APPENDIX K: Emergency Preparedness and Response and COVID-19 Addendum

Background:

This standalone appendix may be utilized by the state during emergency situations to request amendments to its approved waiver, to multiple approved waivers in the state, and/or to all approved waivers in the state. It includes actions that states can take under the existing Section 1915(c) home and community-based waiver authority in order to respond to an emergency. Other activities may require the use of various other authorities such as the Section 1115 demonstrations or the Section 1135 authorities.[i] This appendix may be applied retroactively as needed by the state. Public notice requirements normally applicable under 1915(c) do not apply to information contained in this Appendix.

Appendix K-1: General Information

General Information:

A. State: ALABAMA

B. Waiver Title(s):

AL Home and Community-Based Waiver for Persons with Intellectual Disabilities (ID)
AL HCBS Living at Home Waiver for Persons w/ID (LAH)

C. Control Number(s):

ID 0001.R08.03
LAH 0391.03.03

D. Type of Emergency (The state may check more than one box):

X	**Pandemic or Epidemic**
O	**Natural Disaster**
O	**National Security Emergency**
O	**Environmental**
O	**Other (specify):**

E. Brief Description of Emergency. *In no more than one paragraph each*, briefly describe the: 1) nature of emergency; 2) number of individuals affected and the state's mechanism to identify individuals at risk; 3) roles of state, local and other entities involved in approved waiver operations; and 4) expected changes needed to service delivery methods, if applicable. The state should provide this information for each emergency checked if those emergencies affect different geographic areas and require different changes to the waiver.

COVID-19 pandemic. This amendment will apply waiver-wide for each waiver included in this Appendix, to all individuals impacted by the virus or the response to the virus (e.g. closure of day programs, etc.)

F. Proposed Effective Date: Start Date: January 27, 2020
Anticipated End Date: January 26, 2021

G. Description of Transition Plan.

All activities will take place in response to the impact of COVID-19 as efficiently and effectively as possible based upon the complexity of the change.

H. Geographic Areas Affected:

These actions will apply across the waiver to all individuals impacted by the COVID-19 virus

I. Description of State Disaster Plan (if available) ***Reference to external documents is acceptable:***

N/A

Appendix K-2: Temporary or Emergency-Specific Amendment to Approved Waiver

Temporary or Emergency-Specific Amendment to Approved Waiver:

These are changes that, while directly related to the state's response to an emergency situation, require amendment to the approved waiver document. These changes are time limited and tied specifically to individuals impacted by the emergency. Permanent or long-ranging changes will need to be incorporated into the main appendices of the waiver, via an amendment request in the waiver management system (WMS) upon advice from CMS.

a.___ Access and Eligibility:

i.___ Temporarily increase the cost limits for entry into the waiver.
[Provide explanation of changes and specify the temporary cost limit.]

ii._X_ Temporarily modify additional targeting criteria.
[Explanation of changes]

ID and LAH:
For the duration of the emergency period, all persons enrolled in the Waivers may receive fewer than one service without being subject to discharge. However, all persons enrolled in the waiver will continue to receive monitoring/review of services by a Support Coordinator as needed, and on a quarterly basis as a minimum.

b._X__ Services

i.__X_ Temporarily modify service scope or coverage.
[Complete Section A- Services to be Added/Modified During an Emergency.]

ii. X__Temporarily exceed service limitations (including limits on sets of services as described in Appendix C-4) or requirements for amount, duration, and prior authorization to address health and welfare issues presented by the emergency.
[Explanation of changes]

ID and LAH: When circumstances related to COVID-19 diagnoses or potential contact require it, and upon explicit approval by the Operating Agency, the State will permit temporary increases beyond the currently defined waiver service caps and limitations to allow the needed amount, duration or change in scope within the Waiver to effectively address emergent health, safety and welfare-related needs of participants. The temporary modifications described below apply to the following services, as applicable: Residential Habilitation, Personal Care, Adult Companion, and Respite.

- Limitations on the number of participants served with Residential Habilitation in each certified home may be exceeded, but only when all other alternatives for supports have been exhausted.
- Minimum staffing ratios in Residential Habilitation settings may be exceeded due to staffing shortages, so long as the health and safety of participants is preserved and required minimum staffing ratios are implemented as often and as soon as possible.
- Any previously authorized Personal Care or Adult Companion services, or any combination of these services, may be modified up to a maximum of 18 hours per day without requesting a variance in order to meet the needs of the participants.
- Respite services, including any combination of In-Home or Out-of-Home Respite, may exceed the fiscal year limit of 4320 units.

The Support Coordinator and/or the service provider/self-directed Employer of Record (EOR) will be responsible to review and substantiate a need and capacity to increase traditional Waiver services to effectively address emergent health, safety and welfare-related needs of program participants during the COVID-19 pandemic. Emergency modifications to a participant's person-centered plan must be both reasonable and necessary. The Operating Agency will perform retrospective reviews to assure that fraud, waste and program abuse do not occur as a result of this emergency response measure.

Temporarily allow verbal orders from a physician or other licensed health care provider for non-prescription Specialized Medical Supplies authorized in an individual's care plan as of the date of the COVID 19 PHE, including adult protective undergarments, catheter bags, and other supplies covered under that service, and for nonprescription Assistive Technology authorized in an individual's care plan as of the date of the COVID-19 PHE. This modification will be in effect beginning March 13, 2020 and extend through the end of the month in which the PHE terminates, not to exceed the end date of the approved Appendix K.

iii. ___Temporarily add services to the waiver to address the emergency situation (for example, emergency counseling; heightened case management to address emergency needs; emergency medical supplies and equipment; individually directed goods and services; ancillary services to establish temporary residences for dislocated waiver enrollees; necessary technology; emergency evacuation transportation outside of the scope of non-emergency transportation or transportation already provided through the waiver).
[Complete Section A-Services to be Added/Modified During an Emergency]

iv. _X Temporarily expand setting(s) where services may be provided (e.g. hotels, shelters, schools, churches). Note for respite services only, the state should indicate any facility-based settings and indicate whether room and board is included:
[Explanation of modification, and advisement if room and board is included in the respite rate]:

ID and LAH: When circumstances related to COVID-19 diagnoses or potential contact require it, and upon explicit approval by the Regional Office of the Operating Agency, Out-of-Home Respite services may be provided in an alternative (e.g., non-certified) setting to ensure the health and safety of participants. The provider must submit a detailed plan for staffing, supplying, and monitoring the provision of Out-of-Home Respite in the alternative setting and must supply the appropriate Support Coordination agency and the Regional Office with full contact information and a list of proposed staff members for the alternative setting in advance of its utilization. Out-of-Home Respite is not provided in facility-based settings.

