

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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

The State is seeking to renew Alabama's Home and Community-Based 1915(c) State of Alabama Community Transition (ACT) Waiver. This renewal application will propose to make the following changes and updates:

The state has revised its performance measures to align with other state waivers.

The state is adding legally responsible relatives to applicable services.

The state separated skilled and unskilled respite services to track participation, reporting, and manage budget operations.

The state separated skilled and unskilled nursing services to track participation, reporting, and manage budget operations.

The state will end its participation in the Money Follows the Person grant program effective September 30, 2026. The state will continue to operate its transition program using state funds.

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

1. Request Information (1 of 3)

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

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

Alabama Community Transition Waiver (ACT Waiver)

C. Type of Request: renewal

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

☐ 3 years ☒ 5 years

Draft ID: AL.013.03.00

D. Type of Waiver (select only one):

Regular Waiver

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

04/01/26

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: July 31, 2027). The time required to complete this information collection is estimated to average 163 hours per response for a new waiver application and 78 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

☒ **Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR § 440.160**☒ **Nursing Facility**

Select applicable level of care

☒ **Nursing Facility as defined in 42 CFR § 440.40 and 42 CFR § 440.155**

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

☒ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR § 440.140**☐ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR § 440.150)**

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

1. Request Information (3 of 3)

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

Select one:

☐ Not applicable

☒ Applicable

Check the applicable authority or authorities:

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

☒ Waiver(s) authorized under section 1915(b) of the Act.

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

1915b PCCM-E effective 1/1/2024

AL-08

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

☒ section 1915(b)(1) (mandated enrollment to managed care)

☐ section 1915(b)(2) (central broker)

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

☒ section 1915(b)(4) (selective contracting/limit number of providers)

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

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

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

☒ A program authorized under section 1915(j) of the Act.

☐ A program authorized under section 1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

The Alabama Community Transition Waiver (ACT Waiver) is Alabama's approach to creating a long-term care system that enables people with disabilities or long-term care illnesses to live in their own homes or community settings. The target population is individuals currently residing in an institution. A second target population would be individuals currently being served by one of Alabama's other HCBS Programs whose condition is such that their current program is not meeting their needs and admission to an institution would be imminent if the ACT waiver were not an option to better serve their needs.

The Alabama Medicaid Agency is the administering agency for this program, and the Alabama Department of Senior Services (ADSS) is the operating agency. As the operating agency, ADSS is responsible for the daily management and operation of the program. In the daily management of the program, ADSS focuses on personal centered participant outcomes such as improving participant care, protecting client health and welfare, offering the participant free choice of providers for waiver services. ADSS management responsibilities also include assuring all direct service providers meet the required provider qualifications.

This waiver includes a self-directed option (Personal Choices) offered statewide through a concurrent 1915(j) authority, which allow participants the opportunity to have greater involvement, control, and choice in identifying, accessing and managing certain long-term care services and community supports.

The ACT waiver runs concurrently with Alabama's Integrated Care Network (ICN) 1915(b) waiver.

The 1915b waiver is a PCCM entity (ICN), with the goals to:

- Improve education and outreach about LTSS options
- Provide Primary Care/Medical Care Management that enhances quality of life, and improves health outcomes
- Help drive a shift in the percentage of the LTSS population residing in the HCBS setting

Alabama's 1915b PCCM-E (ICN) will receive a monthly capitated payment inclusive of HCBS Case Management. The ICN will review the Case Management claims and reimburse the HCBS Case Management providers.

3. Components of the Waiver Request

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

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

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

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

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

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

- ☒ **Yes. This waiver provides participant direction opportunities.** Appendix E is required.
- ☐ **No. This waiver does not provide participant direction opportunities.** Appendix E is not required.

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

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

H. Quality Improvement Strategy. Appendix H contains the quality improvement strategy for this waiver.

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

federal financial participation.

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

4. Waiver(s) Requested

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

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

- ☐ Not Applicable
- ☒ No
- ☐ Yes

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

- ☒ No
- ☐ Yes

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

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

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

5. Assurances

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

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

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

Appendix C.

- B. Financial Accountability.** The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR § 441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the

participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

- B. Inpatients.** In accordance with 42 CFR § 441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR § 441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR § 431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of section 1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR Part 433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. If a provider certifies that a particular legally liable third-party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The state provides the opportunity to request a Fair Hearing under 42 CFR Part 431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR § 431.210.
- H. Quality Improvement.** The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the quality improvement strategy specified in **Appendix H**.
- I. Public Input.** Describe how the state secures public input into the development of the waiver:

A link to an electronic copy was sent to the following Agencies, organizations, and Councils:

UAB Medical Center
AL Respite Organization
AARP
Nursing Home Owner/Admin
Independent Living Council
Governor's Office on Disabilities
Independent Living Council
AL Dept of Mental Health
Senior Services
AL Disabilities Advocacy Program
BCBS
State Legislator
Primary Health Care Assn (FQHCs)
Legislative Fiscal Office
AL Dept. of Mental Health
Shared Health
University of South Alabama
Alabama Community Care
Lee-Russell Council of Governments
USA Healthcare
Alabama Arise
Mercy Medical - Pace
UCP
Disability Advocates
AlaCare
UAB
AL Dept of Rehab
AL Hospital Assn.
LRCOG
State Medical Association
The Arc of Alabama
Alabama Community Care
Glenwood, Inc.
Alahealth
BCBST
Navigant
Volunteers of America Southeast, Inc.
Jackson Thornton
WellCare Health Plans, Inc.
Otsuka America Pharmaceuticals, Inc.
Alabama Tombigbee Regional Commission
Leavitt Partners, LLC
Middle Area Agency on Aging
Shared Health
Alabama Department of Senior Services
Quality Outcomes
AmeriHealth Caritas Family of Companies
Volunteers of America Southeast, Inc.
AL Dept of Rehab
UnitedHealthcare
My Care / BCBS
Answered Prayer
East AL Planning and Devel Com.
Answered
Answered Prayer
Amerihealth Caritas

TARCOG
Oxford HealthCare
Optum Healthcare
MHC of North Central Al, Inc
Addus Home Care
Grandview Health
Valentines Diabetic Supply
Otsuka America Pharmaceutical, Inc.
BCBSAL
The Arc of Shelby County
HPE
Terrace Manor Nursing and Rehab
AseraCare Hospice & Prime by AseraCare
AmeriHealth Caritas Family of Companies
West Alabama Regional Commission
Cosby Development & Service Adv.
Dept. of Rehabilitation
University of South Alabama
DHR
Blueprint Health Care
Clebume County Nursing Home
Columbus Speech & Hearing Center
NARCOG
Post Acute Solutoins
Alabama Family Health Care, Inc
American Senior Alliance
Jackson Thornton
Health Management Associates
Perry County Nursing Home
SARCOA / AAA
Walker Rehabilitation Center
Southern Care, LLC dba Sunset Manor
krause financial services, inc
UnitedHealthcare
Alabama Hospital Association
Qualis Health
UAB Health System and USA
gilpin givhan,pc
Manatt
Community Hospital, Inc
Russell Medical
Marion Regional Nursing Home
SeniorSelect Partners, LLC
Alabama Wheelchair Specialists Inc
WellCare Health Plans, Inc.
Kindred at Home
Southern Strategy Group
LHC Hospice
Shared Health
BlueCross and Blue Shield of Alabama
Washington County Nursing Home
Coosa Valley Medical Center
VITAS Healthcare
Pharmacy Care Associates
CRI
Hospice of the Valley, Inc.
Marion Regional Nursing Home

