area of Behavior Analysis, Psychology, Special Education or a related field and three years experience working with persons with Developmental Disabilities. Level 2 providers with a Doctorate do not require supervision.

Level 3: Providers must be either a QIDP (per the standard at 43 CFR 483.430) or be a Board Certified Assistant Behavior Analyst (BCABA). Level 3 providers require supervision averaging at a minimum of one hour per week by either a Level 1 provider or a Level 2 Doctoral provider.

All PBS service providers must complete an Orientation Training. This will consist of training to ensure providers are aware of the minimum standards of practice outlined in the Behavioral Services Procedural Guidelines adopted by the Department. Providers must also complete any additional orientation training refresher courses when BSP Guidelines have been updated. The orientation will be provided by DDD via Department of Mental Health's e-learning software. The DMH will maintain a registry of trained BPS providers and record of their orientation. The provider will maintain a record of who is supervising the Level 3 provider and will make available upon request/audit.

Verification of Provider Qualifications

Entity Responsible for Verification:

DMH Certification Surveyors

Frequency of Verification:

Prior to Contract Approval, Annually or Bi-Annually for already approved providers (based on previous survey score), or more often as needed based on service monitoring concerns.

Appendix C: Participant Services

C-1/C-3: Service Specification

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:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not

specified in statute.

Service Title:

Skilled Nursing

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05020 skilled nursing
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope)*:

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. A RN is required to perform the supervisory visit every 60 days for a LPN providing this service.
The RN completes an in-home assessment to determine if the services may be safely and effectively adiministered 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 physicians 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.

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

RN/LPN Services must be prescribed by a physician and is based upon the individual's assessed need. The need for continued nursing must be ordered by the individual's physician every year at the time of the annual redetermination.

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.

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 Title
Agency	Registered or Licensed Practical Nurse
Individual	Registered or Licensed Nurse Employed by a Self Directing Participant or Family

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:

Agency

Provider Type:

Registered or Licensed Practical Nurse

Provider Qualifications

License *(specify):*

Nurses are licensed under the Code of Alabama; 1975 Sec.34-21

Certificate *(specify):*

Nurses typically are employed by certified waiver providers, Al. Administrative Code Chapters 580-3-23 580-5-33.

Other Standard *(specify):*

The service(s) of the nurse must be documented by a nursing note that includes the identity and Medicaid number of the consumer, the date of service, the beginning and ending time of the service, and the nursing service(s) provided within that time. In addition the nursing note should include, as appropriate, the nurse's assessment, changes in participant's condition, follow-up measures, communications with family, care-givers or physicians, training or other pertinent information. The nurse must sign and date the note.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Alabama Board of Nursing verifies nursing licenses. DMH Certification Surveyors verify waiver provider certification. The Employer must verify that the RN/LPN has not been debarred from providing Medicaid/Medicare services at initial hiring followed by monthly reviews of INDIVIDUALS EXLCUDED FROM PARTICIPATING INTHE ALBAMA TITLE XIX PROGRAM located on the AMA website and/or the OIG website. Documentation of all checks is required.

Frequency of Verification:

Nursing licenses are renewed annually. Debarrment checks are conducted initially and monthly thereafter. Waiver provider certification occurs prior to Contract Approval, Annually or Biennially for already approved providers (based on previous survey score), or more often as needed based on service monitoring concerns.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:

Individual

Provider Type:

Registered or Licensed Nurse Employed by a Self Directing Participant or Family

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

The FMSA (Financial Management Services Agency)will hold the provider enrollment by permission of the Alabama Medicaid Agency.

Note that a nurse, either an RN or an LPN, may work for an agency and also work for an individual or family, so long as there is no duplication of payment or conflict of interest. Either issue would involve the nurse working for an agency which also provides direct services to the participant who is self-directing his or her personal care. Because both the agency's service and the self-directed service will need to be prior authorized (all waiver services are prior authorized from the plan of care), this potential conflict / duplication would be apparent to the Operating Agency, which will ensure it does not arise.

The service(s) of the nurse must be documented by a daily nursing note that includes the identity and Medicaid number of the consumer, the date of service, the beginning and ending time of the service, and the nursing service(s) provided within that time. In addition the nursing note should include, as appropriate, the nurse's assessment, changes in participant's condition, follow-up measures, communications with family, care-givers or physicians, training or other pertinent information. The nurse must sign and date the note daily

Verification of Provider Qualifications

Entity Responsible for Verification:

The Alabama Board of Nursing verifies nursing licenses. The FMSA (Financial Management Services Agency) will verify the nurse is Licensed, The employer must verify that the RN/LPN has not been debarred from providing Medicaid/Medicare services at initial hiring followed by monthly reviews of INDVIDUALS EXCLUDED FROM PARTICIPATING IN THE ALABAMA TITLE XIX PROGRAM located on AMA website and/or the OIG website. Documentation of the checks is required.

Frequency of Verification:

Licenses for Nursing are renewed annually. The FMSA verification will be annual as well. The exclusion list must be checked monthly by the employer. Documentation is required to ensure the checks are completed each month.

Appendix C: Participant Services

C-1/C-3: Service Specification

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:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Specialized Medical Supplies

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14032 supplies
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

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.

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

Supplies reimbursed under this service shall not include common over-the-counter personal care items, supplies otherwise furnished under the Medicaid State plan, 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. 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.

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 Title
Individual	Self Directed Medical Supply Provider
Agency	Specialized Medical Supplies

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Supplies

Provider Category:

Individual

Provider Type:

Self Directed Medical Supply Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Authorized Medical Supplies Vendor

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS

Frequency of Verification:

initially and annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Supplies

Provider Category:

Agency

Provider Type:

Specialized Medical Supplies

Provider Qualifications

License *(specify):*

Business License

Certificate *(specify):*

Certified by the Board of DME and DMH Certification

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DMH/DD Certification

Frequency of Verification:

Prior to contract, annually and biennially

Appendix C: Participant Services

C-1/C-3: Service Specification

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:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Speech and Language Therapy

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11100 speech, hearing, and language therapy
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

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 habilitation 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 individuals 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 clients 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.

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

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.

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 Title
Agency	Speech Therapist employed or contracted by a certified agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Speech and Language Therapy

Provider Category:
Agency
Provider Type:

Speech Therapist employed or contracted by a certified agency.

Provider Qualifications

License *(specify):*

Speech Therapists are licensed under the Code of Alabama, 1975 Sec. 34-28A-1, Ch. 870-x-1-7

Certificate *(specify):*

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

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DMH Certification Surveyors

Frequency of Verification:

Prior to Contract Approval, Annually or Bi-Annually for already approved providers (based on previous survey score), or more often as needed based on service monitoring concerns.

Appendix C: Participant Services

C-1/C-3: Service Specification

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:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Supported Employment Transportation

HCBS Taxonomy:

Category 1: 15 Non-Medical Transportation

Sub-Category 1: 15010 non-medical transportation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

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.

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

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.

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 Title
Agency	Certified Waiver Hourly Services Provider
Agency	Certified Day Habilitation Program
Agency	Public Mass Transit
Agency	Taxi or Common Carrier (Uber, Lyft)
Agency	Residential Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Employment Transportation

Provider Category:

Agency

Provider Type:

Certified Waiver Hourly Services Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

Must have valid driver's license and insurance as required by State Law.

Verification of Provider Qualifications

Entity Responsible for Verification:

DMH/DDD Certification Surveyors

Frequency of Verification:

Prior to Contract Approval, Annually or Bi-Annually for already approved providers (based on previous survey score), or more often as needed based on service monitoring concerns.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Employment Transportation

Provider Category:

Agency

Provider Type:

Certified Day Habilitation Program

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

If providing transportation, must have valid driver's license and insurance as required by State Law.

Verification of Provider Qualifications

Entity Responsible for Verification:

DMH/DDD Certification Surveyors

Frequency of Verification:

Prior to Contract Approval, Annually or Bi-Annually for already approved providers (based on previous survey score), or more often as needed based on service monitoring concerns.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Employment Transportation

Provider Category:

Agency

Provider Type:

Public Mass Transit

Provider Qualifications

License *(specify):*

Certificate *(specify):*

CDL License

Other Standard *(specify):*

Those who want to drive school buses, church buses, shuttles or charter buses carrying 16 or more passengers, must get a Commercial Driver's License Endorsement Class C on their regular driver's license.

Verification of Provider Qualifications

Entity Responsible for Verification:

AL Department of Public Safety: Commercial Driver's License Office.

Frequency of Verification:

Every four years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Employment Transportation

Provider Category:

Agency

Provider Type:

Taxi or Common Carrier (Uber, Lyft)

Provider Qualifications

License *(specify):*

Valid driver's license (called a Class D).

Certificate *(specify):*

Other Standard *(specify):*

Taxi drivers and chauffeurs in Alabama are required only to have a regular current, valid driver's license (called a Class D) and a business license, to operate.

Verification of Provider Qualifications

Entity Responsible for Verification:

AL Department of Public Safety: Local Driver's Licensing Office or Probate Court.

Frequency of Verification:

Every four years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Employment Transportation

Provider Category:

Agency

Provider Type:

Residential Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

AL Administrative Code Chapters 580-3-23, 580-5-33

Other Standard *(specify):*

Person's providing transportation to individuals receiving services must have a valid driver's license and insurance as required by state law

Verification of Provider Qualifications

Entity Responsible for Verification:

DMH/DDD Certification

Frequency of Verification:

Prior to Contract Approval, Annually or biennially for already approve providers (based on previous survey score, or more often as needed based on service monitoring concerns

Appendix C: Participant Services

C-1/C-3: Service Specification

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:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Supported Living Service

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08010 home-based habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Supported Living Services (SLS) shall mean 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.

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

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, Respite or Transportation as separate services, except for Supported Employment Transportation and Personal Care at the Worksite. 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.
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.

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 Title
Agency	Supported Living Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Living Service

Provider Category:
Agency
Provider Type:

Supported Living Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Meeting all requirements for qualification outlined in 580.-3-23 and 580-5-30

Other Standard *(specify):*

The Supported living provider must meet the general requirements for the In-Home Residential specifications outlined from previous waivers. An applicant wishing to provide SLS does not need to provide evidence of compliance with fire and health standards because the service will be provided in the individual's home, but not in the home with the family for SLS. Instead, a new applicant shall submit to the Division a written plan in the form of a proposal, together with an application for programmatic certification, describing how the programmatic standards referenced above will be met. Certification surveys will follow the standards for Hourly Service Providers, and may include visits to the homes of individuals being served.

When the application, supporting data, and site visit, if applicable, prove the program or service is in full compliance with certification requirements, a certificate will be issued by the Division of Developmental Disabilities.

Subsequent site inspections shall be scheduled in accordance with policy and procedures of the Office of Certification. Programmatic re-surveys are conducted at one or two year intervals depending on the previous survey outcome.

Programs delivering SLS shall have a written mission statement for dissemination to prospective clients and their families. This mission statement shall address:

Program philosophy and purpose;
Geographical area served;
Range of services provided; and
Population served, including criteria for service eligibility, program admission and program discharge.

SLS services will be delivered/supervised by a QIDP in coordination with the individual's plan of care. Providers must have documented record of having completed training prior to providing services. Providers of service must maintain a service log that documents specific dates on which services were delivered, consistent with the consumer's person centered plan.

The Department of Mental Health, Division of Developmental Disabilities requires certification of programs delivering Supported Living as a in home residential type service. Site inspections and/or Life Safety inspections shall be scheduled in accordance with policy and procedures of the ADMH/DDD only when there are documented concerns regarding the individual(s) health, safety and/or welfare. Programmatic re-surveys are conducted at one or two year intervals depending on the previous survey outcome.

Each SLS program must develop and maintain appropriate,up-to-date staffing to provide adequate services as outlined in the PCP and POC. Program staff ratios and staff work schedules shall be maintained to meet the needs of individuals. An emergency, on-call staff person, in addition to those normally required to maintain appropriate staffing patterns, shall be available on a 24/7 basis for each individual. Staff scheduling and work place assignments shall be so arranged as to provide services to meet individual needs. Since this service provides supported living, the staffing pattern shall be appropriate to the type and scope of programmed services and shall include staff members who meet qualifications set forth in the approved job descriptions.
Supported Living services will be supervised by a QIDP in coordination with the individual's person centered plan. The role of the QIDP is to ensure services are delivered as outlined in the PCP, POC and are based on individual need.

Qualifications:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with AMA and ADMH Policies/Procedures
5. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

6. All providers must comply with ADMH/DD policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

7. Must have an annual TB Skin test.

Documentation:

Providers must have documented record of having completed training prior to providing services. Providers of service must maintain a service log that documents specific dates on which services were delivered, consistent with the consumers plan of care. All service visits should be signed by the individual being served at each visit. Each visit signature must be original. Copied signatures will not be accepted.

An applicant wishing to provide Supported Living Services under this waiver does not need to provide evidence of compliance with fire and health standards because the service will be provided in the individual's home. Instead, a new applicant shall submit to the Division a written plan in the form of a proposal, together with an application for programmatic certification, describing how the programmatic standards referenced above will be met. Certification surveys will follow the standards for Hourly Service Providers, and may include visits to the homes of individuals being served.

When the application, supporting data, and site visit, if applicable, prove the program or service is in full compliance with certification requirements, a certificate will be issued by the Division of Developmental Disabilities.

Subsequent site inspections shall be scheduled in accordance with policy and procedures of the ADMH/DD Division. Programmatic re-surveys are conducted at one or two year intervals depending on the previous survey outcome.

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH/DD Certification

Frequency of Verification:

Annually or biennially according to survey scores.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.

◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☒ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Local agencies established under Act 310 of the Alabama Statutes and Regional Offices of the Division of Developmental Disabilities.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Executive Officers and owners of provider agencies must obtain both a statewide and a national criminal background clearance. This is a condition for initial certification. This is the responsibility of the Life Safety Division of the Operating Agency. Direct care staff must have a background check from local law enforcement, and a statewide or national check as indicated by the staff member's previous residences and work history. If a person's information as presented garners no results through local and/or state background checks, the national background check is warranted. Or, if information provided indicates experience in another state, a national background check may be warranted. This is checked as a component of the certification survey. ADMH will check the exclusion list at AMA and the OIG websites to ensure the applicant provider has not been previously debarred.

A completed application for certification must be sent by the provider/applicant to DMH Facilities Certification Office (Life Safety) at least sixty (60) days prior to projected date of service implementation. The application process must be completed and temporary operating authority granted by the Commissioner prior to the implementation of any services by the provider. Any additional documentation must be submitted as required and specified by DMH.

DMH may accept a certification/license/ accreditation issued by other generally accepted recognized state or national organizations in lieu of an additional review through the DMH certification process. However, DMH reserves the right to apply DMH certification standards to areas it determines are not adequately addressed in other state or national standards. Further, the DMH reserves the right to conduct reviews, including onsite visits if appropriate, of programs that are certified/licensed/accredited by other entities where there is evidence of significant deficiencies.

The DMH Certification Office submits the application to the respective DMH Division(s) for approval according to the type(s) of services proposed by the provider.

The applicable DMH Division(s) review/approve the application and returns a copy of the approval to the DMH Facilities Certification Office. An initial Life Safety and Programmatic review is conducted, if applicable, by designated DMH representatives. Applications remain valid for up to six (6) months after receipt by DMH if the service has not been initiated by the provider or approved by DMH.

For new applicants/providers, the DMH will conduct criminal background checks on the primary operator and/or subcontractor of the program as defined in the Alabama Administrative Code, Section 580 3 23 .06(1)(a) and Section 580 3 23 .06(1)(b).

Once the provider completes the application process, and based upon its representations of compliance with applicable DMH standards, the program is issued a letter of Temporary Operating Authority by the DMH Commissioner allowing it to operate for a period up to six (6) months pending the outcome of its initial certification site visit.
Author: DMH Office of Certification
Authority: Code of Ala. 1975, §22 50 11.

All employees/volunteers/agents of the provider have reference and background checks prior to employment. Background checks cover the employer’s local vicinity and state. National checks are completed when the person's job history is out of state or there is sufficient reason to warrant one (no record found in local or state systems). Resources to assist in this process include the Department of Public Safety, the Department of Public Health’s Abuse Registry, as well as DMH’s Term-Trac database. Drug testing is included as part of the pre-employment screening process for employees whose job duties involve the care, safety and wellbeing of people and on reasonable suspicion (for-cause) of any employee of the organization. The organization does not hire people who have been convicted of felony crimes.

The Medicaid Re-enrollment process that is on-going assumes the responsibility of ensuring Executive Directors and owners are not listed in any federal exclusion lists.

For participants who are self-directing services, all staff employed by the participant will have a criminal background check completed by the FMSA (Financial Management Service Agency) via internet. Nurses already are licensed by the Alabama Board of Nursing, which includes background screening. Participant's representatives may also be subject to background checks if needed. The Operating Agency reviews this information on a quarterly basis.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

- (●) **No. The state does not conduct abuse registry screening.**
- ( ) **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- (●) **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- ( ) **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- (●) **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ( ) **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

☐ **Self-directed**

☐ **Agency-operated**

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

○ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**

◉ **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

Waiver services can be made to family members who are not 1) parent to child, 2)Spouse to spouse,3) child to parent or 4) family members who are legally responsible for the participant. Other family members must meet all other hiring requirements and qualifications to perform the duties.

○ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

The Operating Agency holds semi-annual orientations for individuals and agencies interested in enrolling in any of the programs and services offered by the Alabama Department of Mental Health, including the waiver programs. This orientation is advertised on the Department's website as a necessary step in becoming enrolled, and details and contact information is included in the advertisement, copied and reprinted below.

The Alabama Department of Mental Health has oversight for a broad network of care, treatment, programs, and services that specifically enable persons with mental illnesses, developmental disabilities, or substance abuse disorders to reside in communities. Individuals and organizations that provide services or are interested in providing such services in your communities must meet certain requirements and must be certified by the Alabama Department of Mental Health.

To begin the process, prospective providers must complete two training courses designed to provide essential information about the certification process, including information on life safety and physical facility standards, nurse delegation, criminal background checks, programmatic requirements, and certification administration, as well as instruction on how to complete the certification application.
* The first course is an online course; this course provides information that will give individuals a general idea of the certification requirements. It includes a test at the end, and a certificate may be generated as verification of completion. Prospective providers should click on the ADMH Education Website to complete the online course. * On successful completion of the online course, prospective providers should register to attend the one-day mandatory live orientation program called "Prospective Community Provider Orientation". This live orientation is presented in an open forum format that provides instruction as well as an opportunity for prospective providers to have their questions answered. Throughout the day, knowledgeable ADMH staff will be available to serve as resources for beginning the certification process. Provider applicants may register for the live orientation program by downloading the registration form by clicking on link below. You must complete the registration form and submit it as instructed on the form, along with the online course completion certificate and the non-refundable $75 registration fee.

A completed application for certification must be sent by the provider/applicant to DMH Facilities Certification Office (Life Safety) at least sixty (60) days prior to projected date of service implementation. The application process must be completed and temporary operating authority granted by the Commissioner prior to the implementation of any services by the provider. Any additional documentation must be submitted as required and specified by DMH.

Once the provider completes the application process, and based upon its representations of compliance with applicable DMH standards, the program is issued a letter of Temporary Operating Authority by the DMH Commissioner allowing it to operate for a period up to six (6) months pending the outcome of its initial certification site visit.
.

If applicant providers have questions about the class registration process, they may contact the DD Certification Division at the telephone number listed on the department's website.

Links found on ADMH website:

ADMH Continuing Education Website for Mental Health Providers and Professionals
* Instructions for Accessing and Completing the Online Course
* Prospective Community Provider Orientation Registration Form
* To Confirm Receipt of Your Registration

Prospective providers are encouraged to visit other areas of the Alabama Department of Mental Health website, including Certification Administration, Life Safety and Technical Services, Nurse Delegation Program, and the Bureau of Special Investigations, which are all areas involved in the certification process. There are many other resources available through each of the department's service divisions - Developmental Disabilities (formerly Intellectual Disabilities or Mental Retardation) and the division of Mental Illness and Substance Abuse. You may also find an abundance of general information on the Internet under the small business administration websites that will give you insight on starting a business in Alabama.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States

methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of new contracted providers that met initial licensure and/or certification standards and other standards established by Medicaid. Numerator:# of new contract providers meeting initial licensure/certification standards established by Medicaid. Denominator: All new contracted providers

Data Source (Select one):
Other
If 'Other' is selected, specify:
Certification Surveys

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of existing contracted providers that continue to meet licensure and/or certification standards and other standards established by AMA. Numerator: # of existing contracted providers that continue to meet licensure and/or certification standards and other standards established by AMA. Denominator: All existing contractor surveys.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Certification Surveys

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Providers which score above 89% are given a two-year certificate and certified less than annually.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of enrolled self directed employees who continue to meet waiver training requirements. Percent equals the number of currently enrolled providers that continue to meet state training standards/requirements divided by the total number currently enrolled providers.

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence

		Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of new self-directed employees/staff that meet state

requirements. Percent equals number of new self directed employees that meet state requirements divided by the number of new self directed employees/staff.

Data Source (Select one):
Other
If 'Other' is selected, specify:
FMSA employee enrollment packet

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: FMSA	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of non-licensed/non-certified providers that met state compliance requirements. Numerator: Number of non-licensed/non-certified providers that met state compliance requirements. Denominator: Number of Non licensed/non-certified providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Certification Surveys

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are

identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of providers that meet training requirements in accordance with state requirements in the approved waiver. Numerator: Number and Percent of providers that meet training requirements in accordance with state requirements in the approved waiver. Denominator: Number of providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Certification Surveys include Record Reviews Onsite and Onsite Observation, Interviews and Monitoring

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Provider agencies are certified initially and either annually or biennially, or placed on provisional status, depending on their survey score. A high score will result in a two-year certificate; a score between 80 and 89 will result in a one-year certificate; and a score below 80 will result in the agency being placed on provisional status.