ID and LAH: Temporarily suspend any requirements for services to be provided in community locations, so as to consistently observe social distancing necessities and minimize potential exposure to COVID-19. To the extent that the services may be administered while safely observing social distancing guidelines, they may be provided in an alternative, non-community setting (e.g., a provider facility such as a gymnasium or home with sufficient space to allow for ample distancing). Any alternative setting for service provision must be reported to, and approved by, the applicable Regional Office.

v.___ Temporarily provide services in out of state settings (if not already permitted in the state's approved waiver). [Explanation of changes]

c.___ Temporarily permit payment for services rendered by family caregivers or legally responsible individuals if not already permitted under the waiver. Indicate the services to which this will apply and the safeguards to ensure that individuals receive necessary services as authorized in the plan of care, and the procedures that are used to ensure that payments are made for services rendered.

d._X__ Temporarily modify provider qualifications (for example, expand provider pool, temporarily modify or suspend licensure and certification requirements).

i.__X_ Temporarily modify provider qualifications.

[Provide explanation of changes, list each service affected, list the provider type, and the changes in provider qualifications.]

ID and LAH:

Provider staff training qualifications may be modified as follows:

- Required staff training for beginning employment, including Nurse Delegation Program training, may be conducted on-line, by telephone, or electronically, as appropriate.
- Any staff persons not fully trained must work under supervision of a fully trained staff person.
- Annual refresher training of staff due through 7/1/2020 may be extended for 90 days.

These modifications apply to the following services and provider types:

Adult Companion Services	Certified Waiver Hourly Services Provider
Skilled Nursing	Alabama-licensed LPN
Personal Care	Certified Waiver Hourly Services Provider (including Personal Care Workers) / Self-Directed Personal Care Workers
Positive Behavior Support	Individual employed or contracted by a certified agency (Level 1 Professional, Certified Level 2 Professional Level 3 Technician)
Residential Habilitation	Certified Residential Facility (includes BCBA, QIDP, Direct Support Staff)
Respite	Certified Waiver Hourly Services Provider (for in-home respite) Self-Directed In-home Respite Services Out of Home Respite, Community Residential Facility

- For Residential Habilitation, Adult Companion or Personal Care services, if family members are temporarily approved to provide these services in order to cover gaps in care resulting from issues related to the COVID-19 pandemic, the Operating Agency will temporarily suspend routine employee screening for said family members (e.g., TB, background checks, drug screens). Suspension of said screenings is temporary, and all required screenings will be required to be completed once the emergency period ends.

ii._X__ Temporarily modify provider types.

[Provide explanation of changes, list each service affected, and the changes in the provider type for each service].

ID and LAH:
Providers may be reimbursed at the approved waiver service limits, per existing Waiver limits and guidelines, when purchasing Specialized Medical Supplies and Assistive Technology items from any available vendor, regardless of inclusion on the existing approved vendor list, who can provide necessary and potentially short-supplied items in stock when supply shortages or costs are impacted by circumstances related to the COVID-19 pandemic.

iii._X Temporarily modify licensure or other requirements for settings where waiver services are furnished.

[Provide explanation of changes, description of facilities to be utilized and list each service provided in each facility utilized.]

ID and LAH:

- Temporarily suspend annual and follow-up certification reviews of existing provider agencies until 7/1/2020. All suspended certification reviews will be completed within 90 days of 7/1/20; however, if the PHE continues beyond 7/1/20, the Operating Agency will conduct desk and electronic reviews, instead of on-site reviews, through the end of the month in which the PHE terminates, not to exceed the end date of the approved Appendix K. Notwithstanding the foregoing, the Operating Agency will continue to complete "For Cause" on-site certification visits when needed based on any pattern of incident reports, complaints or other information indicating concerns regarding individuals' health, safety, rights, access to services, or other aspects of the provider organization's operations.
- For the duration of the PHE and through the end of the month in which the PHE is terminated, provider applications for new settings and/or services may be submitted electronically.

e. _X Temporarily modify processes for level of care evaluations or re-evaluations (within regulatory requirements). [Describe]

ID and LAH:
For a new applicant for waiver services, in the event that a qualifying evaluation is not possible, and substantiating documentation of all eligibility criteria is not available, the State will temporarily accept limited sources of substantiated data, including the most recent IQ test prior to age 18 with an IQ score less than 70, an ID diagnosis without an adaptive assessment prior to age 18, or a physician's statement verifying an ID diagnosis prior to age 18 that directly causes an adaptive behavior impairment.

f._X Temporarily increase payment rates. [Provide an explanation for the increase. List the provider types, rates by service, and specify whether this change is based on a rate development method that is different from the current approved waiver (and if different, specify and explain the rate development method). If the rate varies by provider, list the rate by service and by provider.]