PAYLESS PHARMACY
Panhandle Rural Health, Inc. d/b/a Jay Medical Clinic
Mediware Information Systems
My Care Alabama
Hospice of Montgomery
Turenne and Associates
Noland Health Services
AHC
CCA
VIVA Health, Inc.
Diversicare
Dayspring Hospice
Vision Partners, LLC
UAB
Diversicare of Pell City
Health Management Associates
Genesis HealthCare
Traylor Porter HealthCare
UAB Health System
HHC
AHA
UnitedHealthcare
ADT LLC
AmeriHealth Caritas
alahealth
Millennium Health LLC
HBS
Middle AL Area Agenc on Aging
AL Medicaid Business Analytics
ADCS
Health Management Associates
Genesis HealthCare
Shelton Consulting Services
East Alabama Mental Health Center
Addus HomeCare
Pharmacy Care Associates
Terrace Manor
Navigant
Poarch Creek Indians
M4A
Hospice of Marshall County
Marion Regional Nursing Home
Amerigroup
HMA
Help At Home / Oxford HealthCare
Diversicare of bessemer
NHS Management, LLC
AllHealth CHOICE
VIVA Health
Central Alabama Aging Consortium
South Central Alabama Development Commission-Area Agency on Aging
Mercer
WARC
Methodist Homes of Alabama and Northwest Florida
state analysis, inc
Optum Healthcare
Pangea Healthcare

Bradley Arant Boult Cummings
AARC
Infirmary Health System, Inc.
Performance Clinical Systems
Marion Regional Nursing Home
Genesis Health Care
Children's of Alabama
st vincent's
The Arc of Madison County, Inc.
Quality South, Inc

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

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

7. Contact Person(s)

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

Last Name:

Abron

First Name:

Monica

Title:

Health Systems Director, Program Administration

Agency:

Alabama Medicaid Agency

Address:

501 Dexter Avenue

Address 2:

P.O. Box 5624

City:

Montgomery

State:

Alabama

Zip:

36103-5624

Phone:

(334) 242-5642

Ext:



TTY

Fax:

E-mail:

monica.abron@medicaid.alabama.gov

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

Last Name:

Abron

First Name:

Monica

Title:

Health Systems Director

Agency:

Alabama Medicaid Agency

Address:

501 Dexter Ave

Address 2:

PO Box 5624

City:

Montgomery

State:

Alabama

Zip:

36104

Phone:

(334) 242-5642

Ext:



TTY

Fax:

E-mail:

monica.abron@medicaid.alabama.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under section 1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are **readily** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State:

Alabama

Zip:

Phone:

Ext:

☐

TTY

Fax:

E-mail:

Attachments**Attachment #1: Transition Plan**

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

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

Specify the transition plan for the waiver:

n/a

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

- ☒ **The waiver is operated by the state Medicaid agency.**

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

- ☒ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

Alabama Department of Senior Services

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the state Medicaid agency. Thus this section does not need to be completed.

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

The Alabama Community Transition Waiver (ACT Waiver) is administered by the Alabama Medicaid Agency (AMA) and operated by the Alabama Department of Senior Services. The AMA exercises administrative discretion in the management and supervision of the waiver and issues policies, rules and regulations related to the waiver. The AMA assumes the responsibility of:

Conducting joint trainings with direct service providers enrolled to provide services through the ACT Waiver;

Providing periodic training to discuss policies and procedures in an effort to consistently interpret and apply policies related to the ACT Waiver program, which are outlined in the ACT Waiver manual;

Conducts annual training to disseminate policies, rules and regulations regarding the home and community-based waiver programs and;

Signs all qualified direct service provider contracts enrolled with the Alabama Department of Senior Services to provide waiver services.

The AMA has developed a Quality Management Strategy for the ACT Waiver program. The following activities are components of the Quality Assurance Strategy:

Collect ongoing quarterly data to monitor appropriateness of level of care determinations;

Collect quarterly data from registered nurses by any of the following sources: reviewing a sample of the waiver case management records, direct service provider records, conducting on-site visits to participant's homes as indicated, and tracking complaints and grievances;

Ensure that remediation for non-compliance issues and complaints identified during data collection are handled by requesting the entity involved to submit a plan of correction; and

Collect data and submit quarterly and annual reports to the Operating Agency (OA) staff for evaluation and recommendations for program improvements. The AMA Quality Assurance Division tracks complaints and/or grievances that are received.

The AMA conducts quarterly meetings with the operating agencies to discuss issues and concerns in an effort to ensure providers are following and applying federal and state guidelines in accordance with the approved waiver documents.

Alabama's 1915b PCCM-E (ICN) will receive a monthly capitated payment inclusive of HCBS Case Management. The ICN will review the Case Management claims and reimburse the HCBS Case Management providers.

Appendix A: Waiver Administration and Operation

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

- ☒ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

Based upon the provisions within the 1915(j) State plan program, Personal Choices, waiver participants will be given the opportunity to self-direct specific ACT Waiver services.

The operating agency will use a FMSA contractor that has the capabilities to perform the required tasks in accordance with Section 3504 of the IRS CODE and Revenue Procedure 70-6. The FMSA will assist waiver participants who have chosen to self-direct services with hiring and paying their staff, completing background checks on potential Personal Choices employees, address all applicable payroll taxes of Personal Choices employees, processing time sheets, and paying the employees. The FMSA is paid a flat rate per month per participant.

The monthly rate of an initial enrollee is slightly higher for the first month to accommodate the cost of the background screening and enrollment.

Alabama's 1915b PCCM-E the Integrated Care Network (ICN) will enhance client outcomes in the community by providing Primary Care Case Management as needed. Through the 1915b, the ICN will receive a capitated per member per month payment for 1915c Waiver Case Management activities. The ICN will reimburse the HCBS Case Management provider.

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

Appendix A: Waiver Administration and Operation

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

- **Not applicable**
- **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

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

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

The Operating Agency/ADSS will contract with Alabama's 13 Area Agencies on Aging (AAA) to execute case management. ADSS will monitor these functions as outlined in the MOU and/or policies and procedures.

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

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

Appendix A: Waiver Administration and Operation

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

conducting waiver operational and administrative functions:

ADSS will assess the performance of contracted and/or local/regional non-state entities
The Medicaid Agency will assess the performance of the concurrent 1915b PCCM-E.

Appendix A: Waiver Administration and Operation

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

ADSS will perform annual audits on contracted, local/regional non state entities. AMA is made aware of deficiencies and related corrective action plans by way of correspondence copy.

GENERAL OBJECTIVES

To determine the effectiveness of the HCBS Waiver through the, Quality Assurance Program

To assure waiver participants have access to waiver services through the process of monitoring quality assurance procedures

To assure waiver participants are able to exercise the right of freedom of choice of waiver services and providers, and to choose between home and community based services and institutionalization.

To assure the health and welfare of waiver participants, and to identify, address, and prevent abuse, neglect and exploitation of individuals served by the waiver

To assure waiver participants are receiving services identified in the plan of care by qualified personnel through monitoring a sample of recipient records and personnel records

To assure implementation and ongoing utilization of quality assurance standards of the OA, AMA, and the Center for Medicare and Medicaid Services (CMS) through evaluation of the organizational structures of direct service providers, and reports of quality assurance activities.

These objectives will be met by conducting an annual review of the OA. AMA Nurse Analysts will conduct the review, and the following elements will be evaluated:

A sample of Recipient records will be reviewed to ensure:

1. Level of care and admission criteria are met
2. Plan of care is appropriate and person centered
3. Freedom of choice
4. Patient rights
5. Services reimbursed by Medicaid were provided.

OA policies, procedures, organizational structure and staff qualifications will be reviewed to ensure the OA is operating in accordance with waiver guidelines.

OA documentation of contractual agreements between the OA and the DSP will be reviewed to ensure that qualified providers are rendering services to Medicaid waiver recipients.