Provisional status is a temporary condition which allows an agency to submit a plan of correction and, when approved, implement that plan. Provisional status may not exceed 60 days, and many such status conditions are set at 30 days or less. At the end of that period, a re-survey is conducted, with the expectation that the agency will at least score high enough to give them a one-year certificate. However, should the agency score less than 80 on the re-survey, the certification unit may recommend a second provisional status, which also may not exceed 60 days in length. A follow-up re-survey is conducted at the end of the second provisional period, and if the provider does not score at least an 80, a recommendation is forwarded to the Commissioner of the DMH to de-certify the provider agency.

In addition to the routine certification surveys, the Operating agency may also conduct for cause surveys, in response to concerns or complaints about treatment and care of participants. Frequently the result of a for-cause survey is that the agency gets put on provisional certification and is required to submit and implement a plan of correction.

During a process in which a provider agency is in provisional status, the Regional Offices and Advocacy Section of the operating agency provide increased monitoring and technical assistance. This is both to assure basic health and welfare of the individuals receiving services and to assist the provider agency in coming into compliance.

With regard to performance measure a.i.b. above (non certified providers), this measure only applies to staff employed by consumers / families under the self direction described in Appendix E. If, during the ongoing review of records supplied by the FMSA non-qualified staff are found, payments to those staff will be recouped.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified

strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- (●) **Not applicable-** The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ( ) **Applicable -** The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Each provider has completed a self-assessment for each site that is entered into the ADIDIS system. The monitors at the RO will validate the information for each provider site. For each site found out of compliance, the provider will submit a Transition Plan that will develop the steps needed to become compliant with the HCBS rule. The monitors, and Quality Enhancement staff in each of the RO will be available to work closely with each provider to provide the technical assistance needed until October 2021. By the October deadline, the DD Division will have ample time to begin the process of moving individuals from those provider sites that will not come into compliance, into those that will. Any provider who may be subject to heightened scrutiny will be listed and the compiled list sent to CMS via AMA by the deadline in July 2021. In October, 2021 the final list of settings identified to submit for the heightened scrutiny process will be sent to CMS. Any setting identified that are on the grounds of an institution or adjacent to an institution information will be sent to CMS immediately. The DD Division will continue to work with all providers so that all will be compliant on March 17,2022. On-going monitoring will be completed through the regional office routine monitoring visits. Support coordinators will complete the Individual Experience Assessment on each participant annually to further ensure ongoing compliance. For cause reviews may also be conducted as deemed necessary. Certification staff will be monitoring on the regularly scheduled visits as well. A list of providers who are not compliant as of July 2020 required by CMS will be sent by the deadline. Currently, all providers require some form of remediation.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Person Centered Plan

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- ☐ **Registered nurse, licensed to practice in the state**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☒ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
  Specify qualifications:

A four-year college degree in a human service-related field and completion of a specified course of instruction approved by the Alabama Medicaid Agency and the Department of Mental Health. Support Coordinators must complete an on-line training available on the ADMH website and complete the test with a passing score. In addition, each Support Coordinataor must receive an additional six (6) hours of training during the waiver year. All training attended must be documented in the Support Coordinator's personnel file.

☐ **Social Worker**
Specify qualifications:

☐ **Other**
Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

○ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

◉ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

ADMH/DD division will institute the following corrective action plan to come into compliance with conflict-free case management. Of the 29 case management entities-310 Boards who have legislative authority to provide case management service-25 currently are not conflict free. Each of the 25 received written notification that it will have to make a choice as to which services it will provide for waiver participants; case management or other waiver services. Each entity submitted its plan of action outlining the steps it will implement to become conflict free by December 31, 2019. Each plan will also outline how the transition of participants to another provider for services needed will be completed. ADMH/DDD Central Office staff reviewed each plan to ensure that the provider chooses either the delivery of case management services, or other waiver services and determine appropriateness of each. The CO reviewed the transition plan to ensure that participant needs are not compromised and service delivery continues during this process. The process of identifying gaps in service areas is still ongoing based on plans reviewed. On May 22, 2019 the CO issued a RFP to identify qualified case management entities willing to provide case management services in the counties that are identified uncovered or where a provider presents as a sole provider in that county. Based on the proposals received, the CO will choose new entities to provide case management services in those counties of the state. Although ADMH/DDD expects to be fully compliant at this point, if any county is left without a case management entity, the CO will do one of two things; hire case managers who directly work to provide case management as CO employees, or allow the current case management entity to continue the case management services only if the following conditions are met:
1)Provides full disclosure to participants and assurances that participants are supported in exercising their right of free choice in providers and the ability to choose to receive services in non-disability specific settings of their choice. 2)Describes individual dispute resolution process. 3)Assures that entities separate case management and service provision (different staff). 4)Assures that entities provide case management and services only with the express approval of the state. 5)Provides direct oversight and periodic evaluation of safeguards.
To assure these conditions are met, ADMH/DDD has:1) developed a disclosure form that must be signed by each participant denoting freedom of choice in service providers. This form will include a list of provider agencies that the participant can choose to deliver services. This form must be present in the individual's case file and completed at the time of initial eligibility, annually, at the time of the participant's redetermination, at readmission, or any time during the participant's eligibility period that a change in service(s) occurs.
2)If a waiver participant has a problem with the case manager or service delivery provider, the process for resolution is for the participant/family to contact the Central Office, Community Service Regional Office Director, or the Central Office Advocacy office who will investigate and follow to resolution. The contact information and process will be provided in written form to each participant at least annually. The waiver participant will sign a copy of the resolution process form that will be placed in the individual case file and will receive a copy of the form for his/her personal records for future reference. All contact information must be placed in a conspicuous area within the provider location that is easily visible to program participants, and will be placed on ADMH's public website.
3)Each case management entity's contract with the CO will be amended to include a statement agreeing to the division of case management services from other service provision. This addendum will require signature by the provider. For the entities where the potential for COI remains, the RO will be notified to increase its monitoring of that entity to ensure separation of staff delivering services. Any entity violating the signed agreement will be automatically placed on provisional status and the CO notified immediately. The provider must institute corrective action immediately to avoid breach of contract or the decertification process will begin. The Regional Office staff will monitor any case management providers affected, on at least a quarterly basis, preferably unannounced, or at any time for cause. All findings of these visits will be documented by the RO staff. Implementation of conflict free case management and COA will be completed by December 31, 2019.
4)Additionally, the OA will review the provider affected to ensure that the supervision of case managers and supervision of those providing services are separated administratively. Language will be placed in each contract requiring the separation of supervision in administration. Any provider found violating this section of the contract will be placed on provisional status automatically. The provider must institute corrective action immediately to avoid breach of contract or the decertification process will begin. The Regional Office staff will monitor providers affected, on at least a quarterly basis, preferably unannounced, or at any time for cause.All findings of these visits will be documented by the RO staff and the CO notified of findings.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

A) The individualized planning process is a uniquely blended approach that includes the use of a variety of tools that individuals/families/legal representatives can utilize to prepare for the person centered plan meeting. The tools are designed to prompt the individual and families/legal representatives to goals and objectives that will help identify service needs based on individual desires and preferences prior to the planned meeting.
B) The individual directs the meeting and may invite any person he/she deems appropriate for inclusion and sets the time and place for the meeting. Support Coordinators invite all to attend the meeting.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Overview: There is a global service plan (Person Centered Plan) that is developed with the individuals, family/guardian and friends as appropriate and other persons that provide services and supports to the individual, as appropriate in the planning process, i.e. PT, OT. The Support Coordinator facilitates and writes the PCP. Once the individuals goal and objectives are identified, waiver and non-waiver services are categorized. The Support Coordinator then briefly summarizes all areas of needed services and supports on the individual Plan of Care along with services and supports that the individual is currently receiving regardless of the funding source.

a. Who Develops the Plan, who participates in the process, and the timing of the plan?
The individual's team chosen by the individual (family/guardian & friends, as appropriate, Support Coordinator, QIDP,and/or all other persons providing services and supports to the individual) is responsible for development of the individual's person centered plan. Invitations are extended to, and efforts are made to include, all persons that the individual requests to be invited to his/her meeting. Other specialty areas may not be present at the meeting but may provide written input such as a physician's report or PT/OT evaluations, etc. Each individual has on planning each year and is in control of when and where the meeting occurs.

b. The types of assessments that are conducted to support the person centered plan development process, including securing information about participant needs, preferences and goals, and health status?
The Support Coordinator collects a history of the individual and family prior to the team meeting. Assessments may include: Functional needs assessment, Level of care screening tool, ICAP, Medical Assessments, Clinical Assessments(if indicated, vocational assessments (as appropriate), IEP (if appropriate) informal assessments and observations, informal conversations with the individual/guardian/family, friends and providers,Person Centered Planning Tools. Optional Tools for the planning are: My Preferences-What works for Me; What Doesn't Work for Me, Places I Go, Decisions and Choices I Make Vs. Others Make for Me, My Gifts and Competencies, Lifecourse Trajectory, Lifecourse Integrated Support Star and Tools for Developing a Vision. The PCP meeting itself produces extensive information identifying the individual's preferences, goals and objectives.
From the information gathered before and during the team meeting, a person centered plan is developed, which is essentially an action plan.
c. Once there is a determination of needs from the person centered planning process,information is provided to the individual and/or family by the case management agency (Support Coordination or an intake specialist),regarding providers in their respective area, that offer the services and supports they are requesting. Direct service providers and the Regional Community Services Office also make information available. Visits are arranged, upon request, to the various service provider's sites to give individuals an opportunity to make an informed decision about their services and supports.

d. How the plan development process ensures that the service plan addresses participant goals, needs (including health care needs) and preferences?
The person centered plan is developed with the individual, family/guardian and friends as appropriate and other persons that provide services and supports to the individual as appropriate. The plan identifies individual strengths as well as areas where the individual requires supports. The individual's information that is gathered before and during the team meeting is very thorough and identifies all areas of needed services and supports, and clearly delineates the individual participant's preferences. Individuals are assisted in obtaining preventive and routine health services including physical examinations, immunizations and screenings that are consistent with their age and risk factors as recommended by their personal physician. Preventive health care strategies/interventions contained in the person centered plan, based on the person’s current health status and age, are implemented and will be carried out according to the Centers for Disease Control recommendations regarding preventive/screening practices. Emphasis will be placed on age specific screening tests. Each person’s person-centered plan indicates his/her health needs and outlines specific actions and time frames to address these needs. Actions taken are documented. Health needs include, but are not limited to, physical, neurological, dental, nutrition, vision, hearing, speech/language, PT/OT and psychiatric services. As part of the person centered plan, health care plans and supports are modified in a timely manner based upon acute health care changes.

e. How waiver and other services are coordinated?
The service plans address all supports and services an individual is to receive, including both services provided through the waiver and services provided through other means. For each need, the plan must describe the service or support which will meet that need, and who will provide it. Support Coordinators are responsible for coordinating services provided by other agencies or individuals and monitoring the provision of services during routine monitoring visits.

f. How the plan development process provides for the assignment of responsibilities to implement and monitor the plan. The action plan will outline what everyone is to do to implement the plan, and the Support Coordinator's responsibilities will include monitoring the plan's implementation. The direct service provider has the first responsibility for monitoring its own services to assure the implementation of the person centered plan and the participant's health and welfare. External monitoring, however, is also in place. The Support Coordinator, as stated above, monitors/reviews services, and does so on a quarterly basis as a minimum. In addition, The Regional DMH Office provides a 6 month minimum visit/review to each service site and a semi-annual random review of the Support Coordinator records. Additionally, The DMH Programmatic Certification offices have monitoring of the person centered plan responsibility. If a provider fails to comply that specific indicator will be marked accordingly which impacts the assurance score and ultimately the overall certification score. Other monitoring and technical assistance reviews are completed by DMH Advocacy office and DMH Quality Enhancement office. When concerns are identified to the state/regional office, technical assistance needs are established and timeframes for the needed follow-up actions or additional reviews as appropriate.

g. How and when plans are updated, including when the participant's needs change?
Person Centered Plans are subject to continuous revision based on changes in the individual's condition and/or on assessed need or newly identified goal. However, at a minimum, the entire team performs a formal review at least annually. The Support Coordinator will maintain at least quarterly contact with each individual or their family or guardian. During quarterly contact, the Support Coordinator will monitor the individual's health and welfare. Progress notes will document the contact and whether the outcomes stated in the person's plan are occurring.

It is also the Support Coordinator's responsibility to review the provider's notes at least quarterly, and note any problems, discrepancies, dramatic changes or other occurrences that would indicate a need for renewed assessment. This review of the provider notes will include making further inquiries and taking appropriate action if there is reason to believe the person's health or welfare is potentially at risk.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The team, through the development of profile information, brings out and documents elements of risk, and describes those actions and actors who will compensate for risk elements. This function is accomplished through profiles such as:

"What is important to me?" (the participant)
"What is my current health?" (with prompts for both positive and negative attributes)
"What are my daily routines?"
"What choices do I get to make?"
"What works for me and does not work for me?"
"What are our hopes and fears?" (Optional - used specifically to discuss risks)
"What are the barriers and opportunities?" (Optional - used specifically to discuss risks)
"What do the team and others need to know and do to support me?"

Information pulled into the plan may show several risks, but do so in the most objective, person centered way possible, without setting up a section for "problem behavior" or "risk abatement." When the team develops the action plan, and an objective is going to involve a degree of risk, the objective describes who is going to do what to minimize that risk, whether that be providing experiential learning for the participant, or paving the way by discussing issues beforehand with people with whom the participant is going to come into contact with, or ensuring that direct support staff have the necessary training and resources to support the participant in meeting the objective safely. The family and the provider QIDPs frequently take the lead in designing strategies to accommodate and mitigate risk. Any restriction is noted in the person centered plan and must be monitored by all parties within the timeframes to assess the effectiveness of the plan. All restrictions are expected to fade within a given timeframe, depending on individual behaviors. Both are required elements of the PCP.
In addition, an Individual Safety Assessment is completed during the plan meeting. This assessment addresses more straight forward risk factors such as ability to evacuate in case of a fire, ability to call for help, or does the person need special modification for emergency planning. Each individual should be trained and understand their emergency plan.

Each person should have an individualized emergency plan. People are supported to become knowledgeable about how to access emergency medical care and to access it as needed. Medication ordered by a physician to respond in a potential emergency is available in the appropriate dose, quantity and form. Organizations have emergency plans to deal with a variety of situations and accommodate the individual needs of people. Emergency contact numbers are readily available and accessible to staff and people receiving supports. Information (general topics) which will be discussed in a person-centered planning meeting is presented and communicated to the person in a method he/she understands and/or to the legally authorized representative prior to the scheduled meeting, except in the event an emergency meeting is necessary.

In addition to administrative requirements in Chapter 580-5-33-.3 through .10 and .12 through .13, the organization provides training to staff on the services to be provided and how the person wants to be supported. This training includes:

(a) Review of the person-centered plan.

(b) Information about the specific conditions and required supports of the person to be served, including his/her physical, psychological or behavioral challenges, his/her capabilities, and his/her support needs and preferences related to that support.

(c) Reporting and record keeping requirements.

(d) Procedures for arranging backup worker when needed.

A person-centered plan is developed and approved for the person receiving services; there is documentation establishing that the plan is followed and is modified as needed.

(a) The person-centered plan is adequately detailed so that the worker can provide the services required by the individual.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

An individual coming into services, initially and after the person centered planning process, is provided information about services and supports by the 310 agency. Other providers and/or the Regional Office may also provide information, but the lead responsibility resides with the Support Coordinator. The individual and family verify their choice(s) of provider(s) by signing a document that lists that (those) choice(s). The individual and/or family/guardian are again provided information and an opportunity to exercise choice at the individual's annual review meeting, as well as, choosing providers when other services are added to the POC. If the individual decides prior to the annual review meeting that he /she wants to change current services, a special team meeting is convened with Regional Office staff and/or a DMH Advocate included to address concerns and ensure information is provided about other available services and supports.

The Dissatisfaction of Services form is presented to each waiver participant and his/her family/representative as part of the planning process, and each participant or family/ representative must sign, acknowledging receipt of the information regarding his/her right to a hearing. The individual's signature on the free-choice of provider form, and on the plan of care, combined with the information presented in the Dissatisfaction of Services Form, assures the person is aware of his/her right to choose the services and providers he/she wants.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

Medicaid nurses conduct a scientifically calculated random record review each month of all plans of care for persons initially enrolled or re-determined for waiver services during the previous month. These records are made available through the case management entity and the Regional Community Services Office. Service Plans are also required to be maintained by the service provider and can be made available upon request. In addition, Medicaid Quality Assurance staff perform a separate review of a random sample of plans of care and related documents annually for each provider, to assure the individuals receiving services under the waiver have a plan of care in effect for the period of time the services were provided. This review also ensures that the need for the services that were provided was documented in the plan, and that all service needs were addressed in the plan of care prior to delivery.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

☐ **Medicaid agency**

☒ **Operating agency**

☒ **Case manager**

☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The services and supports that are provided to an individual are based on a person centered plan (PCP) developed by a team based on the goals identified during the planning process.

Monitoring the implementation of the PCP and the participant's health and welfare is the responsibility of the support coordinator, the direct service provider, and members of the planning team as specified in the action plan (who is to follow-up on specific objectives is spelled out in the PCP), the support coordinator, Regional Community Services Office (RCSO), Certification staff, and Protection and Advocacy. The support coordinator reviews the services provided to an individual against the PCP quarterly at a minimum The support coordinator has an in-person follow-up with the individual at least once per quarter, and reviews individual satisfaction with the services provided, the adequacy of these services, and the individual's need or desire, if any, for the planning team to reconvene. If issues arise that adversely affects the individual's health or welfare, such as lack of staff based on the PCP, the Behavior Support Plan and/or the staffing plan, the support coordinator will notify the DMH Regional Community Services Office, which will intervene immediately.

The RCSO monitors both the implementation of the plan and the participant's health and welfare as part of the Participant-Centered Planning and Service Delivery waiver assurances. On an on-going bases the RCSO monitor will pull a sample of waiver participant’s PCP to ensure compliance with the waiver which includes reviewing staffing patterns, ensuring individual emergency plans are being followed, and incidents are being reported. If there is an instance where staffing is inconsistent with the individual plan the RCSO monitoring report will summarize the findings, including notation if a plan of action is needed, if so when is it needed and what is it to cover, and notation of planned follow-up by the RCSO if needed, and when and how (in person, letter or telephone). The RCSO may request that an incident report be submitted for further review. If it is determined that the lack of staffing or emergency plan implementation put the participant at risk of harm to self or others then a “for cause review” by Certification staff can be requested.

The Certification staff reviews a sample of participant records, including the PCP and health and incident records, as a component of the comprehensive provider certification process. As part of the DDD certification process, Certification staff will review a sample size of individual records to ensure the individualized emergency plans are developed for everyone and address a variety of situations based on the person, as well as ways to accommodate the individual needs of that person. This falls under Best Possible Health. Best Possible Health requires 100% in order to receive a certificate to provide services. If this section is not passed with 100% then the provider will be placed on “Provisional” status and a plan of correction must be submitted and implemented. Once the plan of correction is approved the provider will receive a one year certification.

Finally, if a complaint or request for review is made to the ALDMH Internal Rights Protection and Advocacy Program and inadequate staffing or lack of implementation of an emergency plan is noted then the DDD will be asked to investigate.

b. Monitoring Safeguards. *Select one:*

○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**

◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

As described in a. above, every person on the team has a responsibility to monitor both plan implementation and participant health and welfare, and this includes both the QIDPs of the direct care provider and the Support Coordinator. However, the operating state agency also monitors both of these, as described, and in this way ensures that the best interest of the participant is safeguarded. While it is a function of the support coordinator to review the person-centered-plan and follow-up to ensure goals are being addressed, there are other layers of authority that review, monitor, and ensure plans are being implemented.

The DMH Regional Community Services Waiver Coordinator reviews participant's plans throughout the year to ensure the Operating Agency is meeting the required quality indicators as approved in the waiver document. Additionally, the Operating Agency's Certification personnel reviews a sample of participant's person-centered-plan as part of the site review. The Certification personnel will conduct a Positive Outcome Measures survey to ensure the support Coordinator is providing adequate services to meet the person's needs. The Basic Assurances Standards are listed below. In addition, focused conversations that include suggested questions are listed.

580-5-33-.15 Support Coordinator Standards
Indicators:
A. The organization demonstrates the capacity to provide the core elements of support coordination.
B. The Support Coordinator performs a written comprehensive face-to-face assessment of the person's assets, needs, supports, goals and preferences.
C. The Support Coordinator coordinates planning.
D. The Support Coordinator arranges services and supports.
E. The Support Coordinator monitors services and supports.
F. Documentation supports evaluation of the person-centered plan and promotes continuity of services and supports.
G. The Support Coordination agency implements a system for transition/discharge planning.

Support Coordinators coordinate services and resources. The Support Coordinator is an agent who partners with the person to determine priorities and preferences for services. He or she assists the person in assessing needs, defining expected outcomes and developing or coordinating an outcome-based person-centered plan. The Support Coordinator locates services and resources that are consistent with the person's preferences, develops community linkage and monitors, reviews, and revises plans. The Support Coordinator will also seek out generic resources in the community. The Support Coordinator ensures, through this collaborative process, that the choices made by the person are actualized in the broader community.

FOCUSED CONVERSATIONS
Gather information directly from people to determine how they receive Support Coordinator services.
Here are some suggested questions for people and those who know them best. In addition, there are also some questions or areas the organization will want to address.

Suggested questions for the person:
1. What does your support coordinator do?
2. How does he/she help you?
3. How does that work for you?
4. Tell me about what happens when your support coordinator visits.
5. Are you satisfied with the services and supports you receive?
6. Are these the services you want?
7. Do you have enough services? Are they meeting your needs and expectations?
8. Can you change services or providers if you so choose?
9. How do you want your life to be in the future?
10. What is important to you to accomplish or learn?
11. Whom do you talk with about your future?
12. What are your hopes and dreams for yourself?
13. What assistance (if any) do you need to make these things happen?
14. What have you done that you feel good about?
15. What have you accomplished over the past few (one to three) years that has made you feel good about yourself?