ID and LAH:

- Temporarily increase Residential Habilitation rates by 19% for all providers, to account for greater needs for staffing and direct service, given the suspension of Day services, including Day Habilitation, Prevocational Services, and Community Experience. This rate increase will begin on March 1, 2020 and extend through the end of the month in which the PHE terminates, not to exceed the end date of the approved Appendix K.
- Temporarily increase rates for the following services to account for excessive overtime pay for direct support personnel, to cover staffing needs in the event of unusual numbers of sick employees and to account for additional infection control supplies (including personal protective equipment (PPE)) and service costs: Personal Care, Adult Companion, Respite, and Skilled Nursing (LPN Nursing and RN Nursing.) The rate setting methodology remains the same. Upward adjustments are made to account for the supply costs and anticipated overtime for direct support personnel. Resulting temporary rate increases will not exceed 50%. The exact increase will be determined based on current market factors and substantiated, additional costs incurred by providers. This rate increase will begin on March 1, 2020 and extend through the end of the month in which the PHE terminates, not to exceed the end date of the approved Appendix K.
- Self-directed employees may not work more than 16 hours per day, and the sum total of their hours worked in a given week cannot exceed 40. If an exception is required due to issues related to the COVID-19 pandemic, a specific request must be made via Support Coordination through the established request process. In the event an exception is made to allow overtime, the Operating Agency will permit, with documentation of substantiated need, overtime work to allow the needed amount, duration or change in scope within the Waiver to effectively address emergent health, safety and welfare-related needs of participants during the COVID-19 pandemic. This change applies to the following self-directed services: Personal Care, Adult Companion, Respite and Skilled Nursing (LPN Nursing and RN Nursing.)

List of Provider Types and Rates by Service

Service	Base Rate	New Overtime Rate
Adult Companion Services	$3.12	$4.68
LPN Nursing per hour	$20.80	$31.20
Personal Care	$4.12	$6.18
Respite In Home	$3.12	$4.68
Respite Out of Home	$3.12	$4.68
RN Nursing per hour	$36.40	$54.60
Supported Employment Small Group	$3.84	$5.76
Self-Directed Adult Companion	$2.75	$4.13
Self-Directed LPN	$20.80	$31.20
Self-Directed RN	$36.40	$54.60

g._X__ Temporarily modify person-centered service plan development process and individual(s) responsible for person-centered service plan development, including qualifications.

[Describe any modifications including qualifications of individuals responsible for service plan development, and address Participant Safeguards. Also include strategies to ensure that services are received as authorized.]

ID and LAH: The state will ensure the person-centered service plan is modified to allow for additional supports/and or services to respond to the COVID-19 pandemic. The specificity of such services including amount, duration and scope will be appended as soon as possible but no later than 30 days to ensure that the specific service is delineated accordingly to the date it began to be received. For service needs identified to mitigate harm or risk directly related to the COVID-19 pandemic (and substantiated via documentation submitted to RCS via ADIDIS), necessary changes to PCP's and/or Plans of Care (POC's) may be approved retroactively to 3/12/2020. The use of e-signatures that meets privacy and security requirements will be added as a method for the participant or legal guardian signing the PCCP to indicate approval of the plan. Services may start while waiting for the signature to be returned to the case manager, whether electronically or by mail. Signatures will include a date reflecting the PCCP meeting date. An electronic or written signature is required within 45 days of the change(s) made to the PCCP.

h._X__ Temporarily modify incident reporting requirements, medication management or other participant safeguards to ensure individual health and welfare, and to account for emergency circumstances. [Explanation of changes]

ID and LAH:
Providers must submit incident reports for participants who test positive for COVID-19 within 48 hours of receiving notification and disclose any exposure of the COVID-19-positive participant to any other waiver participants and/or staff persons. Incident reports must also be submitted within 48 hours for each other participant potentially exposed. While incident reports are required in these instances, there is no automatic requirement for an investigation or corrective action plan, unless the Medicaid Agency or Operating Agency specifically directs that either/both be completed.

i._ Temporarily allow for payment for services for the purpose of supporting waiver participants in an acute care hospital or short-term institutional stay when necessary supports (including communication and intensive personal care) are not available in that setting, or when the individual requires those services for communication and behavioral stabilization, and such services are not covered in such settings.

[Specify the services.]

j._X__ Temporarily include retainer payments to address emergency related issues.

[Describe the circumstances under which such payments are authorized and applicable limits on their duration. Retainer payments are available for habilitation and personal care only.]

- **ID and LAH**: In response to the defined emergency, and in order to maintain a viable workforce, the state may elect to make retainer payments to waiver providers. Retainer payments are for direct care providers who normally provide services that include habilitation that have a personal care component (Day Habilitation, Prevocational Services, Community Experience, and/or Supported Employment – Small Group), but are currently unable to due to complications experienced during the COVID-19 pandemic (i.e., because the program has been directed to close and the provider cannot enter the participant's home or otherwise provide services through other electronic platform.) The State confirms that retainer payments are for direct care providers who normally provide services that include habilitation that includes a component of personal care and personal care, but are currently unable to due to complications experienced during the COVID-19 pandemic because the waiver participant is sick due to COVID-19; or the waiver participant is sequestered and/or quarantined based on local, state, federal and/or medical requirements/orders. The state will implement a distinguishable process to monitor payments to avoid duplication of billing. The personal assistance retainer will begin March 1, 2020, and the time limit may not exceed the lesser of 30 consecutive days or the number of days for which the State authorizes a payment for "bed-hold" in nursing facilities.

k.___ Temporarily institute or expand opportunities for self-direction.

[Provide an overview and any expansion of self-direction opportunities including a list of services that may be self-directed and an overview of participant safeguards.]

l.___ Increase Factor C.

[Explain the reason for the increase and list the current approved Factor C as well as the proposed revised Factor C]

m.___ Other Changes Necessary [For example, any changes to billing processes, use of contracted entities or any other changes needed by the State to address imminent needs of individuals in the waiver program]. [Explanation of changes]

Appendix K Addendum: COVID-19 Pandemic Response

1. HCBS Regulations

a. ☒ Not comply with the HCBS settings requirement at 42 CFR 441.301(c)(4)(vi)(D) that individuals are able to have visitors of their choosing at any time, for settings added after March 17, 2014, to minimize the spread of infection during the COVID-19 pandemic.