OA documentation of QA visits to DSP will be reviewed to ensure:

1. OA is conducting QA reviews
2. DSP is providing services in accordance with waiver guidelines.

OA complaint and grievance procedures will be reviewed to ensure:

1. A process is in place in accordance with Medicaid waiver guidelines
2. Complaints/grievances are tracked through to resolution
3. Adverse findings are reported to the appropriate authority for final determination
4. Health and safety of the client is not at risk
5. An appeals process is in place in accordance with waiver guidelines.

Visits to client homes may be done to determine:

1. Effectiveness of service provision
2. Appropriateness of services
3. Adequacy of equipment and supplies
4. Accessibility of general condition of home
5. Safety of home and equipment.
6. Participant satisfaction

Appendix A: Waiver Administration and Operation

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR § 431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.* Note: Medicaid eligibility determinations can only be performed by the State Medicaid Agency (SMA) or a government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care evaluation, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care evaluation tool. States should ensure that any use of an evaluation tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions)

submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

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

Performance Measure:

Number and percent of requested reports submitted by the OA reviewed and validated by the designated AMA Program Manager for program compliance. Percentage =
NUMERATOR [Number of OA submitted reports reviewed and validated by the AMA
Program Manager for program compliance] / DENOMINATOR [Number of reports
submitted by the OA]

Data Source (Select one):

Other

If 'Other' is selected, specify:

Quarterly and Ad Hoc Reports submitted by the OA, as documented in the AMA Program Manager Log

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

--	--	--

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of programmatic operating procedures pertaining to the waiver issued by the OA that were approved by AMA prior to being issued by the OA. Percentage = NUMERATOR[Number of programmatic operating procedures pertaining to the waiver issued by the OA that were approved by AMA prior to being issued by the OA]/DENOMINATOR[Number of programmatic

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Cntnd from above... operating procedures pertaining to the waiver issued by the OA] OA programmatic operating procedures submitted for review, as documented in the AMA Program Manager Log

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☒ State Medicaid Agency	☐ Weekly	☒ 100% Review
☐ Operating Agency	☒ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence

		Interval =
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☒ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of waiver program records reviewed by the Medicaid Agency that were compliant with program requirements. Percentage = NUMERATOR [Number of

waiver program records reviewed by the Medicaid Agency that were compliant with program requirements] / DENOMINATOR [Number of waiver program records reviewed by the Medicaid Agency]

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record Reviews, on-site; Record Reviews, off-site (AMA audit results)

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

Data Aggregation and Analysis:

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

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

Performance Measure:

Number and percent of self-directed employees who have a Medicaid Provider Enrollment Agreement with the FMSA. Percentage = NUMERATOR [Number of existing self-directed employees who have a Medicaid Provider Enrollment Agreement] / DENOMINATOR [Number of existing self-directed employees]

Data Source (Select one):

Other

If 'Other' is selected, specify:

FMSA Data

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

	☐ Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

Percent of data reports specified in the agreements, policies and procedures with the Medicaid agency that were submitted on time and in the correct format by the OA.

Percentage = NUMERATOR [Number of data reports provided timely and in the correct format] / DENOMINATOR [Number of data reports due]

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Reports to State Medicaid Agency on delegated Administrative functions, as documented in the AMA Program Manager Log

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

☐ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☒ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of total reported performance measures that were above 86%.

Percentage = NUMERATOR [Number of reported performance measures that were above 86%] / DENOMINATOR [Number of reported performance measures]

Data Source (Select one):

Other

If 'Other' is selected, specify:

Performance measure reporting tool

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

Data Aggregation and Analysis:

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

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

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

The Alabama Medicaid Agency (AMA) exercises administrative authority and responsibility of all waiver related policies, rules and regulations reviews of the OA of the ACT Waiver. AMA conducts meetings to disseminate policies, rules and regulations in an effort to consistently interpret the policies related to the ACT Waiver program. AMA signs all direct service contracts of qualified providers enrolled with ADSS. AMA reviews participant files, personnel files and home visits as a method to monitor the compliance of level of care determination, appropriateness of the plan of care and the monitoring of service providers of quality care as contracted with ADSS.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

If problems arise, AMA will send a letter to the OA addressing the issue(s) and require a response as to their follow-up plan of correction and corrective measures to resolve any/all problems found.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

☒ **No**

☐ **Yes**

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

Appendix B: Participant Access and Eligibility**B-1: Specification of the Waiver Target Group(s)**

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

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☒ Aged or Disabled, or Both - General					
	☒	Aged	65		☒
	☒	Disabled (Physical)	0	0	
	☒	Disabled (Other)	0	0	
☐ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☐ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Intellectual Disability			☐
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

Waiver applicants must currently reside in a Medicaid-certified nursing facility, institution, or be served under another Alabama HCBS Program.

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

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

Specify:

N/A

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Specify the percentage:

- ☐ **Other**

Specify:

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

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

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

- ☐ The following dollar amount:

Specify dollar amount:

The dollar amount *(select one)*

- ☐ Is adjusted each year that the waiver is in effect by applying the following formula:

Specify the formula:

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

- ☐ The following percentage that is less than 100% of the institutional average:

Specify percent:

- ☐ Other:

Specify:

Appendix B: Participant Access and Eligibility

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

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

Applicants that desire to enroll as an ACT Waiver participant will undergo a complete assessment by the ACT Waiver Case Manager and Nurse Consultant. This assessment will include identification of needs-medical, social, and environmental. The ACT CM and Nurse Consultant will assess the current formal and informal supports that are being utilized by the applicant. Availability of informal supports are a vital part of the assessment. ACT Waiver services are unable to be provided 24 hours a day. An informal support system should complement and supplement any approved waiver services.

Based upon orders received from the applicants attending physician and the assessment by the Nurse Consultant and CM, the Alabama Department of Senior Services (ADSS) will determine if the cost of the waiver services necessary to ensure that the participants health and safety is protected will not exceed 100% of the cost for the nursing facility level of care. If it is determined that the applicant's needs are more extensive than the waiver services are able to support, the ACT Case Manager will inform the applicant that their health and safety cannot be assured in the community. The ACT CM will discuss long-term care services and supports that are more appropriate to meet the applicants needs and ensure their health and safety. Since the applicant is a resident of the nursing facility, the CM may recommend that the applicant remain until their condition improves. The ACT CM will inform the applicant that they may re-apply for the waiver when their condition improves.

A plan for transition from the NF may be re-submitted in the future if the participant's needs have decreased sufficiently so that the State can assure the health and safety of the individual and the cost to provide services are within the cost limit established by the State. In the event that the applicant is denied enrollment the applicant will receive a denial letter which outlines their rights to a fair hearing in accordance with Medicaid program rules.

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

- ☒ **The participant is referred to another waiver that can accommodate the individual's needs.**
- ☒ **Additional services in excess of the individual cost limit may be authorized.**

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

ACT Waiver participants are assessed monthly, at a minimum, to ensure that services provided meet their needs and ensures their health and safety. If a change occurs in their condition that appears to be short-term, additional services may be authorized in amount beyond the established limit. The ACT Case Manager and Nurse Consultant will continue to reassess the ACT Waiver participant monthly to determine if the participant's needs have changed.

If upon reassessment, the participant's condition stabilizes, the ACT CM will return the participant to the previously established HCBS waiver plan of care or revise the plan of care as needed.

If the participant's condition has not stabilized or worsens, within a period as specified by the attending physician, the ACT CM will contact the participant's attending physician regarding the participant's condition. Subsequently, the participant will be given the option of receiving services from an alternate service delivery method such as a hospital or nursing home. The ACT CM will discuss with the participant that their health and safety can no longer be met in the community. The ACT CM will discuss long-term care services and supports that are more appropriate to meet the participant's needs. Referrals will be made as needed, i.e. NF, the State Adult Protective Service agency, etc.