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of participant service plans address all participant's assessed needs, including health and safety risk factors. Numerator: Number of participant service plans that address all participant's assessed needs, including health and safety risk factors. Denominator: Number of participants

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Participant Assessment Form and PCP

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other**	☐ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participant service plans that address personal goals.
Numerator: Number of participant service plans that address personal goals.
Denominator: Number of participants.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Personal service plan

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of participants whose service plans were reviewed with the participant according to the timeframes specified in the waiver. Numerator: Number of participants whose service plans were reviewed with the participant according to the timeframes specified in the waiver. Denominator: Number of participants reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Participant Assessment Form and PCP

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = Random Sample Confidence Interval +/-5% 95% Confidence Level
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participants whose needs change and whose service plans were revised accordingly. Numerator: Number of participants whose needs change and whose service plans were revised accordingly. Denominator: Number of participants whose needs change.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Person Centered Service Plan

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = Random Sample Confidence Interval =/-5% Confidence Level 95%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participants who have all assessed needs addressed in the service plan. Numerator: Number of participants who have all assessed needs addressed in the service plan. Denominator: Number of participants reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Person Centered Service Plans

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = Random Sample =/-5% Confidence Interval 95% Confidence Level
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of waiver individuals that receive service and supports in the type specified in the service plan. Numerator: Number of waiver individuals that receive service and supports in the type specified in the service plan. Denominator: The number of participant reviewed

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
Claims

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100%**

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = Random Sample Confidence interval =/-5% Confidence level 95%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

Performance Measure:
Number and percent of waiver individuals that receive service and supports in the amount specified in the service plan. Numerator: Number of waiver individuals that receive service and supports in the amount specified in the service plan. Denominator: Number of participants reviewed

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
Claims

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = Random Sample Confidence interval +/-5% Confidence level 95%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participants that receive service and supports in the duration specified in the service plan. Numerator: Number of participants that receive service and supports in the duration as specified in the service plan. Number of participants reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
Claims

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = Random Sample Confidence interval =/-5% Confidence level 95%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of waiver individuals that receive service and supports in the frequency specified in the service plan. Numerator: Number of waiver individuals that receive service and supports in the frequency specified in the service plan. Denominator: Number of participants reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
Claims

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = Random Sample Confidence interval =/-5% Confidence level 95%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of participant records that have a signed freedom of choice form that specifies that choice was offered among waiver services. Numerator: Number of participant records that have a signed freedom of choice form that specifies that choice was offered among waiver services. Denominator: Number of participants reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Freedom of Choice Form

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = Random Sample +/-5% Confidence Interval 95% Confidence Level
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participants that answered "yes all services" or "sometimes of some services" to being able to choose or change what kind of services they received. Numerator: Number of participants that answered "yes all services" or "sometimes of some services" to being able to choose or change what kind of services they received. Denominator: Total number of survey respondents

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:
NCI Survey

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = Random Sample Confidence interval +/-5% Confidence level 95%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
Number and percent of individuals offered a choice between/among service and providers. Numerator: Number of individuals offered a choice between/among services and providers." Denominator: Number of participants reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Freedom of Choice of Provider Form

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = Random Sample Confidence interval =/-5% Confidence level 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

	Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Remediation of individual problems occurs when problems are discovered by the regional office in monitoring plans. All of the discovery measures previously listed are produced by this monitoring, and the report of monitoring also includes notation of follow-up actions needed. The measures of remediation actions needed and performed are included in the electronic aggregation and reporting system, and are listed below:

Remediation: Measure 1
The number and percent of reviews which required individual technical assistance.

Remediation: Measure 2
The number and percent of reviews which required agency wide technical assistance and training.

Remediation: Measure 3
The number and percent of reviews which required a Plan of Correction.

If there are any reviews which required a plan of correction but the plan was either not submitted, not acceptable or not implemented, follow-up action would consist of referral to a "for-cause" certification review. In addition, depending on what the specific deficits were, funding could be recouped.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- (●) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ( ) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ( ) **Yes. The state requests that this waiver be considered for Independence Plus designation.**
- (●) **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Participants in the waiver will be offered an opportunity to self-direct services as the common law employer of record with budgetary authority if there is sufficient support available. A participant may self-direct select supports and services and also receive traditional supports and services from a provider agency, as long as both services are in the plan of care and are not duplicative. Self directed services include supports(Personal Care and transportation where applicable), companion, nursing (RN, LPN), Specialized Medical Supplies, Equipment, Environmental Accessibility Adaptations, PERS, and Individual Goods and Services for further supports and maintenance.

Participants who self-direct either RN or LPN services, do so at the standard rates for these waiver services to train and monitor any Personal Care assistant activity which may only be provided with delegation from a nurse. The activities which may be delegated are dictated by the rules of the State Board of Nursing. The hours of nurse service necessary for this function must be specified in the plan of care and will be prior authorized. Using this service in this way, for nurse delegation, may only be used by participants who self-direct, and is not available for certified providers because the funding is already included in the rate paid to the providers.

Each participant may select self-directed services, or request more information about it, during the initial and each subsequent planning meeting. Participants newly enrolled into the waiver will be offered the opportunity from the beginning, and individuals already enrolled in the waiver and receiving services will be offered the opportunity no later than their next team meeting, which occurs, at a minimum, once per year. Support Coordinators and Regional Office staff will be able to answer questions about the service option, and provide general written information, and if a participant or his/her family wants more information before making a choice, there will be contracted self-directed liaisons(SDL)available to provide it in each region of the state.

A fiscal intermediary (Financial Management Service Agency or FMSA) will be available for each participant who chooses to self-direct services. The FMSA will be paid as an administrative cost. In addition to the services of the FMSA, participants who self-direct will have a SDL liaison available, also reimbursed as an administrative cost, who will be able to inform and consult, intervene, and trouble shoot any problems the participant may have. The self-directed liaison (SDL) model is adopted as an initial step for those interested in self-directing services. The SDL will make initial contact, explain the services in depth and assist in the completion of the employer paperwork to send to the FMS for initial set up. The SDL will train the EOR on all aspects of self-direction of services, including EOR responsibilities, required documentation, and timesheet processing. The SDL will review EOR paperwork initially and as the EOR gains experience, will check random samples to ensure compliance. Some of the SDL responsibilities, oversight and continued training where documentation indicates on-going problems or utilization, can be directed to a Community Specialist. The waiver service of Community Specialist will be used for this purpose, and self-directing participants will be able to employ any Community Specialist of their choice. This service, which is already approved in the waiver, must by definition be free of conflict of interest, and there are very few stand-alone practitioners at present who also have the necessary knowledge of the mechanics of self-direction to provide all participants all the support they will need.

Participants who select self-direction will have a budget based on the plan of care developed during the person centered planning process. Units of service will be authorized and converted into a dollar amount. Funds saved through wage negotiations will be placed into a savings account managed by the FMSA. The savings plan will be developed based on items/services needed and identified in the PCP/POC. This plan can be revised as participant needs change. The participant will manage their services, with the assistance of the FMSA and self directed liaison and/or support coordinator if requested, by setting the employee rate, utilizing unused dollars to purchase more self-directed services if desired, covering the cost of overtime reimbursement (if applicable), purchasing worker's compensation insurance, or utilizing Individual Goods and Services as appropriate.

Individual Directed Goods and Services can be accessed with accompanying self-directed waiver services and procured through the participant's savings account maintained by the FMSA. The spending plan developed will list the items the participant intends to save for and purchase and must be approved by the SDL and/or support coordinator. The reimbursement or purchase of goods and services on behalf of the waiver participant will be made through the FMSA. When reimbursing the participant a valid receipt will be needed. If the participant cannot pay for the good or service up front then the FMSA will work out a process to procure a receipt and pay the vendor in advance. A valid receipt will be sent to the self-directed liaison and/or support coordinator to ensure the good or service was rendered or received.

Utilization will be reviewed routinely to ensure authorized dollars are being appropriately allocated to ensure health, safety, and welfare of the participant. Under utilization of dollars will be reviewed on an individual basis. Budgets will be reviewed annually and adjusted up or down based on utilization and needs.

The support coordinator should provide an overview to the families/representatives/legal guardians and participant's employee(s) on how to identify and report critical incidents and report incidents. All incidents should be to the case manager and/or Regional Office. The same follow-up procedures found in Appendix G apply

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ◉ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Information describing benefits, responsibilities and liabilities, together with an overview of the FMSA role and process, will be available in a brochure and on the Operating Agency's web site. This information will also describe how waiver participants and/or their families can find more information and go about accessing the service. The brochures will be provided to support coordinator to take with them to all planning meetings, so that they may share the information with participants and team members. Once an individual and/or family indicates interest at a planning meeting, a referral will be made to the self directed liaison for that region to make contact with the person and/or family and explain, in detail, the entire process. If the person / family wish to proceed, the SDL will provide them a packet of forms, which he or she will help them complete if necessary, will explain the budget and budget process, and will initiate the referral to the FMSA with notification to the regional office.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☒ **Waiver services may be directed by a legal representative of the participant.**

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Representative may include family members with whom the participant lives. For individuals who live in their own private residence and need to designate a representative, some special requirements will apply. A representative has to be able to assure the Regional Office that he or she has no conflict of interest and will support the participant's best interests. Second, there must be evidence that he or she is competent, willing and able to fulfill all the responsibilities, including providing sufficiently close supervision to a) assure the participant's health and welfare and b) sign the worker's timesheets with assurance each timesheet is accurate and truthful. Third, the representative must be chosen by the participant, but can neither be paid for being a representative nor be someone who is paid to provide any other service to the participant. In cases where the person chosen by the participant as the representative may be questionable, a background check may be indicated.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Personal Care	☒	☒
Positive Behavior Support	☒	☒
Environmental Accessibility Adaptations	☒	☒
Assistive Technology Services	☒	☒
Adult Companion Services	☒	☒
Community Specialist	☒	☒
Skilled Nursing	☒	☒
Individual Directed Goods and Services	☒	☒
Personal Emergency Response System	☒	☒
Specialized Medical Supplies	☒	☒

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i)*.

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☒ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

The Financial Management Service Agency (FMSA) was procured through a competitive RFP issued by ADMH/DDD. The vendor organization which was awarded the contract demonstrated clear superiority of experience and capabilities. Based on experience, cost, and references. Each contract is set for two years then the RFP process has to be completed again.

PMPM cost for FMS services is based on the number of participants enrolled. The initial enrollment fee and the PMPM fee is based on the number of enrollees. The higher the number enrolled, the PMPM fee is reduced.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The payments for the services provided by the FMSA will be based on an invoice submitted monthly. Payments are calculated according to a per-participant-per-month fee schedule. The fee is for a variety of activities specified in the vendor contract, and the fee is the same for every participant for whom an activity is provided during the month.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- ☒ **Assist participant in verifying support worker citizenship status**
- ☒ **Collect and process timesheets of support workers**
- ☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- ☒ **Other**

Specify:

The FMSA process all worker applications.
The FMSA furnishes background checks on prospective employees.
The FMSA assures prospective employees meet waiver requirements.
The FMSA will enroll self-directed employees that meet requirements and have valid licenses if applicable.
The FMSA will procure goods and/or services on behalf of the participant.
The FMSA will maintain separate savings accounts for each participant and monitor its usage on a regular basis.
The FMS will also report budget balances to the regional office and self directed liaison.
The FMS will perform monthly exclusion checks for all workers as required by federal regulations and AMA policies.

Supports furnished when the participant exercises budget authority:

- ☒ **Maintain a separate account for each participant's participant-directed budget**
- ☒ **Track and report participant funds, disbursements and the balance of participant funds**
- ☒ **Process and pay invoices for goods and services approved in the service plan**
- ☒ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other services and supports**

Specify:

Additional functions/activities:

☒ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**

☒ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**

☒ **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The FMSA will provide reports and documentation to the Central office and the self-directed liaison and/or Support coordinator, and the self-directing participants, that will identify the amounts paid to and on behalf of employees and include copies of the signed time sheets for those employees for each pay period. The reimbursement to the FMSA will be based on the timecard submissions. If there has been an error in timecard submissions then the error will be corrected by the following pay period. The self-directed liaison, Support Coordinator will be responsible for all follow-up conversations with participants or the representative to 1) notify them of any change to compensation and 2) ensure that time keeping processes are clearly understood.

The SDL/support coordinator closely monitors units paid and remaining as well as account balances to ensure there are sufficient funds in each account to cover the cost of payroll. Goods and Services will be authorized through the self-directed liaison and or Support Coordinator and receipts for items paid for up front by the FMSA will be reconciled. A receipt for each item purchased is required for reimbursement.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Support Coordinators will have sufficient training and printed information to explain in general the self directed option to families and participants. If the family is interested in this option, the Support Coordinator will notify the liaison to make contact with the family and participant and explain the option in greater detail. As more families and participants express interest in self-direction, support coordinator will become more knowledgeable about the details, and thus more helpful. The self-directed liaison explains in full to the family/individual what services can be directed and what "self-directing" services means. At any time the individual or family needs clarification or more information, the liaison, the regional office or the Central Office can provide more information.

The self-directed liaison is an essential link to families and waiver participants who are interested in self-directing services. There is printed material that is available on line but word of mouth has been the most effective way of informing people about the program. Support Coordinators are working closely with the self-directed liaison during the initial phase. Support Coordinators will coordinate with the client and SDL and services will be transferred from “traditional” to “self-directed”. Also included in this is the process for developing the budget for the participant based on the current plan of care. All these pieces work together to establish a person into self-directed services.

.

☒ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Personal Care	☒
Community Experience	☐
Supported Employment Transportation	☐
Speech and Language Therapy	☐
Supported Living Service	☐
Respite	☐
Positive Behavior Support	☐
Prevocational Services	☐
Crisis Intervention	☐
Physical Therapy	☐
Housing Stabilization Service	☐
Environmental Accessibility Adaptations	☐
Assistive Technology Services	☐
Adult Companion Services	☒
Benefits and Career Counseling	☐
Community Specialist	☐
Skilled Nursing	☒
Individual	☒

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Directed Goods and Services	
Personal Emergency Response System	☐
Day Habilitation	☐
Occupational Therapy	☐
Residential Habilitation	☐
Employment Support	☐
Specialized Medical Supplies	☐

☒ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

The Operating Agency will contract with or hire a limited number of individuals who have knowledge and experience in the field of Intellectual Disabilities, who have no conflict of interest, and who are willing to be trained to provide detailed information and day-to-day support to families and participants who indicate an interest in using this service option.

These individuals (self-directed liaisons) will be paid a standard rate per hour plus travel expenses. Both contracted or direct employee costs will be covered as an administrative expense. They will be trained by state staff and by the FMSA, in order to have the detailed knowledge with which to assist participants and their families. The supports for the self directed option consist of explaining the benefits and costs (requirements) to the family or participant, explaining how the process works, and exactly what the self directed option entails in terms of responsibility and liability. This discussion ranges from recruiting, hiring, supervising and possibly firing staff, to keeping time sheets, developing backup plans, managing their staff within the funds available, and how to utilize the Goods and Services waiver service. When the family and / or participant choose(s) to proceed, the self-directed liaison will provide the packet of needed forms and explain and demonstrate each one. This is extremely detailed, and the family may ask the liaison to help them complete the forms. Additionally, the budget will be discussed.

The liaison may return to the family as often as necessary to set up the system. The liaison, regional office, and the FMSA will collaborate to ensure the processes are in place to assure the health and welfare of participants, and to ensure that payments and services are legal and sufficient.

The liaisons will meet with the Central Office on a routine bases to review and approve their work. The liaisons will track and document all services rendered based on the scope of their contract and invoice the Department for their time. They may also be asked to consult with the regional office and / or the FMSA about progress or problems in any particular situation. Any concerns regarding the effectiveness of a liaison will be brought to the attention of Operating Agency's central office. The final review element for the liaison's performance is the family or participant. They will be communicating directly with the regional office, and with the support coordinator , and if they wish, an advocate, so any problem they may experience with the liaison can and should be reported through those channels.

The Self-Directed Liaison (SDL) is an essential link to families and waiver participants who are interested in self-directing services. The program remains small but is growing nonetheless. There is printed material available online but word of mouth has been the most effective way of informing people about the program. Support Coordinators work closely with the SDL during the initial phase of self-directed enrollment and will notify the Regional office that a participant has made a choice to be transferred from “traditional” to “self-directed” services.

It is the responsibility of the SDL to provide assistance to anyone interested in self-directing services. This includes identifying the services that can be directed, informing interested parties about their role and responsibility (i.e. timecard submission, documentation, etc.), communicating with participants and notifying case management or the region and central offices of any concerns, and assisting participants with their budget. The SDL is generally the first person that a caregiver contacts with concerns and the SDL then reports issues to the appropriate source.

The SDL works with the fiscal management agency as well. Working with the participant and caregivers, the SDL ensures that time cards are submitted correctly, that the individualized budget is submitted, and provides notification and technical assistance to anyone participating in the program.

After sufficient time has passed and the family gains confidence to handle all aspects of SDS, the SDL will fade and responsibility for assistance will fall to the support coordinator.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one)*.

○ **No. Arrangements have not been made for independent advocacy.**

◉ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

The Alabama Department of Mental Health operates an advocacy program independent of the Division of Developmental Disabilities (the Operating Agency). This program monitors participants to ensure their rights are not violated and operates a toll-free Advocacy Access Line during normal state business hours and a voice mail response system for after-hour callers for participants to request assistance or report issues. The number for this hotline is provided to all participants upon entry to the waiver program and will also be included with the brochure and manual provided to self-directing participants.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

Any participant who is self-directing his or her services may request to discontinue this model at any time by contacting the support coordinator, liaison, or the regional office, all of which will notify the Operating Agency immediately. The support coordinator provides the participant with free choice of providers who will take over delivering the services. If appropriate and desired by the participant, the staff which has been providing the services may be employed by the provider agency selected. The transfer will be as fast as can be arranged depending on the circumstances: if the participant's staff can be employed by an agency to continue the service, this will be done within two weeks. If all new staff needs to be recruited, vetted, hired and trained prior to employment, the process may take a month or more. During that time the original backup plan will need to be implemented, and other providers within the county may also be asked to help staff the participant's needs.

The circumstances under which a participant chooses to voluntarily terminate his/her use of the self- direction model will always be assessed, first by the support coordinator, then as needed, by the regional office or advocacy section, as a routine component of trying to improve the service delivery system.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Participants may be discharged involuntarily from participant direction because of:
1. Health or Welfare issues: the participant's and/or family's desire to continue self-directing will always be considered primary, but the support coordinator, liaison, or regional office will report adverse information to the Operating Agency, and if in the considered judgment of the Operating Agency the participant's health or welfare is in jeopardy, for any reason from abuse to change of condition, that individual will be returned to a traditional form of services.

2. Consistent participant failure to correctly utilize the FMSA services to pay his or her staff, after efforts have been made to provide support and training and have repeatedly failed, will result in termination of self-direction and return to a traditional form of services. Likewise, a participant who consistently discharges staff and ultimately is unable to hire anyone will also be returned to traditional services.

3. Anyone who engages in false approval and reporting of time cards, or in any other way acts to deceive or defraud, will be terminated from self-direction. If the person engaging in the fraud was not the waiver participant, referral will be made to the Medicaid Fraud Unit. If that person was the waiver participant, he or she will simply be returned to traditional services.

4. The method of returning a person to traditional services when they are involuntarily terminated from self-direction is the same as the method used when a person is voluntarily terminated. The support coordinator will provide the participant with free choice of providers who will take over delivering the services, unless it happens that a new service configuration is needed. For example, it may be necessary for the individual to move to a group home, either for care of an accelerated health condition or because the previous setting was exploitive. If appropriate and desired by the participant, the staff which has been providing the services may be employed by the new provider agency, but that will depend on the conditions that led to the termination. The transfer will be as fast as can be arranged depending on the circumstances: if the transition is prolonged, respite will be used as a bridge.

5. Participants who are terminated from self-direction are not provided the opportunity for a Medicaid fair hearing, because self-direction is only one method of receiving the services as long as the participant can be and is transitioned to the same essential set of services and his or her needs are met, no adverse action has occurred.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		225
Year 2		250
Year 3		275
Year 4		300
Year 5		325

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**

☒ **Refer staff to agency for hiring (co-employer)**

☐ **Select staff from worker registry**

☒ **Hire staff common law employer**

☒ **Verify staff qualifications**

☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

The FMSA will provide a background check to the participant and/or representative as a component of the administrative service for which it is paid.

☐ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☒ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☒ **Discharge staff (common law employer)**

☐ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- ☐ **Reallocate funds among services included in the budget**
- ☒ **Determine the amount paid for services within the state's established limits**
- ☐ **Substitute service providers**
- ☒ **Schedule the provision of services**
- ☐ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- ☒ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- ☒ **Identify service providers and refer for provider enrollment**
- ☐ **Authorize payment for waiver goods and services**
- ☒ **Review and approve provider invoices for services rendered**
- ☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The self-directed budget will be developed based on authorized units from the individual's plan of care which is based on the PCP. The process for developing the service plan will not be different from that of traditional waiver services. The individual's support team will meet and develop the person-centered plan based on expressed desires and needs. Based on specified goals and needs for support utilizing the person centered plan, a service plan will be developed with units of service assigned to each waiver service. The service plan can include both traditional waiver services and self-directed services. The authorized units for self-directed services will be converted to a dollar amount that represents the individual's budget for the year. If the individual chooses to self-direct all services then the person-centered planning process would be slightly different. If possible the person and his/her parent/guardian/representative of choice and the support coordinator would develop a person centered plan. The SDL can assist as needed.