(ID, LAH**)**

2. **Services**
    a. ☒ Add an electronic method of service delivery (e.g., telephonic) allowing services to continue to be provided remotely in the home setting for:
        i. ☒ Case management (ID, LAH)
        ii. ☒ Personal care services that only require verbal cueing (ID, LAH)
        iii. ☒ In-home habilitation (ID, LAH)
        iv. ☒ Monthly monitoring (i.e., in order to meet the reasonable indication of need for services requirement in 1915(c) waivers). (ID, LAH)
        v. ☒ Other *[Describe]:*

        ID/LAH: Behavior Supports Professionals, Nurses, and Occupational, Physical & Speech/Language Therapists

    b. ☐ Add home-delivered meals
    c. ☐ Add medical supplies, equipment and appliances (over and above that which is in the state plan)
    d. ☐ Add Assistive Technology

3. **Conflict of Interest: The state is responding to the COVID-19 pandemic personnel crisis by authorizing case management entities to provide direct services. Therefore, the case management entity qualifies under 42 CFR 441.301(c)(1)(vi) as the only willing and qualified entity.**
    a. ☒ Current safeguards authorized in the approved waiver will apply to these entities.
    b. ☒ Additional safeguards listed below will apply to these entities.

    This provision applies only to those case management entities that have not yet completed de-confliction activities. Case management entities that are already in de-conflicted status may not provide direct services.

4. **Provider Qualifications**
    a. ☒ Allow spouses and parents of minor children to provide personal care services **(**ID, LAH)
    b. ☒ Allow a family member to be paid to render services to an individual. (ID**:** Applies to Personal Care, Adult Companion and Residential Habilitation services. LAH: Applies to Personal Care and Adult Companion services.)
    c. ☒ Allow other practitioners in lieu of approved providers within the waiver. *[Indicate the providers and their qualifications]* (ID, LAH)

For the following provider types, temporarily waive requirements for out-of-state providers to be certified and located in Alabama, so long as they are actively licensed/certified by another state's Medicaid agency and so long as they provide services required to cover gaps in care resulting from issues related to the COVID-19 pandemic: RN, LPN, Psychologist, Board Certified Behavior Analyst or Assistant, Occupational Therapist, Physical Therapist, Speech/Language Therapist.

d. ☐ Modify service providers for home-delivered meals to allow for additional providers, including non-traditional providers.

5. Processes

a. ☒ Allow an extension for reassessments and reevaluations for up to one year past the due date. (ID, LAH)
b. ☒ Allow the option to conduct evaluations, assessments, and person-centered service planning meetings virtually/remotely in lieu of face-to-face meetings. (ID, LAH)
c. ☒ Adjust prior approval/authorization elements approved in waiver. (ID, LAH
d. ☒ Adjust assessment requirements (ID, LAH)
e. ☒ Add an electronic method of signing off on required documents such as the person-centered service plan. (ID, LAH)

Contact Person(s)

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

First Name:	Ginger
Last Name	Wettingfeld
Title:	Director, LTC Healthcare Reform
Agency:	Alabama Medicaid Agency
Address 1:	PO Box 5624
Address 2:	501 Dexter Ave
City	Montgomery
State	AL
Zip Code	36104
Telephone:	334-242-5018
E-mail	Ginger.wettingfeld@medicaid.alabama.gov
Fax Number	334-353-4182

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

First Name:	N/A
Last Name	Click or tap here to enter text.
Title:	Click or tap here to enter text.
Agency:	Click or tap here to enter text.
Address 1:	Click or tap here to enter text.
Address 2:	Click or tap here to enter text.
City	Click or tap here to enter text.
State	Click or tap here to enter text.
Zip Code	Click or tap here to enter text.
Telephone:	Click or tap here to enter text.
E-mail	Click or tap here to enter text.
Fax Number	Click or tap here to enter text.

8. Authorizing Signature

Signature: **Date: 6-3-2020**

_____/S/_____
State Medicaid Director or Designee

First Name:	Stephanie
Last Name	Azar
Title:	Commissioner
Agency:	Alabama Medicaid Agency
Address 1:	PO Box 5624
Address 2:	501 Dexter Ave
City	Montgomery
State	AL
Zip Code	36104
Telephone:	334-242-5600
E-mail	Stephanie.azar@medicaid.alabama.gov
Fax Number	334-242-5097

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver that the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification should be readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Complete for each service added during a time of emergency. For services in the approved waiver which the state is temporarily modifying, enter the entire service definition and highlight the change. 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 Specification	
Service Title:	Residential Habilitation (ID)
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
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 following temporary modifications apply: Required staff training for beginning employment, including Nurse Delegation Program training, may be conducted on-line, by telephone, or electronically, as appropriate. Any staff persons not fully trained must work under supervision of a fully trained staff person. In addition, annual refresher training of staff due through 7/1/2020 may be extended for 90 days.

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. When circumstances related to COVID-19 diagnoses or potential contact require it, and upon explicit approval by the Regional Community Services (RCS) office, limitations on the number of participants served with Residential Habilitation in each certified home may be exceeded, but only when all other alternatives for supports have been exhausted. 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 constitute 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 services, directly or indirectly, provided by a member of the individual's 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. The following temporary modifications apply: As an alternative to self-direction, natural caregiver(s)/relative(s) may be hired by a certified provider agency to provide Residential Habilitation services and may be paid by that provider upon mutual agreement and completion of all standard training, including training on the participant's PCP. In this circumstance, the provider of Residential Habilitation is responsible for ensuring the service is provided as authorized in the PCP and that billing occurs in accordance with DDD requirements.

Also excluded:

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).