- ☒ **Other safeguard(s)**

Specify:

In the event that the participant's physician and ADSS (CM and Nurse Consultant) determine that the participant has an extended need for a higher level of care that cannot be provided by the ACT Waiver, the individual's plan of care will be revised and the participant will be transitioned to a hospital or nursing facility based upon the orders of the participants attending physician.

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	675
Year 2	675
Year 3	675
Year 4	675
Year 5	675

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

- ☒ The state does not limit the number of participants that it serves at any point in time during a waiver year.
- ☐ The state limits the number of participants that it serves at any point in time during a waiver year.

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

- ☒ Not applicable. The state does not reserve capacity.
- ☐ The state reserves capacity for the following purpose(s).

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

- ☒ Waiver capacity is allocated/managed on a statewide basis.
- ☐ Waiver capacity is allocated to local/regional non-state entities.

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

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

Entry to the waiver is based on the date of application and the need for services that is determined through an assessment process (HCBS-1) by the ACT CM and Nurse Reviewer in conjunction with the participant and the participant's physician. The PCCP is developed, based upon feedback from the participant/representative and the attending physician and is based upon the individual needs of the participant and the available existing formal and informal supports.

Once admitted to the waiver, a participant has access to all services offered in the waiver that are appropriate to meet their needs and ensure their health and safety in the community.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

- ☒ Section 1634 State
- ☐ SSI Criteria State
- ☐ 209(b) State

2. Miller Trust State.

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

- ☐ No

☒ Yes

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

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

- ☐ Parents and Other Caretaker Relatives (42 CFR § 435.110)
- ☐ Pregnant Women (42 CFR § 435.116)
- ☐ Infants and Children under Age 19 (42 CFR § 435.118)
- ☒ SSI recipients
- ☐ Aged, blind or disabled in 209(b) states who are eligible under 42 CFR § 435.121
- ☒ Optional state supplement recipients
- ☐ Optional categorically needy aged and/or disabled individuals who have income at:

Select one:

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

Specify percentage:

- ☐ Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in section 1902(a)(10)(A)(ii)(XIII) of the Act)
- ☐ Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in section 1902(a)(10)(A)(ii)(XV) of the Act)
- ☐ Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in section 1902(a)(10)(A)(ii)(XVI) of the Act)
- ☐ Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in section 1902(e)(3) of the Act)
- ☐ Medically needy in 209(b) States (42 CFR § 435.330)
- ☐ Medically needy in 1634 States and SSI Criteria States (42 CFR § 435.320, § 435.322 and § 435.324)
- ☒ Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)

Specify:

Individuals deemed eligible for SSI under 42 CFR 435.122, 435.134, 435.135, 435.137, 435.138, Section 6 of Public Law 99-643, and individuals eligible under 42 CFR 435.145 and 435.227.

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

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

Select one and complete Appendix B-5.

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

CFR § 435.217

Check each that applies:

☒ A special income level equal to:

Select one:

- ☒ 300% of the SSI Federal Benefit Rate (FBR)
- ☐ A percentage of FBR, which is lower than 300% (42 CFR § 435.236)

Specify percentage:

- ☐ A dollar amount which is lower than 300%.

Specify dollar amount:

- ☐ Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR § 435.121)
- ☐ Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR § 435.320, § 435.322 and § 435.324)
- ☐ Medically needy without spend down in 209(b) States (42 CFR § 435.330)
- ☐ Aged and disabled individuals who have income at:

Select one:

- ☐ 100% of FPL
- ☐ % of FPL, which is lower than 100%.

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR § 435.217 group effective at any point during this time period.

- ☒ Spousal impoverishment rules under section 1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses spousal post-eligibility rules under section 1924 of the Act. Complete Items B-5-e (if the selection for B-4-a-i is SSI State or section 1634) or B-5-f (if the selection for B-4-a-i is

209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time period after September 30, 2027 (or other date as required by law).

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law) (select one).

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

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

- ☐ **Use spousal post-eligibility rules under section 1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)
- ☐ **Use regular post-eligibility rules under 42 CFR § 435.726 (Section 1634 State/SSI Criteria State) or under § 435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)
- ☒ **Spousal impoverishment rules under section 1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

b. Regular Post-Eligibility Treatment of Income: Section 1634 State and SSI Criteria State after September 30, 2027 (or other date as required by law).

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

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

- ☒ **The following standard included under the state plan**

Select one:

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

(select one):

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

Specify the percentage:

- ☐ **A dollar amount which is less than 300%.**

Specify dollar amount:

- ☐ **A percentage of the Federal poverty level**

Specify percentage:

- ☒ **Other standard included under the state plan**

Specify:

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

- **The following dollar amount**

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

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

Specify:

- **Other**

Specify:

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

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

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

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

Specify:

The state is using post-eligibility rules for the period between Jan 1st 2014 and Dec 31st 2018 as per section 2404 of the ACA

iii. Allowance for the family (select one):

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

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

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

Specify:

☒ **Other**

Specify:

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

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

Select one:

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

Specify:

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

c. Regular Post-Eligibility Treatment of Income: 209(b) State or after September 30, 2027 (or other date as required by law).

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules after September 30, 2027 (or other date as required by law)

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

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

section is not visible.

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

e. Regular Post-Eligibility Treatment of Income: Section 1634 State or SSI Criteria State - January 1, 2014 through September 30, 2027 (or other date as required by law).

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

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

- ☒ **The following standard included under the state plan**

Select one:

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

(select one):

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

Specify the percentage:

- ☐ **A dollar amount which is less than 300%.**

Specify dollar amount:

- ☐ **A percentage of the Federal poverty level**

Specify percentage:

- ☒ **Other standard included under the state plan**

Specify:

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

- ☐ **The following dollar amount**

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

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

Specify:

☐ **Other**

Specify:

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

☐ **Not Applicable**

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

Specify:

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

Specify the amount of the allowance (select one):

☐ **SSI standard**

☐ **Optional state supplement standard**

☐ **Medically needy income standard**

☐ **The following dollar amount:**

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

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

Specify:

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

iii. Allowance for the family (select one):

☒ **Not Applicable (see instructions)**

☐ **AFDC need standard**

☐ **Medically needy income standard**

☐ **The following dollar amount:**

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

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

Specify:

☐ Other

Specify:

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

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

Select one:

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

Specify:

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

f. Regular Post-Eligibility Treatment of Income: 209(b) State - January 1, 2014 through September 30, 2027 (or other date as required by law).

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - January 1, 2014 through September 30, 2027 (or other date as required by law).

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

i. Allowance for the personal needs of the waiver participant

(select one):

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

Specify percentage:

- ☐ The following dollar amount:

Specify dollar amount:

If this amount changes, this item will be revised

- ☐ The following formula is used to determine the needs allowance:

Specify formula:

- ☒ Other

Specify:

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

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

Select one:

- ☒ Allowance is the same
- ☐ Allowance is different.

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR § 435.726 or 42 CFR § 435.735:

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

Select one:

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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

- **Directly by the Medicaid agency**
- **By the operating agency specified in Appendix A**
- **By an entity under contract with the Medicaid agency.**

Specify the entity:

- **Other**
Specify:

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

The OA has Nurse Consultants on staff that perform the initial evaluations. They are registered nurses with a State of Alabama license. These Nurse Consultants have experience and knowledge of the needs of individuals who are transitioning into the community.

The Nurse Consultants are familiar with resources available in the local community and within the state that are paid for outside of Medicaid funds.

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

The ACT Waiver participant's must meet the nursing facility level of care (LOC). The tool used to determine NH LOC is the Alabama Home and Community Based Services Program Assessment (HCBS-1) form. New admissions must meet two of the criteria listed in A-K. A readmission must meet also meet two of the criteria listed A-K. Supporting documentation must be submitted with the application.