The individual will have the ability to hire staff (approved by the FMSA), establish the rate to be paid, use budgeted dollars to pay for additional hours of service if necessary, and utilize the Individual Directed Goods and Services service for items needed to help promote inclusion in the community, decrease reliance on Medicaid services, or increase safety in the home so long as the service or good is not otherwise reimbursable through the waiver or Medicaid. Any dollars saved through wage negotiations or tax changes can be applied to the Goods and Services service up to the cap and a spending plan is developed for each participant.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The individual will be notified of self directed services during the service plan development process. The plan development process requires signatures of all members of the support team, including the individual if able, indicating the services have been reviewed and all involved are in agreement. The self directed services budget amount will be determined and the participant will be informed during the enrollment meeting with the liaison. Requests for adjustments to the self directed services budget will go through the support coordinator. Request will be made to and approved by the regional office. The Operating Agency will not approve changes to the budget based on financial misuse of dollars such as excessive employee pay rate or to pay employee overtime payment, employee bonuses etc. The self-directed budget does not serve as a limit on the amount of waiver services that an individual may receive. The support team will determine the appropriate level of service and the self directed services budget will be built based the participant's assessed need and units authorized. Budget changes will not be approved for purchase of goods and services not authorized.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- (●) **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ( ) **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Safeguards for preventing premature depletion of the individual's budget are multi-layered. Individual Goods and Services will only be authorized if there is enough savings in the individual's budget and there is not a concern of premature depletion. The FMSA will maintain the individual's budget and savings account and will monitor it monthly to ensure utilization remains steady. Individual balance reports will be generated monthly and submitted to the liaison/support coordinator for review. If there appears to be either overutilization or underutilization, the participant will be contacted to outline concerns. If either over utilization or underutilization is an on-going problem, the individual and representative will be consulted and informed of the possibility of involuntary discharge of self-directed services, and a transfer to traditional waiver services will be made.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Following is a description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, subpart E.

Any waiver applicant or recipient has the right to request a fair hearing if denied home and community-based services or if a decision by the operating agency adversely affects his/her eligibility status or receipt of services. If an applicant is determined not eligible by the operating agency, he or she is provided with notification of the determination, the reason and authority for the determination, and an explanation of the appeal rights and procedures available to the applicant. The formal process of notification and appeal is in accordance with 42 C.F.R. Section 431, Subpart E and Chapter 3 (560-X-3) of the Alabama Medicaid Administrative Code. There is an appeal process conducted by the operating agency at the applicant's choice, with the right to further appeal to the Medicaid Agency being explained to the applicant. If an appeal is made to the Medicaid Agency, a hearing officer appointed by the Commissioner of the Medicaid Agency conducts fair hearings. Medicaid legal counsel will be responsible for taking a lead role in the fair hearing process. If the individual/guardian is still dissatisfied after the Fair Hearing, he/she may appeal to the Circuit Court. The OA will be responsible for defending any appeal of the administrative decision.

Waiver recipients are provided with the necessary information regarding their opportunities to request a fair hearing as part of the planning process, by receiving and signing the Dissatisfaction of Services form. This form contains the information regarding his/her right to a hearing and acknowledges receipt of it.

When a change in the individual's needs suggests a change in the waiver services and plan of care, the person's treatment team discusses proposed change(s) with the person and his family/representative prior to implementation. This discussion will include an explanation of the reason for the change, further assessment of the impact of the change, and an effort to elicit agreement on the part of the person and/or his family/representative.

Whenever there is a decision by the operating agency to reduce, suspend, or terminate waiver services to coincide with the person's current need or the person's loss of eligibility for the service, the Department of Mental Health (DMH) will issue a written notice at least 10 days prior to the action to the client and or family/caregiver indicating the client's right to a fair hearing and instructions for initiating an appeal. A copy of the notice will be forwarded to the Medicaid Agency, and it will contain all the due process information required by 42 C.F.R. Section 431, Subpart E. This notification and the Dissatisfaction of Services form referenced above can be obtained from the operating agency.

The organization has a mechanism that provides people supported and their legally authorized representatives with information regarding filing complaints and grievances. At a minimum, the complaints/grievance procedures include the name and telephone number of a designated local contact within the organization.

The designated local contact has the knowledge to inform persons, families and legally authorized representatives of the means of filing complaints and grievances and of accessing advocates, ombudsmen or rights protection within or outside the organization.

Grievance procedure information is available in frequently used areas, particularly where people receive services. Such notices include the 800 numbers of the DMH Advocacy Office, federal protection and advocacy system (ADAP) and local Department of Human Resources.

The organization provides access to persons and advocates, including a DMH internal advocate and the grievance process without reprisal.

Responses to grievances/complaints are provided within a timely manner as specified in the agency’s procedures and in a manner that the person can understand.
The organization implements a system to periodically, but at least annually, review all grievances and complaints for quality assurance purposes.

Within ninety (90) days of employment, all employees who directly provide supports to people receive training in the following areas: Rights of people served, to include the recipient complaint/grievance procedure.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution

process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The Alabama Division of Developmental Disabilities, which is one division of the Alabama Department of Mental Health, is the Operating Agency for this waiver program. The notice of adverse action mentioned in Appendix F-1 includes an optional appeal to the Associate Commissioner of the Division of Developmental Disabilities. The consumer/family has the option to appeal in writing to the Associate Commissioner, who will arrange an appeal review, after which she or he will issue a decision within 21 calendar days. The notice also states that if the consumer/family disagrees with the Associate Commissioner's decision, they may appeal to the Medicaid Agency, and the notice indicates how and by when to do that.

The process will include a thorough review of all documents submitted with the initial application and may also include requests for additional information.

The types of disputes which can be addressed through this process include any adverse actions which have required the notice of due process to be sent to the consumer/family. Participation in this process is at the option of the consumer/family. If they choose not to participate, they may send their request for appeal directly to the Medicaid Agency.

In the rare instance that the adverse action includes terminating a service or dis-enrolling a person from the waiver who does not want to be dis-enrolled, the service will be continued until a review can be held, if the person appeals within the ten days prior of the effective date of the notice.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

The Alabama Department of Mental Health, Office of Advocacy Services.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Department maintains an independent office of advocacy services, reporting directly to the Commissioner's office, which monitors programs, receives complaints through a toll-free advocacy access line during normal State of AL business hours (the number is required to be posted in every certified site and given to each consumer), and investigates or causes to be investigated any rights issue complaints received. A voicemail response is left on the phone line, encouraging after-hour callers to leave a message, which will be retrieved and responded to on the next regular business day. The recorded message also offers options for the caller to follow if more immediate assistance is required.

The types of rights issue complaints that may be reported and will be investigated fall into the following rights categories: a) Due process; b) Education; c) Complaints; d) Safe and humane environment; e) Protection from harm; f) Privacy/confidentiality; g) Personal possessions; h) Communication and social contacts; i) Religion; j) Confidentiality of records; k) Labor; l) Disclosure of services available; m) Quality treatment; n) Individualized treatment or habilitation; o) Participation in treatment or habilitation; p) Least restrictive conditions; q) Research and experimentation; r) Informed consent.

Complaints of abuse, neglect or mistreatment are immediately referred to the responsible program and an investigation is also initiated by Advocacy staff or the program within 24 hours. Any other complaint that, in the opinion of the advocate, involves threat to health or safety is treated the same way. Other complaints are opened, responsible parties notified, and investigations are initiated as soon as possible but no later than 7 working days of the report, with the expectation that the investigation will be completed within 30 working days.

Resolution is required of the provider agency, which must submit a written report. If resolution requires ongoing monitoring, the responsible division's staff will provide this. If resolution requires court intervention, the federal protection and advocacy agency known as the Alabama Disabilities Advocacy Program or the Alabama State Bar Referral Service may be contacted to arrange legal representation for the consumer. If the consumer is receiving services under the waiver and his complaint involves waiver related issues, and he cannot achieve satisfaction through the required resolution, he and his representative are referred to the Medicaid Hearing Process. This rarely occurs, because the authority of the DMH Office of Advocacy Services can resolve most problems.

Reports are generated quarterly, listing the complainant, the nature of the complaint, and the finding of the investigation, and if warranted, a notation of the resolution. These reports are provided to the staff of the Alabama Medicaid Agency

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

State Critical Event or Incident Reporting Requirements

Incident Types	Timeframes
Physical Abuse	Immediate
Sexual Abuse	Immediate
Verbal Abuse	Immediate
Neglect	Immediate
Self-Neglect	Immediate
Mistreatment	Immediate
Exploitation	Immediate
Unnatural Death	Immediate
Moderate Injury	24-hours
Major Injury	24-hours
Choking	24-hours
Fall	24-hours
Seizure	24-hours
Other	24-hours
Medication Error Level I	24-hours
Medication Error Level II	Monthly
Medication Documentation Error	Monthly
Medication Error Level III	24-hours
Missing/Eloped Consumer	Immediate
Natural Death	24 hours
Severe Behavior Problem	24-hours
Natural disaster	24-hours
Fire	24-hours
Physical Assault	24-hours
Sexual Contact	24-hours
Manual Restraint	24-hours
Mechanical Restraint	24-hours
Chemical Restraint	24-hours
Unscheduled Hospital Visit	24-hours

All DMH certified community providers shall report incidents involving individuals that occur in operated or contracted community residential and day programs, either on the provider's premises and or while involved in an event supervised by the provider for all recipients of services. Reporting of incidents is also required when they occur in settings other than those specified above (e.g., overnight visits or outings with families).

Administrative Code Regulations:

580-5-33-.07 Protection from Abuse, Neglect, Mistreatment, and Exploitation
Each entity shall have a written plan that addresses the process of prevention and management of incidents.

The Division of Developmental Disabilities (DDD) preserves the safety, protection, and well being of all individuals receiving services through its certified community agencies, and will take appropriate action on any mistreatment, neglect, abuse or exploitation of those individuals.

The DDD prohibits abuse, neglect, mistreatment and exploitation of individuals served, and has procedures for investigating and reporting such incidents, and for taking disciplinary and corrective actions.

The DDD has promulgated a Community Incident Prevention and Management Plan that provides guidance for community agencies/providers in the implementation of incident prevention and management systems to protect individuals from potential harm, and those agencies are required to implement this Plan as part of their DMH certification requirements.

All certified agencies are required to implement a Community Incident Prevention and Management Plan (IPMS) as required by the Division of Developmental Disabilities, to protect individuals served from harm and improve the agency's

responsiveness to incidents for the purposes of prevention of harm and risk management.

Each certified agency must notify DDD of all reportable incidents and take actions in accordance with the Community IPMS requirements, which include state law and funding source requirements.

Each certified agency shall make changes/enhancements in the agency's Basic Assurances Plan as required by DDD to incorporate innovative strategies for the prevention and management of incidents, to address incident trends, and to update requirements of state law.

c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Participant Training and Education

Each person served by a provider agency is required by regulation to be informed of his rights and responsibilities annually. Rights include being free from abuse, neglect and exploitation. Each person is also informed of the Office of Advocacy toll-free hotline, its purpose and its number. Each person is also informed by the provider of his due process rights. Support Coordinators maintain relationships with individuals to encourage them to talk about what is important to them, including what may be happening that they don' t like. The Office of Advocacy Services of the Department of Mental Health conducts routine random monitoring, and Regional Offices of the Division of Developmental Disabilities conduct routine monitoring, both of which monitoring processes include talking with individuals.

Administrative Code Regulations:

580-5-33-.04 Promotion and Protection of Individual Rights

The organization implements a policy and procedure that clearly defines its commitment to and addresses the promotion and protection of individual rights of people.

The policy lists rights afforded all citizens as indicated by the United Nation's Declaration of Human Rights, by the constitution, laws of the Country and State of Alabama.

The policies and procedures describe the organization's required due process that includes a Human Rights Committee review and documentation of all proposed restriction of a person' rights.

The organization has no standing policies or procedures that restrict individual rights without due process.

The organization documents upon admission and annually thereafter, verification that it provides to persons and their legally authorized representatives an oral and written summary of rights/responsibilities and how to exercise them, in language that the person understands.

Every person shall have the right to due process with regards to complaints/grievances and rights restrictions, within the agency or program providing services. Due Process is, for these purposes, defined as providing the consumer, and/or their family or guardian, with a fair process that requires, at least, an opportunity to present objections to the proposed action being contemplated.

Dignity and Respect 580-5-33-.05 of Alabama Administrative Code

At a minimum, the complaint/grievance procedures shall include:
(a) The name and telephone number of a designated local contact within the entity.
(b) The designated person shall be able to inform persons of the means of filing grievances and of accessing advocates, ombudsmen, or rights protection services within or outside the agency.
(c) Grievance procedure information shall be available in frequently used areas, particularly where people receive services. Such notices shall include the 800 numbers of the DMH Advocacy Office, federal protection and advocacy system (ADAP) and local Department of Human Resources.
(d) Agency shall provide access to advocates, including a DMH internal advocate, and the grievance/complaint process without reprisal.
Procedures for the initiation, review and resolution of complaints and grievances shall be explained to the consumer/advocate and legal guardian.

Due process is defined as providing people supported, and their legally authorized representatives, with a fair process requiring, at least, an opportunity to present objections to the proposed action being contemplated. Due process, including review by a Human Rights Committee, is implemented when it is proposed that a person's rights be restricted for any reason.

Staff are trained in due process procedures including any procedures for placing a limitation or restriction on a person's rights. Each individual's ability to understand and exercise his or her rights is assessed and updated on an ongoing basis but at a minimum, annually.

A Human Rights Committee (HRC) reviews any restriction of a person's right(s) initially and periodically thereafter, but at least annually, during the period which the restriction is imposed and will document such.

When any restrictions are being proposed for a person, the person is supported to attend and provide input at the HRC meeting in which the proposed restriction is being reviewed.

People supported are provided adequate training in due process procedures including any procedures for placing a limitation or restriction on a person's rights and training that supports the removal of rights restrictions.

The continued need for the restriction is reviewed at least quarterly by the Qualified Intellectual Disabilities Professional (QIDP) or more often upon request of the person whose rights are restricted.

The organization utilizes a working and effective HRC that complies with the provisions of Chapter 580-5-33-.04.

The HRC reviews policies, procedures and practices that have the potential for rights restrictions without an individualized assessment.

The HRC reviews the frequencies and reasons surrounding the use of restraint for behavioral or medical purposes.

Additionally, the HRC makes recommendations to the organization for promoting people's rights, proactively promotes and protects people's rights and reviews reports of substantiated allegations of abuse, neglect, mistreatment, exploitation and other data that reveal the organization's practices with respect to human, civil and legal rights and reviews research projects involving human participation to ensure the protection of people who are involve

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The Incident Manager housed in the regional office will review each incident report for each reportable incident described in G-1 a. and determine if the report requires no action follow-up, action follow-up, or an investigation. All allegations of abuse, neglect, mistreatment, or exploitation are incidents that, by regulation, require an investigation. Other incidents may or may not require an investigation, based on the nature of the incident and action already taken by the provider. Nonetheless, all defined incidents must be reported, by the regulations governing certification of providers. Specifically, the provider is required to first assure the participant is safe and being treated as necessary, then report the incident, assess the cause, impact and needed actions regarding the incident, and address the needs so determined. The Regional Office reviews the provider' actions, as reported, to determine their adequacy.

Each Regional Office has a lead staff whose primary function is Incident Prevention and Management. This staff will have other staff of the Division available to assist as needed: for instance, certification, advocacy and Quality Enhancement staff are available, as is a registered nurse. A physician, psychiatrist and behavior analyst are also available on call (these are located in 3 of the 5 regional offices). In addition, the designated staff can involve other professionals in the Regional Office who routinely monitor the provider in question, and anyone else who knows the participant, such as the support coordinator.

If the information submitted by the provider regarding an incident is sufficient to determine a. the person is safe, b. the issues have been resolved, c. if the person needed anything more he is receiving it, d. an analysis has been conducted to determine if the incident could have been prevented, and e. that an analysis has been made to determine if there is a pattern that needs to be addressed, the designated staff will document this with a recommendation to the Regional Director that the incident requires no action follow-up. If the staff recommends, and the Regional Director determines, that an incident requires action follow-up, then the designated staff will coordinate the efforts. Additional staff can be involved as mentioned above, and additional information is gathered either directly by the regional staff or through the provider. The Regional Office can and does assign actions to the provider, with timelines. Completion dates are not to exceed 15 days based on the nature of the incident.

If more information is required of an investigation the Regional Office can extend the timeframe of an investigation. For example, the Regional Office can initiate its own investigation if they suspect the provider is not doing an adequate job, or has a track record of insufficient investigations, or has a clear conflict of interest. Also, the Regional Office will notify local law enforcement of possible criminal activity, if the provider has not done so and the information warrants it. Other entities that are routinely notified include DMH's Advocacy Office and the Adult Protective Services Unit of the Department of Human Resources. Investigation procedures have been trained and are retrained periodically, both for providers and for Regional Offices. Investigations must be closed within 15 days, unless there are extenuating circumstances, such as the absence of a necessary witness, or when repeated efforts to get information from the provider are required. Certification of the provider includes a review of the provider's compliance with factors 4, 5 and 6 and any failure to cooperate with other factors may results in a lowered certification score, which will cause the provider to be placed on provisional certification.

Community providers are required to immediately notify legal guardians/families of all incidents involving people served, regardless of the severity level. Providers are also required to notify legal guardians/families of investigation findings and the agency's plan to prevent similar incidents from occurring in the future.

Participants are not routinely sent information by the DMH, regarding the status or outcome of an investigation. Rather, the provider will talk with the participant to explain any changes in his services that happen because of an investigation, and will discuss the allegation and finding in more detail with a participant who will be able to understand what he or she is being told. Family members and other guardians will always be told the outcome by the provider, and by the Support Coordinator. There are no instances where the family members or guardians will not be notified about the outcome of an investigation. In addition, the participant, his family or his guardian may request a written summary of the investigation report, which the DMH will provide.

Documentation of actions by the provider, by the Regional Office, and by others is maintained in a database at the DMH. This information is used to discern patterns and determine systemic interventions, as described in Appendix H.

Administrative Code Regulations: Each was summarized under G-1 a. above

580-5-33-.07 Protection from Abuse, Neglect, Mistreatment, and Exploitation

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

Alabama Department of Mental Health
--Division of Developmental Disabilities Central and Regional Offices
--Office of Advocacy Services

Alabama Department of Human Resources (certain incidents of abuse, neglect and exploitation must be reported to ADHR by law).

Alabama Medicaid Agency: annual review of DDDs investigations, certification files containing quality enhancement plans and technical assistance reports, and mortality reviews. Quarterly review of Advocacy's reports.

Individual providers are required to report incidents to the perspective community service office (RCS). If the provider has provided sufficient information and corrective action, then the incident is closed. If the RCS office determines that additional information is required, a request for additional information is entered into the IPMS system to the provider agency, additional info is submitted to the RCS office and the incident is closed. If the incident requires an investigation, the RCS may require the provider agency to conduct the investigation, rely on DHR and/or local authorities or Internal Advocacy, or conduct the investigation themselves. The RCS office Director reviews all investigation for completion and thoroughness. Any additional corrective action needs are requested of the provider and followed-up until complete. Additionally, all investigation initiations and completions are forwarded to the Office of Quality and Planning for additional review and approval. Medicaid is informed of critical incidents that are systemic or otherwise rise to the level of decertification. Quarterly operating agency meetings are conducted by Medicaid in which providers on “provisional certification status” for violations of Best Possible Health, Protection from Abuse, Neglect, Mistreatment, and Exploitation and Safe Environments are discussed and actions being taken. Finally, Medicaid completes an annual audit of case management agencies and their sub-contractors to review ADMHs certification process and needed follow-up.

Incident reports are submitted to the Regional Offices and entered into the IPMS system. These incidents are tracked by regional staff to completion and closure. In addition to the above, Regional QE Staff (1 in each of 5 regions) compile and analyze data on a quarterly basis for their region to identify any problematic trends or patterns. Individual provider and recipient issues identified are managed administratively by the regional office staff. Systemic educational development and training needs are managed by the QE staff. Also, on a quarterly basis, the Director of Quality and Planning compiles and analyzes data on a statewide basis and presents to the Developmental Disabilities Sub-coordinating Committee, a statewide stakeholder group, that makes remedial recommendations as needed to the Associate Commissioner for DD Services.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Behavioral Services Procedural Guidelines describe the procedures referenced as restraint, along with the requirements for monitoring and documenting those procedures. Providers are required to train all staff who must implement restraints in the appropriate application of the procedures. If a person is found to be implementing the restraint incorrectly or outside the boundaries of an individual's Behavior Support Plan (BSP), whoever witnesses the event is obligated to report it and the provider is required to submit an incident report and conduct an investigation regarding the inappropriate use, misuse, or unauthorized use of restraint. The Regional Community Services offices review any instances of this and follows up on the investigation, adding recommendations when necessary to those implemented by the provider to remedy the situation and prevent further occurrence. Any Emergency use of Restraint must be reported via the Incident Prevention and Management System (IPMS) procedures. If 3 of these occur within a 6 month period, the team is required to meet to determine the factors leading to the need for those restraints in order to determine what alternatives could have been tried more effectively and evaluate whether restraints should be added to the person's Behavior Support Plan (BSP). Additionally, at any time that Regional Office staff are conducting their usual monitoring of providers and they witness or become aware that any restraint has been used without authorization, it is reported and investigated. Finally, certification staff routinely reviews the use of any restrictive procedure during surveys to ensure appropriateness and adequate due process.

Every staff person who works with an individual for whom restraints are a part of their BSP must receive specific training regarding how to implement the restraint and under what circumstances the restraint can and cannot be used before they can work with the person. All provider direct support professionals, QIDPs, and others must receive training in the Management of Aggressive and severe challenging behavior as part of their orientation training as well as annual refreshers. Professional staff must also have that kind of training. Direct Support Professionals are required to have a high school education, the QIDP must have a minimum of a bachelor's degree as well as training on the Behavioral Guidelines. Most of the providers who contract with the division do not use restraints. Most of the agencies that serve individuals who require restraints, either employ or contract with a Board Certified Behavior Analyst. Emergency use of restraints requires authorization from a QIDP, Program Director, or Physician. Direct Support Professionals cannot just decide to implement a restraint without that authorization.