Provider Specifications

Provider Category(s) *(check one or both)*:	**X**	Individual. List types:	**X**	Agency. List the types of agencies:
				Community Residential Facility

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	X	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

Community Residential Facility	N/A	Al. Administrative Code Chapters 580-3-23 and 580-5-33.	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. Annual and follow-up certification reviews of provider agencies will be suspended until 7/1/2020. 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. When circumstances related to COVID-19 diagnoses or potential contact require it, and upon explicit approval by the Regional Community Services (RCS) office, minimum staffing ratios in Residential Habilitation settings, as required by certification, service definition, and/or individual PCP, may be exceeded due to staffing shortages, so long as the health and safety of participants is preserved and required minimum staffing ratios are implemented as often and as soon as possible. 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. The following temporary modifications apply: Required staff training for beginning employment may be conducted on-line, by telephone, or electronically, as appropriate. Any staff persons not fully trained must work under supervision of a fully trained staff person. In addition, annual refresher training of staff due through 7/1/2020 may be extended for 90 days. 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. The following temporary modifications apply: Required staff training for beginning employment, including Nurse Delegation Program training, may be conducted on-line, by telephone, or

			electronically, as appropriate. Any staff persons not fully trained must work under supervision of a fully trained staff person. In addition, annual refresher training of staff due through 7/1/2020 may be extended for 90 days. 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. Required staff training for beginning employment, including Nurse Delegation Program training, may be conducted on-line, by telephone, or electronically, as appropriate. In addition, annual refresher training of staff due through 7/1/2020 may be extended for 90 days. 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. The following temporary modifications apply: Required staff training for beginning employment, training, may be conducted on-line, by telephone, or electronically, as appropriate. Any staff persons not fully trained must work under supervision of a fully trained staff person. In addition, annual refresher training of staff due through 7/1/2020 may be extended for 90 days. 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.
Residential Aide	N/A	N/A	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.
Family Member	N/A	N/A	DDD will temporarily suspend routine employee screening (e.g., TB, background checks, drug screens) of immediate family members, if the services authorized in this regard are required to cover gaps in care resulting from issues related to the COVID-19 pandemic. Suspension of said screenings is temporary, and all required screenings will be required to be completed once the emergency period ends.

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification

Community Residential Facility	DMH Certification Surveyors	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.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification	
Service Title:	Personal Care (ID & LAH)
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
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.

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). When circumstances related to COVID-19 diagnoses or potential contact require it (substantiating documentation of the need must be maintained and submitted via ADIDIS in advance of any change), any previously authorized Personal Care services may be modified up to a maximum of 18 hours per day without requesting a variance via Request for Action (RFA) from RCS in order to meet the needs of the participants. In the event an exception is made to allow overtime for Personal Care workers, DDD will permit, with documentation of substantiated need, overtime work to allow the needed amount, duration or change in scope within the Waiver to effectively address emergent health, safety and welfare-related needs of participants during the COVID-19 pandemic.

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.

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.

The following temporary modifications apply: Personal Care services may be provided by a natural caregiver(s) or relative(s) (e.g., the spouse, parent, step-parent or child of the waiver recipient) living in the same residence with the person if all of the following are true:

- o The participant is twenty-one (21) years of age or older; and
- o The natural caregiver or relative being paid to provide this service is not also the legal guardian (or Medicaid representative/EOR for self-directed services) for the participant; and
- o The natural caregiver is otherwise qualified and capable of providing the care and assistance needed;
- o A paid provider (either agency or other self-direction worker), who would normally provide the service, is unable to do so at any point during the period for which this Transition Plan is effective.

If the above requirements are met, this service shall not supplant natural supports provided by the natural caregiver(s) or relative(s) living in the same residence with the person. Reimbursement for these services will be managed as per current Self-Direction practices outlined in the ID/LAH Waivers. The services must be rendered according to the existing Plan of Care and according to the service volume(s) already approved therein. Any needed changes to service volume must be requested via Support Coordination through the established request process.

Self-Directed Personal Care may not be provided to participants 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.

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.

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

Provider Specifications

Provider Category(s) *(check one or both)*:	**X**	Individual. List types:	**X**	Agency. List the types of agencies:
	Self-Directed Personal Care Worker		Certified Waiver Hourly Services Provider	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	**X**	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

Certified Waiver Hourly Services Provider	N/A	Al. Administrative Code Chapters 580-3-23 and 580-5-30A/B	Minimum qualifications as defined in rule and/or policy. 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.

Self-Directed Personal Care Worker	N/A	N/A	Minimum qualifications as defined in rule and/or policy. 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 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. The following temporary modifications apply: required staff training for beginning employment, including Nurse Delegation Program training, may be conducted on-line, by telephone, or electronically, as appropriate. Any staff persons not fully trained must work under supervision of a fully trained staff person.
Family Member	N/A	N/A	DDD will temporarily suspend routine employee screening (e.g., TB, background checks, drug screens) of immediate family members, if the services authorized in this regard are required to cover gaps in care resulting from issues related to the COVID-19 pandemic. Suspension of said screenings is temporary, and all required screenings will be required to be completed once the emergency period ends.
Verification of Provider Qualifications			

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Certified Waiver Hourly Services Provider	DMH/DD Certification	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
Self-Directed Personal Care Worker	DMH/DD Certification	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

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	**X**	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification	
Service Title:	Adult Companion Services (ID and LAH)
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
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:

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.

Staying with client in the evening and at night to ensure security.

Accompanying client into the community, such as shopping.

Supervising/assisting with laundry and performing light housekeeping duties that are essential to the care of the client.

Following written instructions such as the care plan and documenting services provided.

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.

Self-Directed Adult Companion Services

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.

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

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

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.)

The following temporary modifications apply: Adult Companion services may be provided by a natural caregiver(s) or relative(s) (e.g., the spouse, parent, step-parent or child of the waiver recipient) living in the same residence with the person if all of the following are true:

- o The participant is twenty-one (21) years of age or older; and
- o The natural caregiver or relative being paid to provide this service is not also the legal guardian (or Medicaid representative/EOR for self-directed services) for the participant; and
- o The natural caregiver is otherwise qualified and capable of providing the care and assistance needed;
- o A paid provider (either agency or other self-direction worker), who would normally provide the service, is unable to do so at any point during the period for which this Transition Plan is effective.

If the above requirements are met, this service shall not supplant natural supports provided by the natural caregiver(s) or relative(s) living in the same residence with the person.

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.

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.

Reimbursement for these services will be managed as per current Self-Direction practices outlined in the ID/LAH Waivers. The services must be rendered according to the existing Plan of Care and according to the service volume(s) already approved therein. Any needed changes to service volume must be requested via Support Coordination through the established request process.