The admission criteria are as follows:

- A. Administration of a potent and dangerous injectable medication and intravenous medication and solutions on a daily basis or administration of routine oral medications, eye drops, or ointment.
- B. Restorative nursing procedures (such as gait training and bowel and bladder training) in the case of clients who are determined to have restorative potential and can benefit from the training on a daily basis per physicians orders.
- C. Nasopharyngeal aspiration required for the maintenance of a clear airway.
- D. Maintenance of tracheostomy, gastrostomy, colostomy, ileostomy and other tubes indwelling in body cavities as an adjunct to active treatment for rehabilitation of disease for which the stoma was created.
- E. Administration of tube feedings by naso-gastric tube.
- F. Care of extensive decubitus ulcers or other widespread skin disorders.
- G. Observation of unstable medical conditions required on a regular and continuing basis that can only be provided by or under the direction of a registered nurse.
- H. Use of oxygen on a regular or continuing basis.
- I. Application of dressing involving prescription medication and aseptic techniques and/or changing of dressing in noninfected, postoperative, or chronic conditions per physicians orders.
- J. Comatose client receiving routine medical treatment.
- K. Assistance with at least one of the activities of daily living below on an ongoing basis:
 - 1. Transfer - The individual is incapable of transfer to and from bed, chair, or toilet unless physical assistance is provided by others on an ongoing basis (daily or multiple times per week).
 - 2. Mobility - The individual requires physical assistance from another person for mobility on an ongoing basis (daily or multiple times per week). Mobility is defined as the ability to walk, using mobility aids such as a walker, crutch, or cane if required, or the ability to use a wheelchair if walking is not feasible. The need for a wheelchair, walker, crutch, cane, or other mobility aid shall not by itself be considered to meet this requirement.
 - 3. Eating - The individual requires gastrostomy tube feedings or physical assistance from another person to place food/drink into the mouth. Food preparation, tray set-up, and assistance in cutting up foods shall not be considered to meet this requirement.
 - 4. Toileting - The individual requires physical assistance from another person to use the toilet or to perform incontinence care, ostomy care, or indwelling catheter care on an ongoing basis (daily or multiple times per week).
 - 5. Expressive and Receptive Communication - The individual is incapable of reliably communicating basic needs and wants (e.g., need for assistance with toileting; presence of pain) using verbal or written language; or the individual is incapable of understanding and following very simple instructions and commands (e.g., how to perform or complete basic activities of daily living such as dressing or bathing) without continual staff intervention.
 - 6. Orientation - The individual is disoriented to person (e.g., fails to remember own name, or recognize immediate family members) or is disoriented to place (e.g., does not know residence is a Nursing Facility).
 - 7. Medication Administration - The individual is not mentally or physically capable of self-administering prescribed medications despite the availability of limited assistance from another person. Limited assistance includes, but is not limited to, reminding when to take medications, encouragement to take, reading medication labels, opening bottles, handing to individual, and reassurance of the correct dose.
 - 8. Behavior - The individual requires persistent staff intervention due to an established and persistent pattern of dementia-related behavioral problems (e.g., aggressive physical behavior, disrobing, or repetitive elopement attempts).
 - 9. Skilled Nursing or Rehabilitative Services - The individual requires daily skilled nursing or rehabilitative services at a greater frequency, duration, or intensity than, for practical purposes, would be provided through a daily home health visit.

The above criteria should reflect the individuals capabilities on an ongoing basis and not isolated, exceptional, or infrequent limitations of function in a generally independent individual who is able to function with minimal supervision or assistance. If an individual meets one or more ADL deficits within criterion (k), they must also meet an additional criterion, (a) through (j), accompanied by supporting documentation, as is currently required. Multiple items met under (k) will still count as one criterion.

Also note, Criterion (a) is also the same as Criterion (k)7. Therefore, if an individual meets criterion (a), criterion (k)7,

cannot be used as the second qualifying criterion.

Additionally, Criterion (g) is the same as Criterion (k)9. Therefore, if an individual meets criterion (g), criterion (k)9, cannot be used as the second qualifying criterion.

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

- ☒ **The same instrument is used in determining the level of care for the waiver and for institutional care under the state plan.**
- ☐ **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

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

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

An initial Level of Care evaluation will be performed while the individual is residing in the nursing facility. The ACT CM submits a Home and Community Base Waiver (HCBS-1) application to the Nurse Reviewer on staff at the Operating Agency to evaluate and make the level of care determination. The Nurse Consultant will evaluate the application to make sure it is complete, supports the need for waiver services, and the medical criteria is met and level of care is approved. The approval of the appropriateness of admission or continued eligibility is assessed from the documentation as per the HCBS-1 assessment tool and other documents which may include physician progress notes, and/or hospital records. A review not only includes meeting the level of care criteria as developed by the Alabama Medicaid Agency but also the assessment of the support systems within the home, the functional limitations of the recipient, the diagnosis and any factors that would place the recipient at risk of being reinstitutionalized once they've returned to the community. An individual's non-waiver support system is vital to the health and safety of a waiver recipient. Waiver services cannot be provided on a 24/7 basis.

Once the application is approved it is entered electronically into the HP/Medicaid system. If no problems are identified, HP enters the approval in the AMA Long Term Care file and writes a waiver eligibility segment indicating the beginning and ending eligibility dates. Verification and acceptance will be returned overnight to the OA.

At the time of redetermination, the individual is currently residing in the community. At that point the evaluation will include and address any current risks for institutionalization.

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

- ☐ **Every three months**
- ☐ **Every six months**
- ☒ **Every twelve months**
- ☐ **Other schedule**

Specify the other schedule:

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

- ☒ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**

- **The qualifications are different.**

Specify the qualifications:

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

Reevaluations of eligibility for the ACT Waiver must be completed every twelve months. This process is the same as the initial application process which includes the determination that the participant continues to meet the level of care and the development of a new plan of care.

The OA is required to process the reevaluations 30-45 days prior to the expiration of the waiver eligibility period.

The ACT Waiver Coordinator maintains a record of each waiver participants re-evaluation date in a Tickler File and will work closely with ADSS to ensure timely re-evaluations. The Tickler File system will prompt the ACT Waiver Coordinator when re-determinations are due. The Act Waiver Coordinator will notify the OA that the redetermination is within the 30-45 day window of expiration and will monitor the submission of re-evaluations/redeterminations.

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

All evaluations and reevaluations are maintained for a minimum period of five years. The participants' records are located with the Operating Agency Case Record

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

Number and percent of participants who have a level of care (LOC) evaluation completed prior to entry into the HCBS waiver. Percentage = NUMERATOR [Number of participants who have a level of care (LOC) evaluation completed prior to entry into the HCBS waiver]/ DENOMINATOR [Number of participants]

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

HCBS application and enrollment data

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

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of applicants for whom there is reasonable indication that services may be needed in the future who have a level of care evaluation completed.
Percentage = NUMERATOR: [Number of applicants for whom there is reasonable indication that services may be needed in the future who have a level of care evaluation completed]/

Data Source (Select one):**Record reviews, off-site**

If 'Other' is selected, specify:

Cntned from above..[Number of applicants for whom there is reasonable indication that services may be needed in the future] HCBS application and enrollment data

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

☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☒ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:

Number and percent of level of care determinations where the LOC instruments and processes were appropriately applied and according to the approved description in the approved waiver. Percentage = NUMERATOR [Number of level of care determinations where the LOC instruments and processes were appropriately applied and according to the approved description in the approved waiver]/

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Cntned from above...DENOMINATOR [Number of LOC determinations]

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

		Group:
	☒ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

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

The AMA has granted the ADSS Nurse Reviewer the authority to make the level of care (LOC) determinations and annual redeterminations (re-evaluations). On a monthly basis, AMA staff will run a query of all ACT applications that are accepted into the HP system. The AMA review nurses will randomly select a percentage of applications for retrospective review. The AMA nurse reviewers will review the Home and Community Based Waiver (HCBS-1), the admission and evaluation data sheet, physician's progress notes, and/or any other documentation to support the client's need for services. Documentation must include, the support systems within the home, the functional limitations of the recipient, medical

diagnosis, unstable medical condition, and any factors that would place the recipient at risk of institutionalization. Redetermination (re-evaluation) must be completed every twelve months. The process is the same as for an initial evaluation. The OA is responsible for completing the re-evaluations in a timely manner, or the claim will deny. The AMA conducts quarterly Quality Assurance meetings which includes staff from LTC and representatives from staff of the ACT Waiver (and other waivers). These meetings are designed to inform, educate, discuss matters of concern, etc...