Manual Restraints are listed in the behavioral guidelines as a Level 3 procedure in a BSP, which requires approval by the individual and his/her team, the Behavior Program Review Committee (BPRC), the Human Rights Committee (HRC). Mechanical Restraints are listed in the guidelines as a Level 4 (most restrictive) procedure in a BSP, which requires all of the previously listed reviews/approvals and must also be submitted for approval by the Director of Psychological and Behavioral Services (DPBS) in the Division of Developmental Disabilities. The DPBS determines the frequency of additional reviews that will be required on a case by case basis for these Level 4 BSPs. Reviews by both the BPRC and HRC committees include that they ascertain whether less restrictive procedures have been tried and documented to have been ineffective prior to approving restrictive procedures, including restraints.

Per the Behavioral Services Procedural Guidelines, Level 3 Procedures are restrictive and may only be used by direct care professionals when they are included in a Behavior Support Plan (BSP). Some of the procedures may be used in emergency situations and are so designated. Emergency use of these procedures requires an order from a QIDP. The use of an Emergency Procedure three times in a six month period requires the individuals planning team to meet, within five working days of the third use, to determine if a BSP is needed. The team's determination must be documented. Staff must be trained in the use of these procedures prior to using. Each BSP containing Level 3 Procedures requires prior approval by the Behavior Program Review Committee (BPRC), review by the Human Rights Committee (HRC), and approval/consent by the individual or the parent/guardian, and must be reviewed and updated at least annually.

Level 4 Procedures are considered the most restrictive and must be in a BSP (exception is Emergency Mechanical Restraint, which has an IPMS documentation requirement and a limit regarding the number of times it can be used). Each BSP containing Level 4 Procedures must be reviewed by the Director of Psychological and Behavioral Services (DPBS) in the Division of Developmental Disabilities, the BPRC, the HRC, and approval/consent by the individual or the parent/guardian. Requests for the use of these procedures should be sent to the DPBS at the same time that consent requests are sent to the parent/guardian. The DPBS or designee will review and respond within two (2) working days of receipt of the BSP with the Level 4 Procedure. Staff must be trained in the used of approved procedures prior to using. The frequency

for review and updating of the BSP with Level 4 Procedures will be indicated in the response sent by the DPBS or designee, however a review is required at least annually.

Manual, Mechanical and Chemical Restraints are permitted in emergency situations and as procedures in properly designed and professionally monitored behavior support plans and implemented by trained staff, as follows.

There are three types of emergency restraints recognized in community programs:
1. Manual: the use of physical holding which is not a part of an approved behavior support plan to involuntarily restrain the movement of the whole or portion of an indivudal's body as a means of controlling his/her physical activities in order to protect him/her or others from injury.
2. Chemical (psychotropic medication): the use of medication(s) that is not a standard treatment for the individual's medical or psychiatric conditions and is used to control behavior or restrict the individual's freedom of movement
3. Mechanical: The use of commercial devices which is not part of an approved behavior support plan to involuntarily restraint the movement of the whole or a portion of an individuals body as a means of controlling her/her physical activities in order to protect hi/her or others from injury.

Positive Behavior and Support
Administrative Code 580-5-33-.11
Objectives and strategies are developed to address behaviors that interfere with the achievement of personal goals or the exercise of individual rights using the least intrusive interventions necessary and the most positively supporting interventions available.

If appropriate, people have a behavior support plan that reduces, replaces or eliminates specific behaviors. Behavior Support Plans are implemented in accordance with the DDD Behavioral Services Procedural Guidelines.

Behavior Support Plans are developed based on information gathered through a functional behavioral assessment that is completed by a qualified professional and identifies physical or environmental issues that need to be addressed to reduce, replace or eliminate the behavior. The Behavior Support Plan outlines the specific behavioral supports that may and may not be used.

All direct support staff receive training in behavioral techniques and plans prior to implementation of support(s) to people.

Data related to the effectiveness of an individual's Behavior Support Plan is reviewed periodically, but at least quarterly, or more often as required by the individual's needs.

Prior to imposing a rights restriction, the person meets with his/her Support Team to discuss the reason for the proposed restriction, except in extreme emergency to prevent the person from harming self or others. Criteria for removing the restriction is developed and shared with the person and legally authorized representative prior to imposing the restriction.

All behavior support plans are approved by the person's Support Team. Each Behavior Support Plan with Level 2 or 3 procedures is reviewed and/or approved by the Behavior Program Review Committee, the Human Rights Committee and the person or the person's legally authorized representative in accordance with DDD PBS 02 Guidelines for Levels of Intervention.

(a) The use of emergency or unplanned behavior interventions that are highly intrusive are in compliance with DDD PBS 02 Level 3 Procedures and are not used more than three(3) times in a six (6) month period without a Support Team meeting to determine needed changes in the person's behavior support plan.

(b) If people require behavioral or medical supports to prevent harm to themselves or others, such supports are provided in accordance with DDD Behavioral Services Procedural Guidelines (DDD-PBS 01 05).

(c) The use of any restraint complies with the provisions of DDD PBS 02 Level 3 Procedures and is applied only by staff with demonstrated competency for the device or procedure used.

(d) The organization ensures that people are not subjected to highly intrusive behavior interventions or punishment for the convenience of staff, or in lieu of a Behavior Support Plan.

(e) The organization prohibits the use of corporal punishment, seclusion, noxious or aversive stimuli forced exercise, or denial of food or liquids that are part of a person's nutritionally adequate diet.

(f) Behavior procedures considered the most restrictive comply with the Level 4 Provisions of DDD PBS 02. Requests for the use of Level 4 Procedures are sent to the Director of Psychological and Behavioral Services for the Division of Developmental Disabilities after reviews have been completed by the Behavior Program Review Committee (BPRC), Human Rights Committee (HRC) and the legally authorized representative. The Director of Psychological and Behavioral Services determines the frequency of further review.

The use of psychotropic medications for behavior support comply with provisions of DDD PBS 02 Level 3 and are authorized by a licensed physician, preferably a psychiatrist. The use of medication(s) to reduce or change behavior associated with psychiatric symptoms shall be considered a Level 3 intervention (DDD PBS 02). These medications are authorized by the person's physician and incorporated into a Behavior Support Plan and/or a Psychotropic Medication Plan.

PRN orders for psychotropic medications are administered in accordance with the Nurse Delegation Program and the Behavioral Services Procedural Guidelines.

A person's Support Team meets to assess and address behavioral and psychiatric needs when PRN medications are used as an Emergency Procedure three (3) times within a six (6) month period.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Alabama Department of Mental Health
--Division of Developmental Disabilities Central and Regional Offices
-Office of Advocacy Services

-Community providers are required to adhere to the Community Incident Prevention and Management System (IPMS) to eliminate, where possible the occurrence of preventable incidents and respond appropriately to reportable incidents.

Factor 4: Protection from Abuse, Neglect, Mistreatment and Exploitation (580-5-33.07)
states that the organization implements policies and procedures that define, prohibit and prevent abuse, neglect, mistreatment, exploitation and unauthorized use of restraints.

ADMH-DD Behavioral Services Procedural Guidelines (updated 2014) indicates that
use of emergency restraints 3 or more times in a 6-month period requires the Interdisciplinary Team (IDT) to meet and consider whether incorporating its use into a formal Behavioral Support Plan (BSP) is appropriate. As a result, ADMH-DD tracks data for the use of 3 or more unauthorized/inappropriate restraints in a 6-month period for individuals that did not have a BSP to address such interventions.

Incident Managers conduct daily reviews of General Event Reports (GERS) in the DD Incident Management System, Therap. The Regional Community Services Incident Review Committee conducts weekly meetings to review reportable incidents and make recommendations to community providers regarding quality of services provided.
Moreover, restraint data and other reportable incident data is collected and analyzed on a quarterly basis by Regional QES. Multi-Event Summary Reports are generated which outline all reportable incidents that occurred within each quarter. Therap enables QES to aggregate and export restraint data into an excel spreadsheet. QES filter restraint data by name to identify individuals that were subjected to an unauthorized/inappropriate use of a restraint.

Individuals meeting the threshold of 3 restraints are identified and the GERs are reviewed to determine if the community provider and/or case management agency convened a special team meeting. The purpose of the meeting is to discuss changes in behavior that warrant excessive restraints and discuss a plan to develop a BSP to develop procedures for addressing such behaviors. Agencies that have not held special meetings to discuss are prompted to do so by the Regional Incident Manager.

The Director of Quality Enhancement collects aggregate incident data, including excessive use of restraints from the Regional Incident Manager and QES and compiles data for waiver reporting.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other

individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

Safeguards Concerning the Use of Restrictive Interventions

The behavioral guidelines describe all of the behavioral training and intervention strategies that are approved for use in Alabama. There are four (4) levels of procedures with each successive level indicative of greater restrictiveness, such that Level 1 procedures are not restrictive at all and Level 4 is highly restrictive. Level 2 procedures that are considered to be somewhat restrictive and require reviews by the BPRC chairperson and the HRC include procedures such as: Escape Extinction, Negative Reinforcement, Positive Practice, Reparation of Property or Restitution, Response Cost Restriction of Environmental Access, Restriction of Movement inside or outside facility, Search, and Exclusionary Timeout procedures. Level 3 procedures require review by the entire BPRC and HRC prior to implementation and include: Modification of Clothing to Limit Access to Self, One to One Staffing due to behaviors, Overcorrection, Manual Restraint, Restriction of Personal Property/visitors/phone calls, Use of Psychotropic Medications, and Closed –Door Timeout. Level 4 procedures must be approved by the BPRC, HRC, and submitted to the DPBS for additional approval and more frequent review to ensure effectiveness of the procedure. There are only four procedures listed at this level of intervention: Mechanical Restraint – Programmatic Use, Mechanical Restraint – Emergency Use, Sensory Screening, and Manual Restraints not otherwise specified in Level 3 (these would be modifications of the usual manual holds that may need to occur with a person). ALL of the restrictive procedures must be directly related to a behavioral challenge and the function being served by that behavior. There must also be training and reinforcement to assist the person in developing more appropriate behaviors to replace the one(s) that led to the restriction. Furthermore, there must be a plan for lifting the restriction that is reasonable in terms of the individual being able to achieve the criteria set. Procedures that are prohibited include: Use of aversive stimuli, such as spray mists or bitter tasting liquids contingent upon behaviors occurring and Corporal Punishment of any kind. While there is not a section in the behavior guidelines that lists the procedures as specifically prohibited, they are not allowed by virtue of not being in the procedures listed. Some of the definitions of procedure do refer to the fact that these are not allowed when the acceptable procedures are defined.

Prior to being assigned to a person who has a BSP, each staff person who works with an individual for whom restrictive procedures are a part of their BSP must receive specific training regarding how to implement the procedure and under what circumstances they can and cannot be used. All provider direct support professionals, QIDPs, and others must receive training in the Management of Aggressive and severe Challenging Behavior as part of their orientation training as well as via annual refreshers. Professional staff must also have that kind of training. All individuals must have Person Centered Plan in which the procedures of a BSP must be included and approved by the team and the person and then approved by the BPRC and HRC and, for the most restrictive procedures, by the DPBS. The Division of Developmental Disabilities offers training opportunities to assist service providers develop the skills related to determining the functions of behaviors being exhibited by individuals served and to connect the prevention and intervention strategies to the behavioral functions in order to increase the likelihood of successful outcomes. BSPs require renewal on an annual basis and all of the review/approval groups mentioned above must assess the new plan and determine whether to approve the revised or new plan based upon the data presented from the previous program. Finally, certification staff routinely review personnel files for all necessary and required training.

Due process is defined as providing people supported, and their legally authorized representatives, with a fair process requiring, at least, an opportunity to present objections to the proposed action being contemplated. Due process, including review by a Human Rights Committee, is implemented when it is proposed that a person's rights be restricted for any reason.

Staff are trained in due process procedures including any procedures for placing a limitation or restriction on a person's rights.

A Human Rights Committee (HRC) reviews any restriction of a person's right(s) initially and periodically thereafter, but at least annually, during the period which the restriction is imposed and will document such.

When any restrictions are being proposed for a person, the person is supported to attend and provide input at the HRC meeting in which the proposed restriction is being reviewed.

People supported are provided adequate training in due process procedures including any procedures for placing a limitation or restriction on a person's rights and training that supports the removal of rights restrictions.

The continued need for the restriction is reviewed at least quarterly by the Qualified Intellectual Disabilities Professional (QIDP) or more often upon request of the person whose rights are restricted.

The organization utilizes a working and effective HRC that complies with the provisions of Chapter 580-3-26.

The HRC reviews policies, procedures and practices that have the potential for rights restrictions without an individualized assessment.

The HRC reviews the frequencies and reasons surrounding the use of restraint for behavioral or medical purposes.

In addition to the requirements in Chapter 580-3-26 (2)(a)-(3), the HRC makes recommendations to the organization for promoting people's rights, proactively promotes and protects people's rights and reviews reports of substantiated allegations of abuse, neglect, mistreatment, exploitation and other data that reveal the organization's practices with respect to human, civil and legal rights and reviews research projects involving human participation to ensure the protection of people who are involved.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Alabama Department of Mental Health
--Division of Developmental Disabilities Central and Regional Offices
--Office of Advocacy Services

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The Operating Agency, in its function of certifying providers, and in its monitoring of direct service provision and service plan implementation, will detect any unauthorized use of restrictive interventions either through records (for instance, notes in a participant's file communicating the restriction), staff comments and discussion, or participant or family feedback during direct interviews or through communication with the advocacy hotline.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

The Behavioral Services Procedural Guidelines require that, for any person prescribed psychotropic or other medications for purposes of addressing/treating behavioral challenges and/or Psychiatric Symptoms, a Psychotropic Medication Plan be developed for the purpose of ensuring that reductions are considered and implemented whenever possible, based upon presentation of data to the treating Psychiatrist/Doctor. The person's habilitation team provides documentation of behavioral data and reports of psychiatric symptoms (if applicable) at every session with the treating doctor for review. If the criteria set by the team have been met, this information is presented to the doctor and consideration is given to a reduction in medication unless contra-indicated for medical or other extenuating circumstances that should be documented. The medication plan can be a section within the person's BSP. If a person is having "spikes" in their behaviors or in psychiatric symptoms, the provider is required to attempt to determine what factors might account for those peaks and make their findings known to the doctor. They are also required to modify the person's plan if necessary to address the factors leading to the ineffectiveness of the medications. Finally, certification staff routinely review records of individuals receiving Psychotropic Medication for all necessary monitoring and documentation including necessary lab work.

Sometimes individuals have behavioral episodes that result in visits to an ER or an admission to a hospital. This requires that notification be provided to the Regional Community Services office and the IPMS procedures are followed in those cases. If it becomes evident that there are problems with medication administration, follow-up monitoring and, sometimes, investigations are conducted as outlined in the IPMS. Finally, certification staff routinely review information related to Best Possible Health, Protection for Abuse, Neglect, Mistreatment, and Exploitation, and Safe Environments.

Medications are reviewed through the IPMS system, quarter regional and statewide QE reports, agency participation in the Nurse Delegation Program, and routine and "for-cause" certification reviews.

Provider employed or contracted nurses directly administer certain medications and delegate others to trained direct care staff. The nurse is responsible to provide periodic and regular evaluation and monitoring of the staff performing the delegated task, and to conduct quality monitoring of the tasks performed by the staff. This evaluation and monitoring must occur at least quarterly. Direct care staff must be medication assistant certified (MAC) workers in order to assist with medication administration. The delegating RN or LPN may withdraw delegation authority (of direct care staff) at any time.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Alabama Department of Mental Health:
--Division of Developmental Disabilities
Three teams of professionals, including a medical doctor, a psychiatrist and a behavior analyst are available through the Regional Offices to advise and assist with programs for reducing medications. These teams also provide education to local doctors who sometimes do not know the risk factors and alternatives to combinations of certain medications.
Regional nurses are required to monitor the administration of medication at each site annually. During the monitoring visit, a sample size of 5% of medication administration records are reviewed by the regional nurses to assess provider performance and identify areas of improvement. Data is collected and recommendations are made on the Regional Nursing Monitoring form. Regional nurses schedule follow-up visits to validate implementation of recommended changes. A final copy is forwarded to the Community Services Director and the provider. Incident reports that include medication errors in three categories are required by IPMS and entered into an electronic database where they are tracked at the consumer and provider level, and trended at the systems level. Intervention will occur from the Regional Offices and/or from Certification as needed.
Certification surveys include reviews of nursing notes and incident reports, every year or every other year, depending on the overall score achieved by the provider on the previous survey. Certification surveys also include for cause surveys and provisional status re-surveys as needed.

--Office of Advocacy Services
Advocates review individuas living situations, including issues regarding health and welfare as well as rights, and check on medication administration on a sample basis.

Alabama Medicaid Agency:
Annual review of DDD's investigations, certification files containing quality enhancement plans and technical assistance reports, and mortality reviews.
Annual survey of providers, including a complete record review on a sample basis.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

○ **Not applicable.** *(do not complete the remaining items)*

◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

State policy follows the nursing practice act of the State. Certain types of medication administration must be performed by a nurse, but other types, such as assisting with the delivery of prescribed oral, topical, inhalant, eye or ear medications may be delegated to a trained direct care staff under a protocol approved by the Board of Nursing.

iii. Medication Error Reporting. *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

Alabama Department of Mental Health:
--Division of Developmental Disabilities

The Division of Developmental Disabilities provides ongoing reports to the Alabama Board of Nursing. Agency reports to the DDD are included in the DDD reports to the Board of Nursing annually.

(b) Specify the types of medication errors that providers are required to *record:*

A. Medication Error a medication error occurs when a recipient receives an incorrect drug, drug dose, dose form, quantity, route, concentration, or rate of administration. A medication error is also defined as some form of variance of the administration of a drug on a schedule other than intended. Therefore, a missed dose or a dose administered one hour before or after the scheduled time constitutes a medication error.

Severities of medication errors are defined as follows:

Level 1 includes incidents in which the individual experienced no or minimal adverse consequences and no treatment or intervention other than monitoring or observation was required.
Level 2 includes incidents in which the individual experienced short term, reversible adverse consequences and treatment(s), and/or intervention(s) was/were needed in addition to monitoring and observation.
Level 3 includes incidents in which the individual experienced life-threatening and/or permanent adverse consequences.

The agency must record level 1, 2 and 3 medication errors.

(c) Specify the types of medication errors that providers must *report* to the state:

The agency must report level 1, 2 and 3 medication errors to RCS. Levels 2 and 3 must be reported verbally within 24 hours. Levels 1 and 2 must be reported on an incident form monthly. Levels 3 must be reported on an incident report form within 72 hours. No action follow-up is required by RCS or the provider for Level 1 medication errors, but such errors are tracked and trended to determine patterns and need for possible intervention.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Alabama Department of Mental Health:
--Division of Developmental Disabilities

Regional nurses are required to monitor the administration of medication at each site annually. During the monitoring visit, a sample size of 5% of medication administration records are reviewed by the regional nurses to assess provider performance and identify areas of improvement. Data is collected and recommendations are made on the Regional Nursing Monitoring form. Regional nurses schedule follow-up visits to validate implementation of recommended changes. A final copy is forwarded to the Community Services Director and the provider.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of abuse, neglect, exploitation, or unexplained death incidents reviewed/investigated within the required timeframe. The Numerator is the total number of abuse, neglect and exploitation or unexplained death incidents/investigated within the required timeframe. Denominator: The total number of abuse, neglect and exploitation or unexplained death incidents/investigated

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**

☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
Num and % of unreported incidents of abuse, neglect,mistreatment,exploitation,and unexplained deaths that were identified during site visit.Numerator:The total # of unreported incidents of abuse,neglect,mistreatment,exploitation,and nexplained deaths that were identified during site visit.Denominator: Total # of unreported incidents of abuse,neglect,mistreatment,exploitation,and unexplained deaths

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
The number and percent of satisfaction survey respondents who report their health and safety needs are being met. Numerator: The number satisfaction survey respondents who report their health and safety needs are being met. The denominator is total number of satisfaction surveys reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
NCI Survey

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative**

		Sample Confidence Interval = 95%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of critical incidents that have been resolved by the OA within 30 days of the date of the critical incident report date. Numerator is the number of critical incidents resolved within 30 days. Denominator is the total number of reported critical incidents.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of critical incident trends where systemic intervention was implemented. Denominator is the total number of critical incident trends where systemic intervention was implemented. The denominator is the total number of critical incident trends.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of individuals with restrictive interventions where proper procedures were followed. Numerator is the number of individuals with restrictive interventions where proper procedures were followed. Denominator is the number of individuals reviewed who had a restrictive intervention applied (reported and not reported)

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
The number and percent of restraints applied three (3) times in a six (6) month period that resulted in a team meeting. Numerator is the number of times restraints were applied three times in a six month period resulting in a team meeting. Denominator is the number of times restraints were applied three times in a six month period

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100%**

		Review
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of service providers who successfully completed the annual refresher training which includes a session on abuse, neglect, mistreatment or exploitation. Numerator is the number of service providers who successfully completed the annual refresher training which includes a session on abuse, neclect mistreatment and exploitation. Denominator is the number of providers.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Provider files

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number of support coordinators who successfully completed the annual refresher training including a session on abuse, neglect, mistreatment and exploitation. Numerator: number support coordinators who successfully completed the annual refresher training that includes a session on abuse, neglect, mistreatment and exploitation.Denominator:the number of support coordinators training files.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of those who responded that their overall health is good, very good or excellent on the survey. Numerator is the number of those responding that their overall health is good, very good or excellent. Denominator is the total number of individuals responding to the survey.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:
NCI

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
The number and percent of satisfaction survey respondents who report their health and safety needs are being met. Numerator: the number of satisfaction survey respondents who report their health and safety needs are being met. Denominator: The total number of satisfaction survey respondents.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:
NCI Survey

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Data from the OA will be collected on a monthly basis and reported to AMA. Trends in data will be addressed as appropriate depending on the results. Remediation by the QE staff in the regional office will identify needs based on trends and act accordingly to minimize variances from the expected goal.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Reports will be sent monthly to the AMA and data will be reviewed. Data reports will be discussed at quarterly meetings to discuss data and trends noticed by AMA. AMA will work with the OA to ensure correction in an efficient manner. Regional nurses are required to monitor 5% the administration of medication at each site annually. During the monitoring visit, a sample size of 5% of medication administration records are reviewed by the regional nurses to assess provider performance and identify areas of improvement. Data is collected and reviewed recommendations are made on the Regional Nursing Monitoring on ways to prevent medication errors on the appropriate form. Regional nurses follow-up to validate implementation of recommended changes. A final copy is forwarded to the Community Services Director and the provider.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☒ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify:

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	5% of Medication Administration records are reviewed annually.