Provider Specifications

Provider Category(s) *(check one or both)*:	**X**	Individual. List types:	**X**	Agency. List the types of agencies:
	Self Directed Adult Companion Employee		**Certified Waiver Hourly Services Provider**	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	X	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

Certified Waiver Hourly Services Provider	N/A	Al. Administrative Code Chapters 580-3-23 and 580-5-33.	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 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 following temporary modifications apply: Required staff training for beginning employment, may be conducted on-line, by telephone, or electronically, as appropriate. Any staff persons not fully trained must work under supervision of a fully trained staff person. In addition, annual refresher training of staff due through 7/1/2020 may be extended for 90 days. 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.

Self Directed Adult Companion Employee	N/A	N/A	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.
Family Member	N/A	N/A	DDD will temporarily suspend routine employee screening (e.g., TB, background checks, drug screens) of immediate family members, if the services authorized in this regard are required to cover gaps in care resulting from issues related to the COVID-19 pandemic. Suspension of said screenings is temporary, and all required screenings will be required to be completed once the emergency period ends.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Certified Waiver Hourly Services Provider	DMH Certification Surveyors	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.
Self Directed Adult Companion Employee	FMSA	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.

Service Delivery Method

Service Delivery Method *(check each that applies)*:	**X**	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification	
Service Title:	Respite (ID and LAH)

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

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. 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. When circumstances related to COVID-19 diagnoses or potential contact require it, and upon explicit approval by the RCS office, Respite services, including any combination of In-Home or Out-of-Home Respite, may exceed the fiscal year limit of 4320 units.

Respite care out of the home is typically provided in a certified group home. When circumstances related to COVID-19 diagnoses or potential contact require it, and upon explicit approval by the Regional Community Services (RCS) office, Out-of-Home Respite services may be provided in an alternative (e.g., non-certified) setting to ensure the health and safety of participants. The provider must submit to RCS a detailed plan for staffing, supplying, and monitoring the provision of Out-of-Home Respite in the alternative setting and must supply the Support Coordination agency and RCS with full contact information and a list of proposed staff members for the alternative setting in advance of its utilization.

Provider Specifications

Provider Category(s) *(check one or both)***:**	**X**	Individual. List types:	**X**	Agency. List the types of agencies:
	Self-directed Out of Home Respite		**Certified Waiver Hourly Services Provider (for In-Home Respite)**	
	Self-Directed In home Respite		**Community Residential Facility**	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	**X**	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Certified Waiver Hourly Services Provider (for In-Home Respite)	N/A	Al. Administrative Code Chapters 580-3-23 and 580-5-33.	
Self-directed Out of Home Respite	N/A	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. The EOR is responsible for the supervision, training and general oversight of the Respite worker. Must be approved by the FMS to provide services	The EOR is responsible for assuring the minimum qualifications are met prior to submission of the worker application to the FMS. The FMS is responsible for conducting the background checks and also verifying minimum hiring qualifications are met for individuals performing this service. A prior approval will be required to accompany the receipt in order for the EOR to receive payment

Community Residential Facility		Al. Administrative Code Chapters 580-3-23 and 580-5-33.	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. The following temporary modifications apply: Required staff training for beginning employment, including Nurse Delegation Program training, may be conducted on-line, by telephone, or electronically, as appropriate. Any staff persons not fully trained must work under supervision of a fully trained staff person. In addition, annual refresher training of staff due through 7/1/2020 may be extended for 90 days. *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.
Self-Directed In home Respite			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. The EOR is responsible for the supervision, training and general oversight of the Respite worker

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Certified Waiver Hourly Services Provider (for In-Home Respite)	DMH Certification Surveyors	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.

Self-directed Out of Home Respite	The EOR is responsible for assuring the minimum qualifications are met prior to submission of the worker application to the FMS. The FMS is responsible for conducting the background checks and also verifying minimum hiring qualifications are met.	Initially by FMS. Exclusion lists are checked monthly.
Community Residential Facility	DMH Certification Surveyors	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.
Self-Directed In home Respite	The EOR is responsible for assuring the minimum qualifications are met prior to submission of the worker application to the FMS. The FMS is responsible for conducting the background checks and also verifying minimum hiring qualifications are met.	Initially by the FMS. Exclusion lists are checked monthly

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	**X**	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification	
Service Title:	Skilled Nursing (ID and LAH)

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

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 administered in the home. This assessment also will identify the need for service and the amount of time needed. Services consist of nursing procedures that meet the person's health needs as ordered by a physician. There is no restriction on the place of service.

LPN services may provide skilled care for the recipient if a licensed physician prescribes the service. The LPN works under the supervision of the RN. The RN evaluates the participant and establishes the Nursing Plan of care prior to assigning services to the LPN. There is no restriction on the place of service.

This service may also, when provided to a participant or family which is self-directing personal care services, include training and supervision related to medical care and/or assistance with ordinarily self-administered medications to be provided by the personal care worker. This training and supervising component of nursing is only available to people who receive personal care at home, either agency-based or self-directed. It is not available to agencies providing residential and day programs, because payment for the nurse supervision is already included in the rate paid for those services.

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.

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.

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, caregivers or physicians, training or other pertinent information. The nurse must sign and date the note.

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.

In the event an exception is made to allow overtime, DDD will permit, with documentation of substantiated need, overtime work to allow the needed amount, duration or change in scope within the Waiver to effectively address emergent health, safety and welfare-related needs of participants during the COVID-19 pandemic.

Rates for Skilled Nursing services may be increased to account for excessive overtime pay for direct support personnel to cover staffing needs in the event of unusual numbers of sick employees and to account for additional infection control supplies (including personal protective equipment (PPE)) and service costs. The rate setting methodology remains the same. Upward adjustments are made to account for the supply costs and anticipated overtime for direct support personnel. Resulting temporary rate increases are not expected to exceed 40%. The exact increase will be determined based on current market factors and substantiated, additional costs incurred by providers.