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

The AMA conducts satisfaction surveys on a quarterly basis. The survey is sent to a random sample of participants/representatives. The purpose of the survey is to evaluate the participants satisfaction with the waiver services. Any adverse responses are tracked through to a resolution either by the OA or AMA, depending upon the issue. A targeted satisfaction survey is sent out (within 45 days of receipt) as a follow-up to assure the clients satisfaction with the resolution. Results of satisfaction surveys are totaled in percentages using a bar graph. On a quarterly basis the results are sent to the OA. Additionally, the OA is responsible for keeping a log of complaints/grievances that must be tracked through to a resolution. Grievances will be resolved within 45 days of receipt by the DSP, OA, or AMA. Grievances are to be resolved in an appropriate and timely manner. If the grievances are not resolved to the satisfaction of the participant or AMA, the OA will be asked to submit a Plan of Correction to resolve the grievance to the participants satisfaction, if possible, or to ensure prevention of re-occurrence. If the grievance is not resolved within 45 days, AMA may assist the OA in reaching a satisfactory resolution. In no instance will grievance resolution exceed 90 days of receipt. The OA will be notified of any complaints/grievances received by AMA involving the OA or any of its providers of care within two working days of receipt. Annually, the OA sends a satisfaction survey to 5% of randomly selected participants receiving waiver services during the year. Responses of dissatisfaction are addressed with the ACT Case Manager who provides follow-up with the participant within three working days and reports findings and resolution to the state office within 30 days of notification. For the provision of Assistive Technology and Home Modification services, the participant must sign a form prior to vendor payment to ensure satisfaction of services. All waiver participants sign a Problem Solving Guide at the time of initial application and re-evaluation that provides them with the avenue to reach resolution of any problems. This form provides the contact information for the ACT Coordinator at the OA where participants may lodge complaints at any time. The State Office will notify the ACT Case Manager within three working days of the complaint. The ACT Case Manager will follow-up on the complaint within three days from the State Office notification. The ACT Case Manager will report resolution to the State Office within 30 days of notification of complaint. ACT Nurse Reviewers at the AMA will review a random selection of 5% of waiver participants records annually to ensure compliance with the waiver document and participant satisfaction with service. Satisfaction of services is reviewed during the monthly home visits and documented in the participant record.

ii. Remediation Data Aggregation

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

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

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

☒ **No**

☐ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

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

As part of the assessment and service coordination visit, participants and/or responsible parties are provided with adequate information to make an informed decision as to where the participants care will be received. Service coordination addresses problems and feasible solutions. It also includes an exploration of all the resources utilized by the participant, both formal and informal, as well as those waiver services which may be available to meet the participants needs.

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

Each waiver participant must make a written choice for either institution or community care, which will remain in effect until such time as the participant changes their choice. The only exception to making a written choice is when the participant is not capable of signing the form. In such cases, services are not denied if a written choice cannot be obtained. The reason(s) for absence of a signed choice must be carefully documented by the case manager. A responsible party should be encouraged to assume responsibility for working with the case manager in arranging for an appropriate plan of care. This may include the responsible party signing the forms.

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

The forms are maintained in the Operating Agency Case record.

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance

to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

Accommodations made for Limited English Proficiency (LEP) persons include a language line as well as several publications in Spanish on the Medicaid website such as: the Covered Services Handbook, and basic eligibility documents. The language translation line offers numerous languages and meaningful access through the Medicaid toll free telephone number. Through the translators the LEP person can request and receive any available Medicaid assistance and apply for available Medicaid services. Spanish speaking individuals are the largest Limited English Proficiency population in the State of Alabama.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	Adult Day Health		
Statutory Service	Case Management		
Statutory Service	Homemaker		
Statutory Service	Personal Care		
Statutory Service	Skilled Respite		
Statutory Service	Unskilled Respite		
Extended State Plan Service	Medical Supplies		
Other Service	Adult Companion Service		
Other Service	Assistive Technology		
Other Service	Home Delivered Meals		
Other Service	Home Modifications		
Other Service	Personal Assistant Service (PAS)		
Other Service	Personal Emergency Response Systems (PERS)-Installation/Monthly Fee		
Other Service	Pest Control Service		
Other Service	Skilled Nursing RN		
Other Service	Skilled Nursing-LPN		
Other Service	Transitional Assistance Services		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

04 Day Services

04050 adult day health

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service Definition (Scope):

Adult Day Health (ADH) is a service that provides ACT Waiver participants with a variety of health, social, recreational, and support activities in a supervised group setting for four or more hours per day on a regular basis.

Transportation between the participants place of residence and the adult day health center will be provided as a component part of Adult Day Health Service. The cost of this transportation is included in the rate paid to providers of Adult Day Health Service.

Adult Day Health is provided based on the needs of the individual client.

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

The unit of service will be a participant day of Adult Day Health Service consisting of four or more hours at the center. The four hour minimum for a participant day does not include transportation time, lunch breaks or free time. The number of units authorized per visit must be stipulated on the Plan of Care and the Service Authorization Form.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

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

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Care Worker
Agency	Registered Nurse or Licensed Practical Nurse
Agency	Director of Center

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Health

Provider Category:

Agency

Provider Type:

Adult Day Care Worker

Provider Qualifications

License (specify):

Alabama Drivers License

Certificate (specify):

None

Other Standard (specify):

Have a valid Alabama driver's license if transporting Adult Day Health clients; possess a valid, picture identification.

All Adult Day Health Workers must have at least six (6) hours in-service training per calendar year and submit to a program for the testing, prevention, and control of tuberculosis annually.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency

Alabama Medicaid Agency

Frequency of Verification:

Verified annually or bi-annually based on provider history

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Health

Provider Category:

Agency

Provider Type:

Registered Nurse or Licensed Practical Nurse

Provider Qualifications

License (specify):

Licensed by the Alabama Board of Nursing

Certificate (specify):

None

Other Standard (specify):

Two (2) years experience as a Registered Nurse or Licensed Practical Nurse preferred. Must submit to a program for the testing, prevention, and control of tuberculosis annually.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency

Alabama Medicaid Agency

Frequency of Verification:

Verified annually or bi-annually based on the provider history

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Adult Day Health

Provider Category:

Agency

Provider Type:

Director of Center

Provider Qualifications

License (specify):

None

Certificate (specify):

None

Other Standard (specify):

Have a high school diploma or equivalent.