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake

during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.
Appendix A Medicaid Oversight: Medicaid Agency will trend and analyze and share findings with the Administration of the Operating Agency. The quality assurance and improvement methodology employed by Medicaid staff gathers information from on-site and off-site record reviews and direct observation, as well as, from data forwarded from the operating agency. Weighting and trending of the multiple data elements is achieved with an algorithm designed by the University of Alabama at Birmingham to be used for all the State's HCBS Waiver Programs.

Appendix B Level of Care Evaluations: the Administration of the Operating Agency will jointly consider the findings from the performance measures and determine the necessary actions. Specifically, the Director of System Management will trend and analyze quarterly and annually; the Associate Commissioner will prioritize; and the Director of Waiver and Case Management Services and/or the Director of Quality and Planning will implement the prioritized recommendations with the support of the Directors of the Regional Community Service Offices. All system changes are shared with the Alabama Medicaid Agency prior to implementation.

Appendix C Qualified Providers and Certification: The Administration of the Operating Agency will jointly consider the findings from certification surveys and the related performance measures, and determine the necessary actions. Specifically, the Director of Quality and Planning and the Director of Certification will analyze and trend the information quarterly and annually and share this information with the Quality Council/Developmental Disabilities Sub-Coordinating Committee. This council is comprised of various provider stakeholder groups, Protection and Advocacy, DD Council representative, families, and individuals with disabilities receiving supports and services. Prioritized recommendations from the council will be reviewed by the Associate Commissioner and Divisional Executive Staff. Implementation which require changes to the ADMH Administrative Code rules and regulations must be approved by the Administration of the Department of Mental Health. All system changes related to the waiver are shared with the Alabama Medicaid Agency prior to implementation.

Appendix D Service Planning: The Regional Offices of the Operating Agency will review the information from the monitoring of case management agencies and provide quarterly summaries of findings and recommendations. This information from the performance measures can be reviewed agency by agency, aggregated by region, and aggregated statewide. It can also be trended from quarter to quarter and year to year, within the same aggregation parameters. The Director of Waiver and Case Management Services will analyze and trend statewide data and also consider and prioritize the recommendations of the Regional Offices. The Associate Commissioner will approve recommendations for implementation. All system changes related to the waiver are shared with the Alabama Medicaid Agency prior to implementation.

Appendix G Health and Welfare: The Regional Offices review all incident and investigation reports quarterly and provide summaries and analysis to the Director of Quality and Planning, who shares this information, as well as statewide trends, with the Quality Council. Prioritized recommendations from this council will be reviewed by the Associate Commissioner and Divisional Executive Staff. Implementation which require changes in the rule must be approved by the Administration of the Department of Mental Health. All system changes related to the waiver are shared with the Alabama Medicaid Agency prior to implementation.

Appendix I Fiscal Accountability: The Alabama Medicaid Agency will, through its monitoring process, discover problems and resolve them. The Medicaid Agency will also see, through trending of these monitoring reports, any areas of concern which may need to be addressed through efforts ranging from training to policy and regulation to changes in the MMIS edits and audits.

In conjunction with the Director of Quality and Planning, the Director of Systems Management will provide quarterly summaries and analysis of waiver discovery and remediation indicators. Quality Improvement Strategy data for Health and Welfare, as well as Level of Care, Qualified Providers, Service Planning, and Self-Directed Services will be presented during the same Quality Council/Developmental Disabilities Sub-Coordinating Committee meeting. This Quality Council is comprised of various provider stakeholder groups, Protection and Advocacy, DD Council representative, families, and individuals with disabilities receiving supports and services. If recommendations are made they will be prioritized and reviewed by the Associate Commissioner and Divisional Executive Staff. Implementation which require changes to the ADMH Administrative Code rules and

regulations must be approved by the Administration of the Department of Mental Health. Evaluation of the QIS plan is on-going as data is presented quarterly. The QIS will be updated to track discovery and remediation data as program requirements change. At a minimum, the QIS plan will be reviewed upon CMS three year assurances review and updated upon renewal. All system changes related to the waiver are shared with the Alabama Medicaid Agency prior to implementation.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

All system design changes have a component of evaluation built into the plan before the design change is implemented. For example, the Division implemented a new set of regulatory standards October 1, 2012. The Division contracted with the Council on Quality and Leadership (CQL) to align our requirements with their Basic Assurances(c). The change required extensive and ongoing training of community services providers. It included ongoing reports and evaluations by the Department of Mental Health, Division of Developmental Disabilities Certification Staff with community providers. Finally, training was provided by CQL to certification staff and has been validated annually.
The current direction of system design change is multifaceted. First, beginning October 1, 2014, the provider organizations will be required to develop and implement an ongoing quality enhancement plan or Basic Assurances System. Providers will complete an organizational assessment of their compliance with the Basic Assurances. Based on the assessment, they will have to identify priority areas to target for improvement for each factor and/or develop monitoring systems to ensure maintenance of compliance. Second, Divisional Quality Enhancement Staff have entered into a training with CQL to become certified quality analysts. In this role, they have analyzed the first year of certification data and are developing focused trainings on specific areas both regionally and statewide to provide assistance to community organizations. Third, Divisional QE staff and other certified trainers are required to provide three (3) 4-day workshops in Personal Outcome Measures Training(c) as developed by CQL. The vision is for all waiver participants to participate in an outcome interview to determine preference, the presence or absence of outcomes and supports, and the priorities for attainment, which will become the foundation of the individuals' person centered plans. This is how the Division envisions more effective person centered planning in order to meet the new CMS Regulations regarding Home and Community Based Services.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

ADMH-DD's Quality Council Committee meets during the DD Coordinating Subcommittee (also referred to as DD Sub) on a quarterly basis to receive reports from DD staff on regarding waiver services, provider certification, individual health and welfare (incident management), case management and budgeting. Recurrent trends and other issues are often identified by the committee and the responsible office is tasked with researching the area of concern, consulting with appropriate staff, and providing a resolution to the larger group in a timely manner. The committee is then afforded the opportunity to make inquiries, request follow-up information and make recommendations to further implement system improvements.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ◉ **NCI AD Survey :**
- ○ **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

enThe State of Alabama assures the financial accountability and integrity of waiver payments through the following activities:
The Alabama Medicaid Agency serves as the administering agency for this Waiver Program. The operating agency is the Alabama Department of Mental Health. The Medicaid Agency and the Department of Mental Health are both audited externally by the Alabama Department of Examiners of Public Accounts on an annual basis.

All providers are required to secure an independent audit of their financial statements.

The Operating Agency is responsible for initial certification and annual audits of providers. Medicaid's Networks and Quality Assurance Division will take a sample of each type of provider over a rolling three-year period to audit from all Waivers. Data is collected from providers by any of the following sources: reviewing a sample of the waiver case management records, direct service providers records, consumer satisfaction surveys, and tracking complaints and grievances. Additionally, the plan of care and data sheets are reviewed and compared against the plan of care to ensure that services were provided according to the plan of care.

The audits completed by the OA have a confidence level of 95% with a +/- 5% margin of error. Medicaid will choose one provider from each type (roughly about 15 types of providers across all Waivers) each quarter to audit (desk review). Audits do not differ by service or provider.

The results of the audit are provided to the Operating Agency. We do not have a contract with the provider; therefore, it is the responsibility of the OA to credential and provide audit feedback to the provider.

If AMA finds 15 or more discrepancies (total from the administrative, personnel, training, and client tool components) between its audit findings and the OA's audit findings for a given provider, AMA will issue a Corrective Action Plan (CAP) indicating the steps the OA must implement within a designated timeframe to remedy the issues.

Reimbursement made for services not provided in accordance with the plan of care, or not sufficiently documented, is recouped. Medicaid implemented the following system to ensure services are billed according to the plan of care to produce more accuracy in billing.

On October 1, 2017, the Alabama Medicaid Agency implemented an Electronic Visit Verification and Monitoring (EVVM) system to monitor visits to Home and Community Based Waiver Services clients. The EVVM system will enable more accuracy in service tracking, reporting, and billing for in-home care providers. The Electronic Visit and Verification system performs automated scheduling, time/attendance tracking and claim submission that:

** Maintains a repository of authorized services*

** Allows web based scheduling of service visits*

** Verifies a workers' location and length of service visit*

** Automatically creates a claim record for review*

** Identifies late or undelivered services*

** Issues alerts for late and missed visits*

** Automatically submits claim records for payment*

** Provides flexible reporting in real-time*

** Check in/out immediately reflected on the web*

The Electronic Visit Verification and Monitoring system requires the worker to check-in and check-out using the worker's mobile devices to log the visit on the EVVM app or by using the recipient's phone to dial into an Interactive Voice Response system. The system provides GPS location authentication and real-time communication to view and monitor by the provider, Operating Agency, and the Alabama Medicaid Agency. This system ensures the integrity of providers billing for

Medicaid payment of waiver services. The EVVM system reduces fraud and errors and is a proactive monitoring tool. Providers can monitor and review claims in real time and confirm claims for payment upon review. Additionally, the system will alert the case managers/providers when critical services are missed or late, thus preventing an overpayment for services not performed.

Service authorizations are loaded into the system from the Operating Agencies, thus preventing the provider from adding or editing the authorization for services. A claim cannot be confirmed and submitted for payment without a valid authorization. A visit can be scheduled only if there is an authorization for that service and client. A warning message pops up if the visit conflicts with another or not enough remaining units in the authorization, thus preventing fraudulent billing or an overpayment.

Every service captured by the Mobile app or IVR, or entered via the Web creates a claim. The provider has to confirm the claim before they are submitted for payment. Behind the scenes editing occurs continuously based on AL business rules and billing requirements. The provider can edit claims; however, a report can be produced to monitor if a provide has a systemic issue with editing claims which can raise a flag of fraud.

Another method that ensures the integrity of providers billing for Medicaid payment of waiver services is through the ADIDIS system for the Alabama Department of Mental Health. The provider billings are entered into a web-based claims processing system hosted by a vendor (Harmony Information Systems) for the Department of Mental Health. The ADIDIS system checks claims prior authorizations to ensure the services billed are approved by the operating agency's review of the plan of care. From the ADIDIS system, approved claims flow directly to the Medicaid Management Information System through DXC, the Fiscal Intermediary. The Medicaid Management Information Systems (MMIS) performs validation edits and audits to ensure program compliance. Audits check for duplicate services, and service limitations and related services are compared to Medicaid policy and guidelines.

Medicaid's Networks and Quality Assurance Unit reviews a sample of waiver case management records and additionally the plan of care and data sheets are reviewed and compared against the plan of care to ensure that services were provided according to the plan of care. Reimbursement made for services not provided in accordance with the plan of care, or not sufficiently documented, is recouped.

The Fiscal Agent Liaison Division/Contract Monitoring Unit (DXC) of the Alabama Medicaid Agency monitors the processing and payment of Medicaid claims through the Claims Processing Assessment System (CPAS). Errors are identified real-time and corrections initiated. For electronically submitted claims, the edit process is performed several times per day; for paper claims, it is performed five times per week. If a claim fails any of these edits, it is returned to the provider. The claim is processed using both clerical and automated procedures. Once the claim pass through edits, the system reviews each claim to make sure it complies with Alabama Medicaid policy and performs cost avoidance. Cost avoidance is a method that ensures Medicaid is responsible for paying for all services listed on the claim. The system then performs audits by validating claims history information against information on the current claim. Audits check for duplicate services, limited services, and related services and compares them to Alabama Medicaid policy. The claim is then assigned a status (approved to pay, denied, or suspended). Suspended claims must be worked by DXC personnel or reviewed by Alabama Medicaid Agency personnel, as required. Claims paid in error will be submitted for recoupment. Once the reviewer initiates the recoupment, the claims goes back through the system and the FFP is removed.

Monthly reports of expenditures are received by the designated Long Term Care staff in order to monitor irregular expenses. The CMS 372 report is generated annually which records cost effectiveness and cost comparisons. Provider records are audited annually or more frequently at the discretion of the Medicaid Agency.

The entity responsible for conducting the periodic independent audit of the waiver program as required by the Single State Audit Act is the Alabama Department of Examiners of Public Accounts.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of claims that are supported by documentation that services were delivered. Numerator: the number of claims supported by documentation that services were delivered. Denominator: the number of claims reviewed.

Data Source *(Select one):*
Financial records (including expenditures)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☒ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *Random Sample Confidence Interval =+/- 5% Confidence Level 95%*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*

	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☒ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☒ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
Number and percent of claims paid for individuals who were eligible on the date the service was provided. Numerator: The number of claims paid for individuals who were eligible on date the service was delivered. Denominator: The number of claims paid.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Claims data

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☒ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☒ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
	☒ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
Number and percent of claims paid for the service that was specified on the participant plan of care. Numerator is the number of participants records sampled that showed the service that was paid for was included on the participant's plan of care. Denominator: The total number of participants in the sample.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Claims data and participant records.

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☒ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *Random Sample Confidence Interval =+/- 5% Confidence Level 95% Confidence Level 95%*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and***	☐ ***Other***

	Ongoing	*Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☒ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
Number and percent of claims coded and paid for in accordance with the reimbursement methodology in the approved waiver. Numerator: Number of claims coded and paid for in accordance with the methodology in the approved waiver. Denominator: Number of claims paid

Data Source *(Select one):*
Record reviews, on-site
If 'Other' is selected, specify:
Claims

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*

☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *Random Sample Confidence Interval =+/- 5% Confidence Level 95%*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of rates that remain consistent with the approved rate methodology throughout the five-year waiver cycle, Numerator: Number of rates that remain consistent with the approved rate methodology; Denominator: Number of rates reviewed.

Data Source *(Select one):*
Financial audits
If 'Other' is selected, specify:
Claims data

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =*

		Random Sample =/-5% Confidence Interval 95% Confidence Level
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.*

Reports are shared with the Operating Agency and the Performing Provider. Reimbursement made for services not provided in accordance with the plan of care, or not sufficiently documented, is recouped. The phrase "not provided in accordance..." is defined as exceeding an average expected rate of utilization by more than 10% and having no documentation for the exception. All waiver services are prior authorized, so that the annual limits on units of service cannot be exceeded, but average utilization, month to month, can vary.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☒ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ ***No***

○ ***Yes***

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

The Alabama Medicaid Agency is responsible for establishing provider payment rates for waiver services. Payment made by Medicaid to the ID waiver providers are on a fee-for-service basis and are based upon a number of factors and all rates, with the exception of residential services, were formulated using the following :

Current pricing for similar services
State-to-State comparisons
Geographical comparisons within the state
Comparisons of different payers for similar services

Rates do not vary geographically. The rates are posted on ADMH website.

For each waiver service, a HCPC code is determined with a rate assigned to each code. The Medicaid Management Information system (MMIS) pays the claim based upon the State's determined pricing methodology applied to each service by provider type, claim type, recipient benefits and policy limitations. All claims submitted for adjudication must pass certain edits in MMIS. Once a claim passes through edits, the system reviews each claim to make sure it complies with AMA policies. The MMIS then performs audits by validating claims history information against information on the current claim. Audits check for duplicate services, limited services, and related services and compare them to Alabama Medicaid policy to ensure that recipient benefits are paid according to current policies.

Rates established are reasonable and customary to ensure continuity of care, quality of care, and continued access to care. All rates are posted on ADMH's website. Re-evaluation of pricing and rate increases are considered as warranted based upon provider inquiries, problems with service access, and budgetary considerations. In cases where allocations from the state Legislature are received, rates increases are determined by the OA based on provider inquiries, problems with service access or where services have not been adequately adjusted due to budget constraints. The OA was involved with ODEP's VisionQuest Rates and Restructuring project and working on reviewing rates of service. A subgroup comprised of internal staff, external stakeholders (providers and advocacy), and Medicaid staff met monthly. Albeit all the work this group's did not truly come to fruition due to level funding by the legislature. However, using the information from the project another workgroup was formed and the rates were finally set after an examination of other state rates using the list compiled by ODEP SMEs and available on the Lead Center website entitled Review of HCBS Reimbursement Data for Day/Employment that includes most state information, but chose primarily a comparison of nearby states (NC, GA, LA, MS, AR, TN, SC). The group also looked at some of the information from the ODEP project. The group remains intact and assembled as necessary. Reimbursement rates (i.e. Day Habilitation and Prevocational) are associated with the minimum staffing ratios needed to support persons based on whether the service is delivered in a facility-based (provider controlled) setting or an integrated community setting, taking account of the different staffing ratios and costs that are applicable for services delivered in integrated community settings. There are four reimbursement rate levels based on four acuity tiers for both Facility Based Day Habilitation and Community Based Day Habilitation. An individual's acuity tier is based on his/her ICAP score. Staffing ratios for both facility-based day habilitation and community-based day habilitation service provision vary based on acuity tier. For facility, the staffing ratios vary from a low of 1:15 to a high of 1:1. For community, the staffing ratios vary from a low of 1:4 to a high of 1:1. Rate adjustments are then added if transportation to/from the service is included in the rate paid to the provider. Reviewing the rates is an ongoing process and all waiver service rates were not rebased, however have been reviewed. Those rates rebased included this far have been those service rates that support employment,(Discovery/Assessment, Benefits Planning, Individual Job Coaching and Benefits Reporting Service). To determine the rate for Supported Living service, utilization for in-home habilitation and personal care were reviewed to determine an average hours of both services per day. Once that number was determined, the yearly total of the service anticipated was calculated by the year and divided by twelve (12) to get the monthly total. Work continues on restructuring rates for the other services. The general public had opportunity to comment on the rates during the public comment period for the amendment. Any changes are noted. Should the state legislature pass an increase in our appropriations for either a provider dedicated staff wage increase, such as an hourly increase for DSPs, or for a COLA, for all or selected provided rates, these costs will be reflected in subsequent year payments and reported on Form 372. We will inform CMS of these changes but shall not amend the rates since the rate setting methodology will not change. Fee for service methodology was used with all services except residential rates which is based on Individual Residential Budgeting Instrument (IRBI) which factors in individual needs based on acuity and level of care identified. Residential Habilitation is the only residential service. Residential Habilitation Service is based on individual needs, ICAP levels, and acuity level and each participant receiving that service has a Individual Residential Budgeting Instrument (IRBI) completed and submitted. An Individual IRBI can be re-calculated and submitted as the needs and levels change. The rates for self-directed Adult Companion Service and Personal care were based using the same methodology used for traditional services but, reduced by 11% that accounts for the removal of administrative and indirect costs. Skilled Nursing rates are aligned with Medicaid's

payment for SPS and other waivers' rates for the same service.

Some of the services were reviewed in 2016, but all were reviewed in July 2018 when the rates and restructuring workgroup met. The focus at that time was Residential Rates with suggested changes to the IRBI, personal care rates and nursing rates. Also, the workgroup that met several times in the Spring of 2019 to review the waiver in preparation for the renewal reviewed the rates. Again, the focus was on increases in the IRBI, nursing rates and personal care. The suggestions were put into the budget request and the Alabama Legislature appropriated the funds to increase the IRBI by 2.5% ,Personal Care by 5.6% , and Personal Care on the worksite by from $4.35 per 15 minute unit to $6.00 per 15 minute unit to encourage employment.

The rates were reviewed, and some rates increased in 2016, the legislature did provide an increase for 2020 for Residential Services that increased the service by 2.5% which was added into Appendix J information. Personal Care will also be increased by 5.6%, and Supported Employment Individual Job Coach is receiving a 50% increase to incentivize employment for waiver. Community Experience and Community Prevocational Services have been based on the staffing level needed based on the acuity of the person receiving these services in the community.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

Each waiver participant, once approved, is added to the Alabama Medicaid's Recipient Level of Care Panel. This file holds approved dates of eligibility for waiver services.

Provider billings are entered into a web-based claims processing system hosted by a vendor (Harmony Information Systems) for the Department of Mental Health. This system, known as ADIDIS, checks claims against prior authorizations to ensure the services billed are approved by the operating agency's review of the plan of care. From the ADIDIS system, approved claims flow directly to the Medicaid Management Information System through DXC, the Fiscal Intermediary as follows:

Payments made by Medicaid to providers are on a fee-for-service basis. Each covered service is identified on a claim by a procedure code.

For each recipient, the claim allows span billing for a period up to one month. There may be multiple claims in a month; however no single claim can cover services performed in different months.

If the submitted claim covers dates of service where part, or all of which were covered in a previously paid claim is rejected. The provider is required to make the corrections on the claim and resubmit for processing.

Payment is based on the number of units of service reported on the claim for each procedure code.

Accounting for actual costs and units of services provided during the waiver year, are captured on the CMS 372 Report.

All claims must be filed within twelve months from the date of service.

Payment is based on the number of units of service reported on the claim for each procedure code. There is a clear differentiation between waiver services and non-waiver services and a clear audit trail exists from the point of service through billing and reimbursement. Discrepancies are initially handled at the local level.

The ID Waiver administrator monitors expenditures on a bi-annual basis or as often as needed and monitors problems with particular service providers. If costs appear to be out of line or unusual, the provider is contacted and follow-up action is implemented as needed.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- (●) ***No. state or local government agencies do not certify expenditures for waiver services.***
- ( ) ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

The system performs validation edits to ensure the claim is filled out correctly and contains appropriate information for processing. Edits ensure the recipient's name matches the recipient identification number (RID); the procedure code is valid for the diagnosis; the recipient is eligible and the provider is active for the dates of service; and other similar criteria are met. For electronically submitted claims, the edit process is performed several times per day. For paper claims, it is performed five (5) times per week. If a claim fails any of these edits, it is returned to the provider.

Once claims pass through edits, the systems reviews the claim history information against information on the current claim. Audits check for duplicate services, service limitation, and related services and compare them to Alabama Medicaid policy. The system then prices the claim using the State determined pricing methodology applied to each service by provider type, claim type, recipient benefits, or policy limitations.