Provider Specifications

Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
	Registered or Licensed Nurse Employed by a Self Directing Participant or Family		**Registered or Licensed Practical Nurse**	

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

Registered or Licensed Practical Nurse	Nurses are licensed under the Code of Alabama; 1975 Sec.34-21	Nurses typically are employed by certified waiver providers, Al. Administrative Code Chapters 580-3- 23 580-5-33.	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.
Registered or Licensed Nurse Employed by a Self Directing Participant or Family	Al. Administrative Code Chapters 580-3-23 580-5-33.	N/A	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			

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Registered or Licensed Practical Nurse	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.	Nursing licenses are renewed annually. Debarment 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.
Registered or Licensed Nurse Employed by a Self-Directing Participant or Family	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.	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.

Service Delivery Method

Service Delivery Method *(check each that applies)*:	**X**	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification

Service Title:	Specialized Medical Supplies (ID and LAH)

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

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. The following temporary modifications apply: Temporarily allow verbal orders from a physician or other licensed health care provider for non-prescription Specialized Medical Supplies authorized in an individual's care plan as of the date of the COVID-19 PHE. This modification will be in effect beginning March 13, 2020 and extend through the end of the month in which the PHE terminates, not to exceed the end date of the approved Appendix K.

Providers may be reimbursed at the approved waiver service limits, per existing Waiver limits and guidelines, when purchasing Specialized Medical Supplies from any available vendor, regardless of inclusion on the existing approved vendor list, who can provide necessary and potentially short-supplied items in stock when supply shortages or costs are impacted by circumstances related to the COVID-19 pandemic.

This service is not available to participants under the age of 21 years as medical supplies are covered through EPSDT for this age group.

Provider Specifications

Provider Category(s) *(check one or both)*:	**X**	Individual. List types:	**X**	Agency. List the types of agencies:
	Self Directed Medical Supply Provider		**Specialized Medical Supplies**	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Self-Directed Medical Supply Provider	N/A	N/A	Authorized Medical Supplies Vendor Providers may be reimbursed at the approved waiver service limits, per existing Waiver limits and guidelines, when purchasing Specialized Medical Supplies from any available vendor, regardless of inclusion on the existing approved vendor list, who can provide necessary and potentially short-supplied items in stock when supply shortages or costs are impacted by circumstances related to the COVID-19 pandemic.
Specialized Medical Supplies	Business License	Certified by the Board of DME and DMH Certification	N/A

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Self-Directed Medical Supply Provider	FMS	initially and annually
Specialized Medical Supplies	**ADMH**	Prior to contract, annually

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	**X**	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification	
Service Title:	Assistive Technology Services (ID and LAH)

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

Service Definition (Scope)**:**

Assistive technology means an item, or 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 mean a service that directly assist an individual in the selection, acquisition, or use of an assistive technology device that may include:

(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. Temporarily allow verbal orders from a physician or other licensed health care provider for non-prescription Assistive Technology authorized in an individual's care plan as of the date of the COVID-19 PHE. This modification will be in effect beginning March 13, 2020 and extend through the end of the month in which the PHE terminates, not to exceed the end date of the approved Appendix K.

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.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	**X**	Agency. List the types of agencies:
				Assistive Technology Providers
				Home Medical Equipment and Services Providers (Specialized Durable Medical Equipment)
				Self-Directed Home Medical Equipment Agency

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Assistive Technology Providers	Business License	N/A	ADMH Certified/Enrolled Providers Providers may be reimbursed at the approved waiver service limits, per existing Waiver limits and guidelines, when purchasing Assistive Technology items from any available vendor, regardless of inclusion on the existing approved vendor list, who can provide necessary and potentially short-supplied items in stock when supply shortages or costs are impacted by circumstances related to the COVID-19 pandemic.
Home Medical Equipment and Services Providers (Specialized Durable Medical Equipment)		Al. Administrative Code Chapters 580-3-23 580-5-33.	Providers of this service must meet the same standards required for the providers under the Alabama State Plan. Providers may be reimbursed, per other existing Waiver limits and guidelines, when purchasing items for Assistive Technology from non-traditional vendors who have necessary and potentially short-supplied items in stock when supply shortages or costs are impacted by circumstances related to the COVID-19 pandemic.
Self-Directed Home Medical Equipment Agency		Licensure is by the Alabama Board of Home Medical Equipment Services Providers.	Providers of this service must meet the same standards required for the providers under the Alabama State Plan. Providers may be reimbursed at the approved waiver service limits, per existing Waiver limits and guidelines, when purchasing Assistive Technology items from any available vendor, regardless of inclusion on the existing approved vendor list, who can provide necessary and potentially short-supplied items in stock when supply shortages or costs are impacted by circumstances related to the COVID-19 pandemic.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Assistive Technology Providers	ADMH	Initial and annually thereafter

Home Medical Equipment and Services Providers (Specialized Durable Medical Equipment)	Licensure is by the Alabama Board of Home Medical Equipment Services Providers		**Annually**	
Self-Directed Home Medical Equipment Agency	**FMSA**		Upon purchase.	
Service Delivery Method				
Service Delivery Method *(check each that applies)*:	**X**	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification	
Service Title:	Positive Behavior Support (ID and LAH)

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

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. Billable tasks include: conducting functional behavior assessments, behavior support plan (BSP) development, training to implement the BSP, data entry/analysis/graphing, monitoring effectiveness of BSP, writing progress notes/reports, etc. BSP may include consultation provided to families, other caretakers, and habilitation services providers. BSP shall place primary emphasis on the development of desirable adaptive behavior rather than merely the elimination or suppression of undesirable behavior. A behavior support plan may only be implemented after positive behavioral approaches have been tried, and its continued use must be reviewed every thirty days with reports due quarterly.

Positive Behavior Support (PBS) waiver service is comprised of two general categories of service tasks. These are:

1) Development of a Behavior Support Plan (BSP) and (2) implementation of a BSP. In addition, this waiver service has three service levels: two professional and one technical, each with its own procedure code and rate of payment. The service levels are distinguished by the qualifications of the service provider and by supervision requirements. Both professional and technical level service providers may perform tasks within both service categories, adhering to supervision requirements that are described under provider qualifications.