Tested for tuberculosis annually.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency

Alabama Medicaid Agency

Frequency of Verification:

Verified annually or bi-annually based on provider history

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Case Management

HCBS Taxonomy:

Category 1:

01 Case Management

Sub-Category 1:

01010 case management

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service Definition (Scope):

Case Management (CM) Services assist individuals who receive waiver services in gaining access to needed and desired waiver and other State Plan services, as well as needed medical, social, educational and other appropriate services, regardless of the funding source for the services to which access is gained. CM services may be used to locate, coordinate, and monitor necessary and appropriate services. CM activities will be used to assist in the transition of an individual from institutional settings into community settings. The CM will assist in the coordination of services that help maintain an individual in the community. CM activities may also serve to provide necessary coordination with providers of non-medical and non-waiver services when the services provided by these entities are needed to enable the individual to function at the highest attainable level or to benefit from programs for which the person may be eligible. CM are responsible for ongoing monitoring of the provision of waiver and non-waiver services included in the participant's Plan of Care. CM is a waiver service available to all ACT Waiver clients. CM assist clients to make decisions regarding long term care services and supports. CM ensures continued access to waiver and non-waiver services that are appropriate, available and desired by the participant.

Alabama's 1915b PCCM-E (ICN) will receive a monthly capitated payment inclusive of HCBS Case Management. The ICN will review the Case Management claims and reimburse the HCBS Case Management providers.

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

The amount, frequency or duration of this service is dependent upon the participant needs as set forth in the Plan of Care for waiver case management.

The unit of service will be per 15 minute increments commencing on the date that the participant is determined eligible for ACT Waiver services and entered into the Medicaid Long Term Care (LTC) file. Case Management service provided prior to waiver approval should be considered transitional.

There is a maximum limit of 180 days under the HCBS waiver to assist an individual to transition from an institution to a community setting. The CM should have regular contact with the individual or sponsor throughout the transition period. If CM is provided it should not be billed until the first day the participant is transitioned and has begun to receive waiver services in order to qualify as waiver funds. If the individual fails to transition to the ACT Waiver, reimbursement will be at the administrative rate.

Alabama's 1915b PCCM-E (ICN) will receive a monthly capitated payment inclusive of HCBS Case Management. The ICN will review the Case Management claims and reimburse the HCBS Case Management providers.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

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

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Governmental Agency

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Case Management

Provider Category:

Agency

Provider Type:

Governmental Agency

Provider Qualifications

License (specify):

Professionals having earned a Bachelors degree or a Masters degree, from an accredited college or university, or having earned a degree from an accredited School of Nursing.

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

OA staff is responsible for verifying date of expiration of license of the case management staff.

Frequency of Verification:

Verification of provider qualifications is monitored annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Homemaker

Alternate Service Title (if any):

HCBS Taxonomy:**Category 1:**

08 Home-Based Services

Sub-Category 1:

08050 homemaker

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

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

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

Service Definition (Scope):

Homemaker Service provides assistance with general household activities such as meal preparation and routine house cleaning and tasks, such as changing bed linens, doing laundry, dusting vacuuming, mopping, sweeping, cleaning kitchen appliances and counters, removing trash, cleaning bathrooms, and washing dishes. The service may also include assistance with such activities as obtaining groceries and prescription medications, and writing and mailing items.

Homemaker service will only be provided for the waiver participant and will not extend to other individuals in the household.

Homemaker Services authorized based on the needs of individual participant as reflected in the Plan of Care.

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

The unit of service will be 15 minutes of direct Homemaker Service provided in the participant's residence (except when shopping, laundry services, etc.. must be done off site). The number of units and services provided to each client is dependent upon the individual waiver participant's needs as set forth in the Plan of Care. The amount of time authorized does not include the Homemaker's transportation time to or from the client's residence, or the Homemaker's break or mealtime.

These services will only be provided for individuals who require assistance as a result of their disability and will also be for tasks not generally provided by a parent.

Service Delivery Method (check each that applies):

- ☒ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

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

- ☒ Legally Responsible Person
- ☒ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Self-Directed In Home Homemaker
Agency	Home Care Agency

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Homemaker

Provider Category:

Individual

Provider Type:

Self-Directed In Home Homemaker

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Self-directed workers are individual providers selected and employed by the participant or their representative under the approved 1915(j) authority.

Self-directed workers must:

Be at least 18 years of age;

Completed the 10th grade;

Must have no physical or mental impairment that would prevent providing the needed oversight and care to the person;
Pass required background checks in accordance with state law, including screening for crimes related to violence, abuse, neglect, exploitation, or other disqualifying offenses;

Demonstrate the ability to read, write, and follow instructions sufficient to safely perform assigned tasks, as determined by the participant or representative;

Complete training appropriate to the tasks performed, as determined by the participant and documented in the Person-Centered Care Plan (PCCP).

Training includes, as applicable, instruction on the participant's specific needs and preferences, assistance with activities of daily living and supervision necessary to ensure the participant's health and safety, emergency procedures, incident recognition and reporting requirements, and respect for participant rights, including confidentiality and cultural preferences.

A relative, including a legally responsible relative, and/or legal guardian may serve as a provider, provided all applicable qualifications are met and the individual does not serve as the participant's representative/Employer of Record (EOR).

Services are provided according to the PCCP and are not duplicative of other services.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Financial Management Services Agency (FMSA) is responsible for verifying and maintaining documentation of provider qualifications prior to service delivery, including background checks and required documentation.

The participant or representative is responsible for ensuring the selected provider is capable of performing assigned tasks and that required training is completed prior to service delivery.

The FMSA maintains records of provider qualifications and supports compliance with employment and documentation requirements. The State maintains oversight through case management monitoring and review of service delivery to ensure services are delivered in accordance with the PCCP and waiver requirements.

The State maintains records of qualified providers and ensures this information is available to participants upon request.

Frequency of Verification:

Provider qualifications are verified prior to initial service delivery.

Ongoing monitoring is conducted through case management activities, including review of service delivery and documentation to ensure continued compliance with waiver requirements.

Background checks and exclusion screenings are conducted in accordance with state policy, including periodic rechecks as required.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Home Care Agency

Provider Qualifications

License (specify):

Agency providers must hold all required business or privilege licenses issued by the applicable local (county or municipal) authority, as required under Alabama law as authorized under Ala. Code §§ 11-51-90 et seq. and 40-12-1 et seq. Nurse supervisors must maintain a license in good standing in accordance with applicable Alabama licensing statutes and regulations, including the Alabama Nurse Practice Act (Ala. Code § 34-21-1 et seq.).

Certificate (specify):

If the provider is a Home Health Agency, the provider must also hold a Certificate of Need (CON) issued in accordance with Ala. Code § 22-21-260 et seq., and must be licensed as a Home Health Agency pursuant to Ala. Code § 22-21-20 et seq., and applicable Alabama Department of Public Health regulations.

Agencies that are not licensed as Home Health Agencies are not required to obtain a Certificate of Need unless otherwise required under Alabama law. These providers require a Waiver of Certificate of Need approved by the Alabama Medicaid Agency.

Other Standard (specify):

Workers are employed by a Medicare/Medicaid Certified Home Health Agency or other health care agencies under a Waiver approved by Alabama Medicaid. Minimum qualifications are as follows:

- Must have national background checks required by law and regulation;
- Must be at least 18 years of age;
- Must have references which are verified and documented; and
- Must be able to read and write and understand instructions.

All Homemaker workers must comply with Alabama Medicaid's current tuberculosis (TB) testing policy.

Homemaker workers are required to complete initial training and orientation prior to providing services. In addition, a minimum of twelve (12) hours of relevant in-service training per calendar year is required. Annual in-service training plans must be pre-approved by ADSS.