Once the system completes claim processing, it assigns each claim a status: approved to pay, denied, or suspended. Approved to pay and denied claims are processed through the financial cycle twice a month, at which time an Explanation of Payment (EOP) report is produced and checks are written, if applicable. Suspended claims must be worked by DXC Technology or reviewed by Alabama Medicaid Agency personnel, as required.

Claims approved for payment are paid with a single check or electronic funds transfer (EFT) transaction according to the check write schedule published by the Alabama Medicaid Agency. The check is sent to the provider's payee address with an EOP, which also identifies all denied claims, pending claims, and adjustments. If the provider is enrolled in the electronic funds (EFT) transfer process, the payment is deposited directly into the provider's bank account and the EOP is mailed separately to the provider.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

◉ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***

○ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☒ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment *(3 of 7)*

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment *(4 of 7)*

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

○ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*

◉ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

State DMH (Alabama Department of Mental Health) is the operating agency for the ID waiver. The State agency provide ID waiver services such as: Day Habilitation, Employment Support, Personal Care, Prevocational Services, Residential Habilitation, Respite, Adult Companion Services, Benefits and Career Counseling, Benefits Reporting Services, Assessment/Discovery, Crisis Intervention, Environmental Accessibility Adaptations, Housing Coordination, Individual Directed Goods and Services, Occupational Therapy, Personal Emergency Response System, Physical Therapy, Positive Behavior Support, Skilled Nursing, Assistive Technology, Specialized Medical Supplies, Speech and Language Therapy, and Supported Employment Transportation and Supported Living.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- (●) ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ( ) ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ( ) ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- (●) ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ( ) ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ( ) ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- (●) ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

Providers may reassign payments only to DMH, the operating agency for the ID waiver.

ii. Organized Health Care Delivery System. *Select one:*

- ○ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***
- ◉ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

The DMH, the various Local Authorities established under Act 310, and other providers of waiver services all provide one or more Medicaid service and are eligible to be OHCDS. Providers may enroll directly with the Medicaid Agency if they wish but in this case they must also contract with the DMH in order for the DMH to pay the state match for them. Free choice of providers is assured by the policies and procedures in effect and practices carried out by case managers. All providers are certified and monitored between certification surveys. All subcontractors are submitted to the state for review of applicable provisions. Payments are fee-for-service through an approved MMIS system.

iii. Contracts with MCOs, PIHPs or PAHPs.

- ◉ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ○ ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☐ ***Appropriation of State Tax Revenues to the State Medicaid agency***

☒ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

The non-federal share of waiver payments is transferred to the Alabama Medicaid Agency by the Alabama Department of Mental Health(DMH). This is managed through an IGT process in which the Medicaid Agency determines, during each billing cycle, how much non-federal match is needed to reimburse adjudicated claims, and invoices DMH, whereupon DMH transfers these funds to the Medicaid Agency.

For Medicaid payments under this waiver, the source of non-federal match transferred to the Medicaid Agency by the Department of Mental Health, as
100% appropriated by the legislature to the DMH from three tax-based funds: The General Fund; the Education Trust Fund; and the Mental Health Trust Fund.

The Department of Mental Health is adding the use Local Match to the non-federal match payment in this renewal.

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable***. *There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***

○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***

◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home***

of the individual.

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

All costs related to room and board were clearly excluded from the formulas used to build the Individual Residential Budgeting Instrument, as follows:

*The rate setting methodology for residential habilitation is driven by the staff hours needed by each individual, divided by the number of other individuals sharing those staff hours (staff hours). A standard rate per hour for direct service staff was developed from surveys. Supervision hours (house managers and QIDPs) are derived by formula from the direct support hours. Additional professional hours can be added to the worksheet as well. *Note: An enhanced rate per hour for staff may be given to those homes that qualify and are certified to provide residential services in either a Specialized Medical Residential Services home or a Specialized Behavioral Services home. There is no cost center for adding room and board as part of direct care.*

Indirect administrative and non-personnel operating costs were derived from averages of the same cost centers as reported in Medicaid cost reports. The Medicaid cost reports did not include any room and board. A 15% administrative percentage was derived as an average ratio of administrative personnel costs to direct service personnel costs, within the sampled cost reports. A non-personnel operating cost of $19.25 per day (with $3.50 specifically for basic transportation) was identified as an average of such cost centers on the same Medicaid cost reports.

Participant's benefits pay for room and board.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ○ ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***

○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

☐ ***Nominal deductible***

☐ ***Coinsurance***

☐ ***Co-Payment***

☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***

○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	61456.80	5698.00	67154.80	176288.00	4153.00	180441.00	113286.20
2	59787.24	5869.00	65656.24	181577.00	4278.00	185855.00	120198.76
3	59440.05	6045.00	65485.05	187024.00	4406.00	191430.00	125944.95
4	59076.40	6226.00	65302.40	192635.00	4538.00	197173.00	131870.60
5	59464.02	6413.00	65877.02	198414.00	4674.00	203088.00	137210.98

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID
Year 1	5260	5260
Year 2	5260	5260
Year 3	5260	5260
Year 4	5260	5260
Year 5	5260	5260

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in*

item J-2-a.

The average length of stay was derived from the most recently filed CMS 372 report for the Home and Community-Based Services Waiver for the period 10/1/2016 through 9/30/2017 and trended by 3% per year, but capped in years 3-5 at 365 as not to exceed the annual limit.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

This information is based on data that will be reported in the CMS-372 Report for the 2017 (October 1 2016-September 30, 2017) waiver year and trended by 3%. The data source is "inflation data.com" as reviewed on June 13,2019.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

This information is based on data that will be reported in the CMS-372 Report for the 2017 (October 1 2016-September 30, 2017) waiver year and trended by 3%. The data source is "inflation data.com" as reviewed on June 13,2019.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

This information is based on data that will be reported in the CMS-372 Report for the 2017 (October 1 2016-September 30, 2017) waiver year and trended by 3%. The data source is "inflation data.com" as reviewed on June 13,2019.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

This information is based on data that will be reported in the CMS-372 Report for the 2017 (October 1 2016-September 30, 2017) waiver year and trended by 3%. The data source is "inflation data.com" as reviewed on June 13,2019.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Day Habilitation	
Employment Support	
Personal Care	
Prevocational Services	
Residential Habilitation	

Waiver Services	
Respite	
Adult Companion Services	
Assistive Technology Services	
Benefits and Career Counseling	
Community Experience	
Community Specialist	
Crisis Intervention	
Environmental Accessibility Adaptations	
Housing Stabilization Service	
Individual Directed Goods and Services	
Occupational Therapy	
Personal Emergency Response System	
Physical Therapy	
Positive Behavior Support	
Skilled Nursing	
Specialized Medical Supplies	
Speech and Language Therapy	
Supported Employment Transportation	
Supported Living Service	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						41856852.33
Day Habilitation Level 2	15 minute	1306	2525.00	2.47	8145195.50	
Day Habilitation Level 1 w Transport	15 minute	244	1799.00	2.26	992040.56	
Day Habilitation Level 2 w Transport	15 minute	306	1792.00	3.05	1672473.60	
Day Habilitation Level 3 w Transport	15 minute	107	1722.00	3.84	707535.36	
Day Habilitation Level 1	15 minute	702	1856.00	1.94	2527649.28	
Day Habilitation					3063644.64	
GRAND TOTAL:						323262785.76
Total Estimated Unduplicated Participants:						5260
Factor D (Divide total by number of participants):						61456.80
Average Length of Stay on the Waiver:						364

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Level 3	15 minute	432	2009.00	3.53		
Day Habilitation Level 4 w Transport	15 minute	15	1005.00	4.85	73113.75	
Day Habilitation Level 4	15 minute	166	1867.00	4.53	1403946.66	
Community Day Habilitation Level 1	15 minute	351	1856.00	4.16	2710056.96	
Community Day Habilitation Level1 w Transport	15 minutes	122	1779.00	4.80	1041782.40	
Community Day Habilitation Level 2	15 minutes	653	2525.00	4.76	7848407.00	
Community Day Habilitation Level 2 w/ Trans	15 minute	306	1792.00	5.40	2961100.80	
Community Day Habilitation Level 3	15 minutes	432	2009.00	5.94	5155254.72	
Community Day Habilitation Level 3 w/Trans	15 minutes	53	1722.00	6.58	600530.28	
Community Day Habilitation Level 4	15 minutes	166	1867.00	9.06	2807893.32	
Community Day Habilitation Level 4 w/ Trans	15 minutes	15	1005.00	9.70	146227.50	
Employment Support Total:						59152.00
Individual Job Developer	15 minutes	5	320.00	10.00	16000.00	
Individual Job Coach	15 minutes	5	320.00	7.50	12000.00	
Assessment/Discovery	15 minutes	10	120.00	10.00	12000.00	
Employment Small Group 1: 2-3	15 minutes	8	160.00	7.90	10112.00	
Employment Small Group 1:4	15 minutes	10	200.00	4.52	9040.00	
Personal Care Total:						19153722.24
Self Directed Personal Care	15 minutes	200	7668.00	3.48	5336928.00	
Personal Care on Worksite	15 minutes	12	2619.00	6.00	188568.00	
Personal Care Transportation	mile	148	2619.00	0.52	201558.24	
Personal Care	15 minute	425	7668.00	4.12	13426668.00	
Prevocational Services						1592100.00

GRAND TOTAL:	323262785.76
Total Estimated Unduplicated Participants:	5260
Factor D (Divide total by number of participants):	61456.80
Average Length of Stay on the Waiver:	364

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:						
Prevocational Facility Based	hour	95	900.00	12.20	1043100.00	
Prevocational Community Based	hour	50	450.00	24.40	549000.00	
Residential Habilitation Total:						255469654.80
Residential Habilitation	day	3300	348.00	221.97	254910348.00	
In Home Residential Habilitation	15 minutes	37	3315.00	4.56	559306.80	
Respite Total:						206531.52
Respite Out of Home	15 minutes	26	1273.00	3.12	103265.76	
Respite In Home	15 minutes	26	1273.00	3.12	103265.76	
Adult Companion Services Total:						281943.75
Adult Companion Services Self Directed	15 minutes	25	1917.00	2.75	131793.75	
Adult Companion Services	15 minutes	25	1925.00	3.12	150150.00	
Assistive Technology Services Total:						7429.40
Assistive Technology	item	10	1.00	371.47	3714.70	
Assistive Technology Self Directed	item	10	1.00	371.47	3714.70	
Benefits and Career Counseling Total:						3480.00
Benefits Counseling	15 minutes	6	40.00	10.00	2400.00	
Benefits Reporting Assistance	15 minutes	10	36.00	3.00	1080.00	
Community Experience Total:						2287220.00
Community Experience 1:3	15 minutes	60	4940.00	6.10	1808040.00	
Community Experience 1:1	15 minutes	10	4940.00	9.70	479180.00	
Community Specialist Total:						1076.40
Community Specialist	15 minutes	5	18.00	11.96	1076.40	
Crisis Intervention Total:						191056.32
Crisis Intervention					191056.32	

GRAND TOTAL:	323262785.76
Total Estimated Unduplicated Participants:	5260
Factor D (Divide total by number of participants):	61456.80
Average Length of Stay on the Waiver:	364

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	15 minutes	63	324.00	9.36		
Environmental Accessibility Adaptations Total:						49920.00
Environmental Accessibility Adaptations Self Directed	item	5	1.00	4992.00	24960.00	
Environmental Accessibility Adaptations	item	5	1.00	4992.00	24960.00	
Housing Stabilization Service Total:						2400.00
Housing Stabilization Service	15 minutes	6	40.00	10.00	2400.00	
Individual Directed Goods and Services Total:						5000.00
Individual Directed Goods and Services	item	5	1.00	1000.00	5000.00	
Occupational Therapy Total:						92749.80
Occupational Therapy	15 minutes	69	94.00	14.30	92749.80	
Personal Emergency Response System Total:						22000.00
PERS Self Directed	item	5	1.00	1000.00	5000.00	
PERS	item	5	1.00	1000.00	5000.00	
PERS Monthly Fee	monthly	5	12.00	100.00	6000.00	
PERS Self-Directed Monthly Fee	Montly	5	12.00	100.00	6000.00	
Physical Therapy Total:						57228.60
Physical Therapy	15 minutes	69	58.00	14.30	57228.60	
Positive Behavior Support Total:						1333515.30
Positive Behavior Support 1 Prof Certified	15 minutes	413	59.00	19.50	475156.50	
Postive Behavior Support 2 Professional	15 minutes	439	76.00	14.30	477105.20	
Positive Behavior Support 3 Technician	15 minutes	445	94.00	9.10	380653.00	
Positive Behavior Support 1 Prof Certified Self Directed	15 minutes	1	5.00	19.50	97.50	

GRAND TOTAL:	323262785.76
Total Estimated Unduplicated Participants:	5260
Factor D (Divide total by number of participants):	61456.80
Average Length of Stay on the Waiver:	364

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Positive Behavior Support 2 Professional Self Directed	15 minutes	1	18.00	14.30	257.40	
Positive Behavior Support 3 Technician Self Directed	15 minutes	1	27.00	9.10	245.70	
Skilled Nursing Total:						120712.80
RN Nursing	hour	43	48.00	36.40	75129.60	
LPN Nursing Self Directed	hour	3	45.00	20.80	2808.00	
LPN Nursing	hour	33	48.00	20.80	32947.20	
RN Nursing Self Directed	hour	6	45.00	36.40	9828.00	
Specialized Medical Supplies Total:						54000.00
Specialized Medical Supplies	month	20	12.00	150.00	36000.00	
SpecializedMedical Supplies Self Directed	month	10	12.00	150.00	18000.00	
Speech and Language Therapy Total:						43972.50
Speech and Language Therapy	15 minutes	25	123.00	14.30	43972.50	
Supported Employment Transportation Total:						520.00
Supported Employment Transportation mile	mile	25	40.00	0.52	520.00	
Supported Living Service Total:						370548.00
Supported Living Service	monthly	10	12.00	3087.90	370548.00	
				GRAND TOTAL:		323262785.76
				Total Estimated Unduplicated Participants:		5260
				Factor D (Divide total by number of participants):		61456.80
				Average Length of Stay on the Waiver:		364

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						35822305.03
Day Habilitation Level 2	15 minute	553	2525.00	2.47	3448922.75	
Day Habilitation Level 1 w Transport	15 minutes	112	1799.00	2.26	455362.88	
Day Habilitation Level 2 w Transport	15 minutes	143	1792.00	3.05	781580.80	
Day Habilitation Level 3 w Transport	15 minutes	50	1722.00	3.84	330624.00	
Day Habilitation Level 1	15 minutes	300	1856.00	1.94	1080192.00	
Day Habilitation Level 3	15 minutes	420	2009.00	3.53	2978543.40	
Day Habilitation Level 4 w Transport	15 minutes	12	1005.00	4.85	58491.00	
Day Habilitation Level 4	15 minutes	156	1867.00	4.53	1319371.56	
Community Day Habilitation Level 1	15 minute	401	1856.00	4.16	3096104.96	
Community Day Habilitation Level1 w Transport	15 minutes	132	1779.00	4.80	1127174.40	
Community Day Habilitation Level 2	15 minutes	753	2525.00	4.76	9050307.00	
Community Day Habilitation Level 2 w/ Trans	15 minute	316	1792.00	5.40	3057868.80	
Community Day Habilitation Level 3	15 minutes	440	2009.00	5.94	5250722.40	
Community Day Habilitation Level 3 w/Trans	15 minutes	56	1722.00	6.58	634522.56	
Community Day Habilitation Level 4	15 minutes	176	1867.00	9.06	2977043.52	
Community Day Habilitation Level 4 w/ Trans	15 minutes	18	1005.00	9.70	175473.00	
Employment Support Total:						78896.00
Individual Job Developer	15 minutes	7	320.00	10.00	22400.00	
Individual Job Coach	15 minutes	7	320.00	7.50	16800.00	
Assessment/Discovery	15 minutes	12	120.00	10.00	14400.00	
Employment Small Group 1: 2-3	15 minutes	10	160.00	7.90	12640.00	
Employment Small					12656.00	

GRAND TOTAL:	314480879.23
Total Estimated Unduplicated Participants:	5260
Factor D (Divide total by number of participants):	59787.24
Average Length of Stay on the Waiver:	365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Group 1:4	15 minutes	14	200.00	4.52		
Personal Care Total:						20050233.48
Self Directed Personal Care	15 minutes	215	7668.00	3.48	5737197.60	
Personal Care on Worksite	15 minutes	15	2619.00	6.00	235710.00	
Personal Care Transportation	mile	153	2619.00	0.52	208367.64	
Personal Care	15 minutes	439	7668.00	4.12	13868958.24	
Prevocational Services Total:						1592100.00
Prevocational Facility Based	hour	85	900.00	12.20	933300.00	
Prevocational Community Based	hour	60	450.00	24.40	658800.00	
Residential Habilitation Total:						250816333.32
Residential Habilitation	day	3247	348.00	221.97	250816333.32	
In Home Residential Habilitation	15 minutes	0	0.00	0.01	0.00	
Respite Total:						258164.40
Respite Out of Home	15 minutes	35	1273.00	3.12	139011.60	
Respite In Home	15 minutes	30	1273.00	3.12	119152.80	
Adult Companion Services Total:						344338.50
Adult Companion Services Self Directed	15 minutes	30	1917.00	2.75	158152.50	
Adult Companion Services	15 minutes	31	1925.00	3.12	186186.00	
Assistive Technology Services Total:						8915.28
Assistive Technology	item	12	1.00	371.47	4457.64	
Assistive Technology Self Directed	item	12	1.00	371.47	4457.64	
Benefits and Career Counseling Total:						4496.00
Benefits Counseling	15 minutes	8	40.00	10.00	3200.00	
Benefits Reporting Assistance	15 minutes	12	36.00	3.00	1296.00	

GRAND TOTAL:	314480879.23
Total Estimated Unduplicated Participants:	5260
Factor D (Divide total by number of participants):	59787.24
Average Length of Stay on the Waiver:	365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Experience Total:						**2828150.00**
Community Experience 1:3	15 minutes	70	4940.00	6.10	**2109380.00**	
Community Experience 1:1	15 minutes	15	4940.00	9.70	**718770.00**	
Community Specialist Total:						**0.00**
Community Specialist	15 minutes	0	0.00	0.01	**0.00**	
Crisis Intervention Total:						**191056.32**
Crisis Intervention	15 minutes	63	324.00	9.36	**191056.32**	
Environmental Accessibility Adaptations Total:						**49920.00**
Environmental Accessibility Adaptations Self Directed	item	5	1.00	4992.00	**24960.00**	
Environmental Accessibility Adaptations	item	5	1.00	4992.00	**24960.00**	
Housing Stabilization Service Total:						**2800.00**
Housing Stabilization Service	15 minutes	7	40.00	10.00	**2800.00**	
Individual Directed Goods and Services Total:						**6000.00**
Individual Directed Goods and Services	item	6	1.00	1000.00	**6000.00**	
Occupational Therapy Total:						**98126.60**
Occupational Therapy	15 minutes	73	94.00	14.30	**98126.60**	
Personal Emergency Response System Total:						**76000.00**
PERS Self Directed	item	5	1.00	1000.00	**5000.00**	
PERS	item	5	1.00	1000.00	**5000.00**	
PERS Monthly Fee	item	5	12.00	1000.00	**60000.00**	
PERS Self-Directed Monthly Fee	monthly	5	12.00	100.00	**6000.00**	
Physical Therapy Total:						**60546.20**
Physical Therapy	15 minutes	73	58.00	14.30	**60546.20**	

GRAND TOTAL:	**314480879.23**
Total Estimated Unduplicated Participants:	**5260**
Factor D (Divide total by number of participants):	**59787.24**
Average Length of Stay on the Waiver:	365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Positive Behavior Support Total:						**1368705.00**
Positive Behavior Support 1 Prof Certified	15 minutes	430	59.00	19.50	**494715.00**	
Postive Behavior Support 2 Professional	15 minutes	450	76.00	14.30	**489060.00**	
Positive Behavior Support 3 Technician	15 minutes	450	94.00	9.10	**384930.00**	
Positive Behavior Support 1 Prof Certified Self Directed	15 minutes	0	0.00	0.01	**0.00**	
Positive Behavior Support 2 Professional Self Directed	15 minutes	0	0.00	0.01	**0.00**	
Positive Behavior Support 3 Technician Self Directed	15 minutes	0	0.00	0.01	**0.00**	
Skilled Nursing Total:						**140821.20**
RN Nursing	hour	50	48.00	36.40	**87360.00**	
LPN Nursing Self Directed	hour	3	45.00	36.40	**4914.00**	
LPN Nursing	hour	43	48.00	20.80	**42931.20**	
RN Nursing Self Directed	hour	6	45.00	20.80	**5616.00**	
Specialized Medical Supplies Total:						**72000.00**
Specialized Medical Supplies	month	25	12.00	150.00	**45000.00**	
SpecializedMedical Supplies Self Directed	month	15	12.00	150.00	**27000.00**	
Speech and Language Therapy Total:						**54525.90**
Speech and Language Therapy	15 minutes	31	123.00	14.30	**54525.90**	
Supported Employment Transportation Total:						**624.00**
Supported Employment Transportation mile	mile	30	40.00	0.52	**624.00**	
Supported Living Service Total:						**555822.00**
Supported Living Service	monthly	15	12.00	3087.90	**555822.00**	
				GRAND TOTAL:		**314480879.23**
				Total Estimated Unduplicated Participants:		**5260**
				Factor D (Divide total by number of participants):		**59787.24**
				Average Length of Stay on the Waiver:		365