The following temporary modifications apply: Behavior Supports professionals may provide services by electronic means (e.g., Skype/Zoom), per HIPAA standards, rather than by face-to-face meetings.

The two professional service provider levels are distinguished by the qualifications of the person providing the service. Both require advanced degrees and specialization, but the top level also requires board certification in behavior analysis. The third service provider level is technical and requires that the person providing the service be under supervision to perform PBS tasks. Providers of this service is required to perform the required monthly exclusion lists, AMA and OIG for all staff. Documentation of monthly checks are required.

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.

Provider Specifications

Provider Category(s) *(check one or both)*:	**X**	Individual. List types:	**X**	Agency. List the types of agencies:
	Self-Directed Board-Certified Behavior Analyst or Assistant		**Individual employed or contracted by a certified agency.** Temporarily waive requirements for out-of-state providers to be certified and located in Alabama, so long as they are actively licensed/certified by another state's Medicaid agency and so long as they provide services required to cover gaps in care resulting from issues related to the COVID-19 pandemic	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian	

Provider Qualifications (*provide the following information for each type of provider)*:			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

Self-Directed Board-Certified Behavior Analyst or Assistant	N/A	Board Certified Behavior Analyst or Assistant	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.

Individual employed or contracted by a certified agency.	N/A	Board Certified Behavior Analyst or Assistant	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. The following temporary

			modifications apply: Required staff training for beginning employment may be conducted on-line, by telephone, or electronically, as appropriate. Any staff persons not fully trained must work under supervision of a fully trained staff person. In addition, annual refresher training of staff due through 7/1/2020 may be extended for 90 days.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Self-Directed Board-Certified Behavior Analyst or Assistant	**FMSA**	Upon enrollment.
Individual employed or contracted by a certified agency.	DMH Certification Surveyors	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.

Service Delivery Method

Service Delivery Method *(check each that applies)*:	**X**	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification	
Service Title:	Physical Therapy (ID and LAH)

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

Service Definition (Scope)**:**

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.

The following temporary modifications apply: Physical Therapists may provide services by electronic means (e.g., Skype/Zoom), per HIPAA standards, rather than by face-to-face meetings.

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.

Provider Specifications				
	☐	Individual. List types:	**X**	Agency. List the types of agencies:

Provider Category(s) *(check one or both)*:		**Physical Therapist employed or contracted by a certified agency**. Temporarily waive requirements for out-of-state providers to be certified and located in Alabama, so long as they are actively licensed/certified by another state's Medicaid agency and so long as they provide services required to cover gaps in care resulting from issues related to the COVID-19 pandemic

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Physical Therapist employed or contracted by a certified agency.	Physical Therapists are licensed under the Code of Alabama, 1975 Sec.34-24-212	Al. Administrative Code Chapters 580-3-23 and 580-5-33.	Minimum qualifications as defined in rule and/or policy.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Physical Therapist employed or contracted by a certified agency.	DMH Certification Surveyors	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.

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification	
Service Title:	Occupational Therapy (ID and LAH)

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

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.

The following temporary modifications apply: Occupational Therapists may provide services by electronic means (e.g., Skype/Zoom), per HIPAA standards, rather than by face-to-face meetings.

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.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	**X**	Agency. List the types of agencies:
				Occupational Therapist employed or contracted by a certified agency. Temporarily waive requirements for out-of-state providers to be certified and located in Alabama, so long as they are actively licensed/certified by another state's Medicaid agency and so long as they provide services required to cover gaps in care resulting from issues related to the COVID-19 pandemic

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian	

Provider Qualifications (*provide the following information for each type of provider)*:			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Occupational Therapist employed or contracted by a certified agency.	Occupational Therapists are licensed under the Code of Alabama, 1975 Sec. 34-39-5	Al. Administrative Code Chapters 580-3-23 and 580-5-33.	.

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Occupational Therapist employed or contracted by a certified agency.	DMH Certification Surveyors	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.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification	
Service Title:	Speech & Language Therapy (ID & LAH)

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

Service Definition (Scope)**:**

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 individual's communication skills comprehension and expression. Provision of this service in the community is an alternative to an institutional level of care. Therapist may also provide training to staff and caregivers (such as a client's family and/or foster family).

Services to direct caregivers will be allowed when the service to caregivers is for the direct benefit of the recipient and is necessary to enable the recipient to be cared for outside of an institution. Speech Therapy is expected to be therapeutic with outcomes and goals based on the therapist evaluation.

The following temporary modifications apply: Speech & Language Therapists may provide services by electronic means (e.g., Skype/Zoom), per HIPAA standards, rather than by face-to-face meetings.

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.

Provider Specifications				
	☐	Individual. List types:	**X**	Agency. List the types of agencies:

Provider Category(s) *(check one or both)*:		Speech Therapist employed or contracted by a certified agency. Temporarily waive requirements for out-of-state providers to be certified and located in Alabama, so long as they are actively licensed/certified by another state's Medicaid agency and so long as they provide services required to cover gaps in care resulting from issues related to the COVID-19 pandemic

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Speech Therapist employed or contracted by a certified agency.	Speech Therapists are licensed under the Code of Alabama, 1975 Sec. 34-28A-1, Ch. 870-x-1-7	Al. Administrative Code Chapters 580-3-23 580-5-33.	

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Speech Therapist employed or contracted by a certified agency.	DMH Certification Surveyors	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.

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	**X**	Provider managed

[i] Numerous changes that the state may want to make may necessitate authority outside of the scope of section 1915(c) authority. States interested in changes to administrative claiming or changes that require section 1115 or section 1135 authority should engage

CMS in a discussion as soon as possible. Some examples may include: (a) changes to administrative activities, such as the establishment of a hotline; or (b) suspension of general Medicaid rules that are not addressed under section 1915(c) such as payment rules or eligibility rules or suspension of provisions of section 1902(a) to which 1915(c) is typically bound.