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						35907037.70
Day Habilitation Level 2	15 minute	545	2525.00	2.47	3399028.75	
Day Habilitation Level 1 w Transport	15 minute	110	1799.00	2.26	447231.40	
Day Habilitation Level 2 w Transport	15 minute	135	1792.00	3.05	737856.00	
Day Habilitation Level 3 w Transport	15 minute	45	1722.00	3.84	297561.60	
Day Habilitation Level 1	15 minute	285	1856.00	1.94	1026182.40	
Day Habilitation Level 3	15 minutes	395	2009.00	3.53	2801249.15	
Day Habilitation Level 4 w Transport	15 minutes	10	1005.00	4.85	48742.50	
Day Habilitation Level 4	15 minutes	150	1867.00	4.53	1268626.50	
Community Day Habilitation Level 1	15 minute	416	1856.00	4.16	3211919.36	
Community Day Habilitation Level1 w Transport	15 minutes	135	1779.00	4.80	1152792.00	
Community Day Habilitation Level 2	15 minutes	761	2525.00	4.76	9146459.00	
Community Day Habilitation Level 2 w/ Trans	15 minute	321	1792.00	5.40	3106252.80	
Community Day Habilitation Level 3	15 minutes	444	2009.00	5.94	5298456.24	
Community Day Habilitation Level 3 w/Trans	15 minutes	61	1722.00	6.58	691176.36	
Community Day Habilitation Level 4	15 minutes	182	1867.00	9.06	3078533.64	
Community Day Habilitation Level 4 w/ Trans	15 minutes	20	1005.00	9.70	194970.00	
Employment Support						86576.00
				GRAND TOTAL:		312654681.05
				Total Estimated Unduplicated Participants:		5260
				Factor D (Divide total by number of participants):		59440.05
				Average Length of Stay on the Waiver:		365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:						
Individual Job Developer	15 minutes	9	320.00	10.00	28800.00	
Individual Job Coach	15 minutes	9	160.00	7.50	10800.00	
Assessment/Discovery	15 minutes	14	120.00	10.00	16800.00	
Employment Small Group 1: 2-3	15 minutes	11	160.00	7.90	13904.00	
Employment Small Group 1:4	15 minutes	18	200.00	4.52	16272.00	
Personal Care Total:						20715821.28
Self Directed Personal Care	15 minutes	225	7668.00	3.48	6004044.00	
Personal Care on Worksite	15 minutes	18	2619.00	6.00	282852.00	
Personal Care Transportation	mile	156	2619.00	0.52	212453.28	
Personal Care	15 minutes	450	7668.00	4.12	14216472.00	
Prevocational Services Total:						1738500.00
Prevocational Facility Based	hour	75	900.00	12.20	823500.00	
Prevocational Community Based	hour	75	500.00	24.40	915000.00	
Residential Habilitation Total:						247185792.00
Residential Habilitation	day	3200	348.00	221.97	247185792.00	
In Home Residential Habilitation	15 minutes	0	0.00	0.01	0.00	
Respite Total:						436893.60
Respite Out of Home	15 minutes	75	1273.00	3.12	297882.00	
Respite In Home	15 minutes	35	1273.00	3.12	139011.60	
Adult Companion Services Total:						424751.25
Adult Companion Services Self Directed	15 minutes	35	1917.00	2.75	184511.25	
Adult Companion Services	15 minutes	40	1925.00	3.12	240240.00	
Assistive Technology Services Total:						10401.16

GRAND TOTAL:	312654681.05
Total Estimated Unduplicated Participants:	5260
Factor D (Divide total by number of participants):	59440.05
Average Length of Stay on the Waiver:	365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assistive Technology	item	14	1.00	371.47	5200.58	
Assistive Technology Self Directed	item	14	1.00	371.47	5200.58	
Benefits and Career Counseling Total:						6744.00
Benefits Counseling	15 minutes	12	40.00	10.00	4800.00	
Benefits Reporting Assistance	15 minutes	18	36.00	3.00	1944.00	
Community Experience Total:						3218410.00
Community Experience 1:3	15 minutes	75	4940.00	6.10	2260050.00	
Community Experience 1:1	15 minutes	20	4940.00	9.70	958360.00	
Community Specialist Total:						0.00
Community Specialist	15 minutes	0	0.00	0.01	0.00	
Crisis Intervention Total:						194088.96
Crisis Intervention	15 minutes	64	324.00	9.36	194088.96	
Environmental Accessibility Adaptations Total:						49920.00
Environmental Accessibility Adaptations Self Directed	item	5	1.00	4992.00	24960.00	
Environmental Accessibility Adaptations	item	5	1.00	4992.00	24960.00	
Housing Stabilization Service Total:						4000.00
Housing Stabilization Service	15 minutes	10	40.00	10.00	4000.00	
Individual Directed Goods and Services Total:						7000.00
Individual Directed Goods and Services	item	7	1.00	1000.00	7000.00	
Occupational Therapy Total:						102159.20
Occupational Therapy	15 minutes	76	94.00	14.30	102159.20	
Personal Emergency Response System Total:						37400.00
PERS Self Directed	item	8	1.00	1000.00	8000.00	

GRAND TOTAL:	312654681.05
Total Estimated Unduplicated Participants:	5260
Factor D (Divide total by number of participants):	59440.05
Average Length of Stay on the Waiver:	365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
PERS	item	9	1.00	1000.00	9000.00	
PERS Monthly Fee	monthly	9	12.00	100.00	10800.00	
PERS Self-Directed Monthly Fee	Montly	8	12.00	100.00	9600.00	
Physical Therapy Total:						63034.40
Physical Therapy	15 minutes	76	58.00	14.30	63034.40	
Positive Behavior Support Total:						1410311.50
Positive Behavior Support 1 Prof Certified	15 minutes	453	59.00	19.50	521176.50	
Postive Behavior Support 2 Professional	15 minutes	460	76.00	14.30	499928.00	
Positive Behavior Support 3 Technician	15 minutes	455	94.00	9.10	389207.00	
Positive Behavior Support 1 Prof Certified Self Directed	15 minutes	0	0.00	0.01	0.00	
Positive Behavior Support 2 Professional Self Directed	15 minutes	0	0.00	0.01	0.00	
Positive Behavior Support 3 Technician Self Directed	15 minutes	0	0.00	0.01	0.00	
Skilled Nursing Total:						153660.00
RN Nursing	hour	55	48.00	36.40	96096.00	
LPN Nursing Self Directed	hour	3	45.00	20.80	2808.00	
LPN Nursing	hour	45	48.00	20.80	44928.00	
RN Nursing Self Directed	hour	6	45.00	36.40	9828.00	
Specialized Medical Supplies Total:						90000.00
Specialized Medical Supplies	month	30	12.00	150.00	54000.00	
SpecializedMedical Supplies Self Directed	month	20	12.00	150.00	36000.00	
Speech and Language Therapy Total:						70356.00
Speech and Language Therapy	15 minutes	40	123.00	14.30	70356.00	

GRAND TOTAL:	312654681.05
Total Estimated Unduplicated Participants:	5260
Factor D (Divide total by number of participants):	59440.05
Average Length of Stay on the Waiver:	365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Employment Transportation Total:						728.00
Supported Employment Transportation mile	mile	35	40.00	0.52	728.00	
Supported Living Service Total:						741096.00
Supported Living Service	monthly	20	12.00	3087.90	741096.00	
				GRAND TOTAL:		312654681.05
				Total Estimated Unduplicated Participants:		5260
				Factor D (Divide total by number of participants):		59440.05
				Average Length of Stay on the Waiver:		365

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						35823303.58
Day Habilitation Level 2	15 minutes	525	2525.00	2.47	3274293.75	
Day Habilitation Level 1 w Transport	15 minutes	95	1799.00	2.26	386245.30	
Day Habilitation Level 2 w Transport	15 minutes	120	1792.00	3.05	655872.00	
Day Habilitation Level 3 w Transport	15 minues	40	1722.00	3.84	264499.20	
Day Habilitation Level 1	15 minutes	250	1856.00	1.94	900160.00	
Day Habilitation Level 3	15 minutes	350	2009.00	3.53	2482119.50	
Day Habilitation Level 4 w Transport	15 minutes	10	1005.00	4.85	48742.50	
Day Habilitation Level 4	15 minutes	125	1867.00	4.53	1057188.75	
Community Day Habilitation Level 1	15 minute	425	1856.00	4.16	3281408.00	
Community Day					1238184.00	
				GRAND TOTAL:		310741861.05
				Total Estimated Unduplicated Participants:		5260
				Factor D (Divide total by number of participants):		59076.40
				Average Length of Stay on the Waiver:		365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Habilitation Level1 w Transport	15 minutes	145	1779.00	4.80		
Community Day Habilitation Level 2	15 minutes	780	2525.00	4.76	9374820.00	
Community Day Habilitation Level 2 w/ Trans	15 minute	325	1792.00	5.40	3144960.00	
Community Day Habilitation Level 3	15 minutes	450	2009.00	5.94	5370057.00	
Community Day Habilitation Level 3 w/Trans	15 minutes	68	1772.00	6.58	792863.68	
Community Day Habilitation Level 4	15 minutes	195	1867.00	9.06	3298428.90	
Community Day Habilitation Level 4 w/ Trans	15 minutes	26	1005.00	9.70	253461.00	
Employment Support Total:						99040.00
Individual Job Developer	15 minutes	10	320.00	10.00	32000.00	
Individual Job Coach	15 minutes	10	160.00	7.50	12000.00	
Assessment/Discovery	15 minutes	15	120.00	10.00	18000.00	
Employment Small Group 1: 2-3	15 minutes	15	160.00	7.90	18960.00	
Employment Small Group 1:4	15 minutes	20	200.00	4.52	18080.00	
Personal Care Total:						21825061.20
Self Directed Personal Care	15 minutes	235	7668.00	3.48	6270890.40	
Personal Care on Worksite	15 minutes	21	2619.00	6.00	329994.00	
Personal Care Transportation	mile	160	2619.00	0.52	217900.80	
Personal Care	15 minutes	475	7668.00	4.12	15006276.00	
Prevocational Services Total:						1872700.00
Prevocational Facility Based	hour	65	900.00	12.20	713700.00	
Prevocational Community Based	hour	95	500.00	24.40	1159000.00	
Residential Habilitation Total:						243323514.00
Residential Habilitation	day	3150	348.00	221.97	243323514.00	

GRAND TOTAL:	310741861.05
Total Estimated Unduplicated Participants:	5260
Factor D (Divide total by number of participants):	59076.40
Average Length of Stay on the Waiver:	365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
In Home Residential Habilitation	15 minutes	0	0.00	0.01	0.00	
Respite Total:						476611.20
Respite Out of Home	15 minutes	80	1273.00	3.12	317740.80	
Respite In Home	15 minutes	40	1273.00	3.12	158870.40	
Adult Companion Services Total:						513504.75
Adult Companion Services Self Directed	15 minutes	45	1917.00	2.75	237228.75	
Adult Companion Services	15 minutes	46	1925.00	3.12	276276.00	
Assistive Technology Services Total:						11144.10
Assistive Technology	item	15	1.00	371.47	5572.05	
Assistive Technology Self Directed	item	15	1.00	371.47	5572.05	
Benefits and Career Counseling Total:						12376.00
Benefits Counseling	15 minutes	25	40.00	10.00	10000.00	
Benefits Reporting Assistance	15 minutes	22	36.00	3.00	2376.00	
Community Experience Total:						3608670.00
Community Experience 1:3	15 minutes	80	4940.00	6.10	2410720.00	
Community Experience 1:1	15 minutes	25	4940.00	9.70	1197950.00	
Community Specialist Total:						0.00
Community Specialist	15 minutes	0	0.00	0.01	0.00	
Crisis Intervention Total:						191056.32
Crisis Intervention	15 minutes	63	324.00	9.36	191056.32	
Environmental Accessibility Adaptations Total:						49920.00
Environmental Accessibility Adaptations Self Directed	item	5	1.00	4992.00	24960.00	
Environmental Accessibility Adaptations	item	5	1.00	4992.00	24960.00	

GRAND TOTAL:	310741861.05
Total Estimated Unduplicated Participants:	5260
Factor D (Divide total by number of participants):	59076.40
Average Length of Stay on the Waiver:	365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Housing Stabilization Service Total:						**4400.00**
Housing Stabilization Service	15 minutes	11	40.00	10.00	**4400.00**	
Individual Directed Goods and Services Total:						**8000.00**
Individual Directed Goods and Services	item	8	1.00	1000.00	**8000.00**	
Occupational Therapy Total:						**104847.60**
Occupational Therapy	15 minutes	78	94.00	14.30	**104847.60**	
Personal Emergency Response System Total:						**48400.00**
PERS Self Directed	item	10	1.00	1000.00	**10000.00**	
PERS	item	12	1.00	1000.00	**12000.00**	
PERS Monthly Fee	monthly	12	12.00	100.00	**14400.00**	
PERS Self-Directed Monthly Fee	Montly	10	12.00	100.00	**12000.00**	
Physical Therapy Total:						**66352.00**
Physical Therapy	15 minutes	80	58.00	14.30	**66352.00**	
Positive Behavior Support Total:						**1426630.40**
Positive Behavior Support 1 Prof Certified	15 minutes	458	59.00	19.50	**526929.00**	
Postive Behavior Support 2 Professional	15 minutes	465	76.00	14.30	**505362.00**	
Positive Behavior Support 3 Technician	15 minutes	461	94.00	9.10	**394339.40**	
Positive Behavior Support 1 Prof Certified Self Directed	15 minutes	0	0.00	0.01	**0.00**	
Positive Behavior Support 2 Professional Self Directed	15 minutes	0	0.00	0.01	**0.00**	
Positive Behavior Support 3 Technician Self Directed	15 minutes	0	0.00	0.01	**0.00**	
Skilled Nursing Total:						**165391.20**
RN Nursing	hour	60	48.00	36.40	**104832.00**	

GRAND TOTAL:	**310741861.05**
Total Estimated Unduplicated Participants:	**5260**
Factor D (Divide total by number of participants):	**59076.40**
Average Length of Stay on the Waiver:	365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
LPN Nursing Self Directed	hour	3	45.00	20.80	2808.00	
LPN Nursing	hour	48	48.00	20.80	47923.20	
RN Nursing Self Directed	hour	6	45.00	36.40	9828.00	
Specialized Medical Supplies Total:						108000.00
Specialized Medical Supplies	month	35	12.00	150.00	63000.00	
SpecializedMedical Supplies Self Directed	month	25	12.00	150.00	45000.00	
Speech and Language Therapy Total:						75632.70
Speech and Language Therapy	15 minutes	43	123.00	14.30	75632.70	
Supported Employment Transportation Total:						936.00
Supported Employment Transportation mile	mile	45	40.00	0.52	936.00	
Supported Living Service Total:						926370.00
Supported Living Service	monthly	25	12.00	3087.90	926370.00	
				GRAND TOTAL:		310741861.05
				Total Estimated Unduplicated Participants:		5260
				Factor D (Divide total by number of participants):		59076.40
				Average Length of Stay on the Waiver:		365

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						38631332.40
Day Habilitation Level 2	15 minute	515	2525.00	2.47	3211926.25	
Day Habilitation Level 1 w Transport	15 minutes				345587.90	
				GRAND TOTAL:		312780729.49
				Total Estimated Unduplicated Participants:		5260
				Factor D (Divide total by number of participants):		59464.02
				Average Length of Stay on the Waiver:		365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		85	1799.00	2.26		
Day Habilitation Level 2 w Transport	15 minutes	110	1792.00	3.05	601216.00	
Day Habilitation Level 3 w Transport	15 minutes	30	1722.00	3.84	198374.40	
Day Habilitation Level 1	15 minutes	240	1856.00	1.94	864153.60	
Day Habilitation Level 3	15 minutes	700	2009.00	3.53	4964239.00	
Day Habilitation Level 4 w Transport	15 minutes	10	1005.00	4.85	48742.50	
Day Habilitation Level 4	15 minutes	115	1867.00	4.53	972613.65	
Community Day Habilitation Level 1	15 minute	435	1856.00	4.16	3358617.60	
Community Day Habilitation Level1 w Transport	15 minutes	155	1779.00	4.80	1323576.00	
Community Day Habilitation Level 2	15 minutes	790	2525.00	4.76	9495010.00	
Community Day Habilitation Level 2 w/ Trans	15 minute	330	1792.00	5.40	3193344.00	
Community Day Habilitation Level 3	15 minutes	456	2009.00	5.94	5441657.76	
Community Day Habilitation Level 3 w/Trans	15 minutes	75	1772.00	6.58	874482.00	
Community Day Habilitation Level 4	15 minutes	203	1868.00	9.06	3435588.24	
Community Day Habilitation Level 4 w/ Trans	15 minutes	31	1005.00	9.70	302203.50	
Employment Support Total:						135480.00
Individual Job Developer	15 minutes	15	320.00	10.00	48000.00	
Individual Job Coach	15 minutes	15	160.00	7.50	18000.00	
Assessment/Discovery	15 minutes	18	120.00	10.00	21600.00	
Employment Small Group 1: 2-3	15 minutes	20	160.00	7.90	25280.00	
Employment Small Group 1:4	15 minutes	25	200.00	4.52	22600.00	
Personal Care Total:						23053372.20
Self Directed					6671160.00	

GRAND TOTAL:	312780729.49
Total Estimated Unduplicated Participants:	5260
Factor D (Divide total by number of participants):	59464.02
Average Length of Stay on the Waiver:	365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care	15 minutes	250	7668.00	3.48		
Personal Care on Worksite	15 minutes	23	2619.00	6.00	361422.00	
Personal Care Transportation	mile	165	2619.00	0.52	224710.20	
Personal Care	15 minutes	500	7668.00	4.12	15796080.00	
Prevocational Services Total:						2630320.00
Prevocational Facility Based	hour	60	900.00	12.20	658800.00	
Prevocational Community Based	hour	101	800.00	24.40	1971520.00	
Residential Habilitation Total:						239461236.00
Residential Habilitation	day	3100	348.00	221.97	239461236.00	
In Home Residential Habilitation	15 minutes	0	0.00	0.01	0.00	
Respite Total:						556046.40
Respite Out of Home	15 minutes	95	1273.00	3.12	377317.20	
Respite In Home	15 minutes	45	1273.00	3.12	178729.20	
Adult Companion Services Total:						650306.25
Adult Companion Services Self Directed	15 minutes	55	1917.00	2.75	289946.25	
Adult Companion Services	15 minutes	60	1925.00	3.12	360360.00	
Assistive Technology Services Total:						12629.98
Assistive Technology	item	17	1.00	371.47	6314.99	
Assistive Technology Self Directed	item	17	1.00	371.47	6314.99	
Benefits and Career Counseling Total:						15024.00
Benefits Counseling	15 minutes	30	40.00	10.00	12000.00	
Benefits Reporting Assistance	15 minutes	28	36.00	3.00	3024.00	
Community Experience Total:						3998930.00
Community Experience 1:3	15 minutes	85	4940.00	6.10	2561390.00	

GRAND TOTAL:	312780729.49
Total Estimated Unduplicated Participants:	5260
Factor D (Divide total by number of participants):	59464.02
Average Length of Stay on the Waiver:	365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Experience 1:1	15 minutes	30	4940.00	9.70	1437540.00	
Community Specialist Total:						0.00
Community Specialist	15 minutes	0	0.00	0.01	0.00	
Crisis Intervention Total:						209252.16
Crisis Intervention	15 minutes	69	324.00	9.36	209252.16	
Environmental Accessibility Adaptations Total:						59904.00
Environmental Accessibility Adaptations Self Directed	item	6	1.00	4992.00	29952.00	
Environmental Accessibility Adaptations	item	6	1.00	4992.00	29952.00	
Housing Stabilization Service Total:						4800.00
Housing Stabilization Service	15 minutes	12	40.00	10.00	4800.00	
Individual Directed Goods and Services Total:						9000.00
Individual Directed Goods and Services	item	9	1.00	1000.00	9000.00	
Occupational Therapy Total:						107536.00
Occupational Therapy	15 minutes	80	94.00	14.30	107536.00	
Personal Emergency Response System Total:						52800.00
PERS Self Directed	item	11	1.00	1000.00	11000.00	
PERS	item	13	1.00	1000.00	13000.00	
PERS Monthly Fee	monthly	13	12.00	100.00	15600.00	
PERS Self-Directed Monthly Fee	Montly	11	12.00	100.00	13200.00	
Physical Therapy Total:						70499.00
Physical Therapy	15 minutes	85	58.00	14.30	70499.00	
Positive Behavior Support Total:						1444660.10
Positive Behavior Support 1 Prof Certified	15 minutes	463	59.00	19.50	532681.50	

GRAND TOTAL:	312780729.49
Total Estimated Unduplicated Participants:	5260
Factor D (Divide total by number of participants):	59464.02
Average Length of Stay on the Waiver:	365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Postive Behavior Support 2 Professional	15 minutes	470	76.00	14.30	510796.00	
Positive Behavior Support 3 Technician	15 minutes	469	94.00	9.10	401182.60	
Positive Behavior Support 1 Prof Certified Self Directed	15 minutes	0	0.00	0.01	0.00	
Positive Behavior Support 2 Professional Self Directed	15 minutes	0	0.00	0.01	0.00	
Positive Behavior Support 3 Technician Self Directed	15 minutes	0	0.00	0.01	0.00	
Skilled Nursing Total:						172629.60
RN Nursing	hour	63	48.00	36.40	110073.60	
LPN Nursing Self Directed	hour	3	45.00	20.80	2808.00	
LPN Nursing	hour	50	48.00	20.80	49920.00	
RN Nursing Self Directed	hour	6	45.00	36.40	9828.00	
Specialized Medical Supplies Total:						126000.00
Specialized Medical Supplies	month	40	12.00	150.00	72000.00	
SpecializedMedical Supplies Self Directed	month	30	12.00	150.00	54000.00	
Speech and Language Therapy Total:						80909.40
Speech and Language Therapy	15 minutes	46	123.00	14.30	80909.40	
Supported Employment Transportation Total:						1144.00
Supported Employment Transportation mile	mile	55	40.00	0.52	1144.00	
Supported Living Service Total:						1296918.00
Supported Living Service	monthly	35	12.00	3087.90	1296918.00	

GRAND TOTAL:	312780729.49
Total Estimated Unduplicated Participants:	5260
Factor D (Divide total by number of participants):	59464.02
Average Length of Stay on the Waiver:	365