Basic training elements provided prior to service delivery include, but are not limited to:

- Procedures and expectations related to the worker role, including compliance with the Person-Centered Care Plan;
- Rights and responsibilities of the worker and the participant;
- Reporting, documentation, and record-keeping requirements;
- Procedures for arranging backup coverage when needed;
- Identification of appropriate supervisory and agency contacts;
- Assisting with activities of daily living (ADLs) and instrumental activities of daily living (IADLs);

-Training specific to abuse, neglect, and exploitation and DHR reporting requirements;
 -Incident identification and incident reporting requirements; and
 -Universal precautions, including TB.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Operating Agency

AAA

Home Health or Home Care Agency

Frequency of Verification:

Verified initially and bi-annually thereafter

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):**HCBS Taxonomy:****Category 1:**

08 Home-Based Services

Sub-Category 1:

08030 personal care

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

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

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

Service Definition (Scope):

ACT Waiver Personal Care Services provide assistance with eating, bathing, dressing, personal hygiene, activities of daily

living. This service may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the plan of care, this service may also include such housekeeping chores as bed making, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the waiver participant, rather than the participants family. Personal care providers must meet State standards for this service.

Personal care must be provided by an individual that is qualified and employed by a certified Home Health Agency or other Health Care Agencies approved by the Commissioner of the Alabama Medicaid Agency.

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

The Unit of Service will be per 15 minute increments of direct PC service provided. The number of units authorized per visit must be stipulated on the Plan of Care and the Service Provider Contract.

(Except for 1915j participants-Under no circumstances will payment be made for services furnished to an adult disabled child by the parent, to a parent by their child, to a recipients spouse, or to a minor by a parent or stepparent.) EPSDT/State Plan Benefits will be exhausted prior to use of waiver services.

Service Delivery Method (check each that applies):

- ☒ **Participant-directed as specified in Appendix E**
☒ **Provider managed**
☐ **Remote/via Telehealth**

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

- ☒ **Legally Responsible Person**
☒ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Self-Directed In Home Personal Care Worker
Agency	Home Care Agency or Home Health Agency

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Personal Care

Provider Category:

Individual

Provider Type:

Self-Directed In Home Personal Care Worker

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Self-directed workers are individual providers selected and employed by the participant or their representative under the approved 1915(j) authority.

Self-directed workers must:
 Be at least 18 years of age;

Completed the 10th grade;

Must have no physical or mental impairment that would prevent providing the needed oversight and care to the person;

Pass required background checks in accordance with state law, including screening for crimes related to violence, abuse, neglect, exploitation, or other disqualifying offenses;

Demonstrate the ability to read, write, and follow instructions sufficient to safely perform assigned tasks, as determined by the participant or representative;

Complete training appropriate to the tasks performed, as determined by the participant and documented in the Person-Centered Care Plan (PCCP).

Training includes, as applicable, instruction on the participant's specific needs and preferences, assistance with activities of daily living and supervision necessary to ensure the participant's health and safety, emergency procedures, incident recognition and reporting requirements, and respect for participant rights, including confidentiality and cultural preferences.

A relative, including a legally responsible relative, and/or legal guardian may serve as a provider, provided all applicable qualifications are met and the individual does not serve as the participant's representative/Employer of Record (EOR).

Services are provided according to the PCCP and are not duplicative of other services.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Financial Management Services Agency (FMSA) is responsible for verifying and maintaining documentation of provider qualifications prior to service delivery, including background checks and required documentation.

The participant or representative is responsible for ensuring the selected provider is capable of performing assigned tasks and that required training is completed prior to service delivery.

The FMSA maintains records of provider qualifications and supports compliance with employment and documentation requirements. The State maintains oversight through case management monitoring and review of service delivery to ensure services are delivered in accordance with the PCCP and waiver requirements.

The State maintains records of qualified providers and ensures this information is available to participants upon request.

Frequency of Verification:

Provider qualifications are verified prior to initial service delivery.

Ongoing monitoring is conducted through case management activities, including review of service delivery and documentation to ensure continued compliance with waiver requirements.

Background checks and exclusion screenings are conducted in accordance with state policy, including periodic rechecks as required.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Personal Care

Provider Category:

Agency

Provider Type:

Home Care Agency or Home Health Agency

Provider Qualifications

License (specify):

Agency providers must hold all required business or privilege licenses issued by the applicable local (county or municipal) authority, as required under Alabama law as authorized under Ala. Code §§ 11-51-90 et seq. and 40-12-1 et seq. Nurse supervisors must maintain a license in good standing in accordance with applicable Alabama licensing statutes and regulations, including the Alabama Nurse Practice Act (Ala. Code § 34-21-1 et seq.).

Certificate (specify):

If the provider is a Home Health Agency, the provider must also hold a Certificate of Need (CON) issued in accordance with Ala. Code § 22-21-260 et seq., and must be licensed as a Home Health Agency pursuant to Ala. Code § 22-21-20 et seq., and applicable Alabama Department of Public Health regulations.

Agencies that are not licensed as Home Health Agencies are not required to obtain a Certificate of Need unless otherwise required under Alabama law. These providers require a Waiver of Certificate of Need approved by the Alabama Medicaid Agency.

Other Standard (specify):

Workers are employed by a Medicare/Medicaid Certified Home Health Agency or other health care agencies under a Waiver approved by Alabama Medicaid. Minimum qualifications are as follows:

- Must have national background checks required by law and regulation;
- Must be at least 18 years of age;
- Must have references which are verified and documented; and
- Must be able to read and write and understand instructions.

All Personal Care workers must comply with Alabama Medicaid's current tuberculosis (TB) testing policy.

Personal Care workers are required to complete initial training and orientation prior to providing services. In addition, a minimum of twelve (12) hours of relevant in-service training per calendar year is required. Annual in-service training plans must be pre-approved by ADSS.

Basic training elements provided prior to service delivery include, but are not limited to:

- Procedures and expectations related to the worker role, including compliance with the Person-Centered Care Plan;
- Rights and responsibilities of the worker and the participant;
- Reporting, documentation, and record-keeping requirements;
- Procedures for arranging backup coverage when needed;
- Identification of appropriate supervisory and agency contacts;
- Assisting with activities of daily living (ADLs) and instrumental activities of daily living (IADLs);
- Training specific to abuse, neglect, and exploitation and DHR reporting requirements;
- Incident identification and incident reporting requirements; and
- Universal precautions, including TB.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Operating Agency

AAA

Home Health or Home Care Agency

Frequency of Verification:

Annually upon initial approval by AMA and biannually thereafter if no compliance concerns exist

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Skilled Respite

HCBS Taxonomy:**Category 1:**

09 Caregiver Support

Sub-Category 1:

09012 respite, in-home

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

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

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

Service Definition (Scope):

Respite Care is provided to individuals unable to care for themselves and is furnished on a short-term basis because of the absence of, or need for relief of those persons normally providing the care. Skilled Respite is provided for the benefit of the client and to meet client needs in the absence of the primary caregiver(s) rather than to meet the needs of others in the client's household. Respite Care is based on the needs of the individual client as reflected in the person-centered care plan.

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

Respite Care is direct care provided in the client's residence. The amount of time does not include the Respite Care Worker's (RCW) transportation time to or from the client's residence or the Respite Care Worker's break or mealtime. The number of units and services provided to each client is dependent upon the individual client's need as set forth in the client's Person-Centered Care Plan established by the case manager. A unit is defined as fifteen (15) minutes.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

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

- ☐ Legally Responsible Person
- ☒ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health or Home Care Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Skilled Respite

Provider Category:

Provider Type:

Provider Qualifications
License (specify):

Agency providers must hold all required business or privilege licenses issued by the applicable local (county or municipal) authority, as required under Alabama law as authorized under Ala. Code §§ 11-51-90 et seq. and 40-12-1 et seq. Nurse must maintain a license in good standing in accordance with applicable Alabama licensing statutes and regulations, including the Alabama Nurse Practice Act (Ala. Code § 34-21-1 et seq.).

Certificate (specify):

If the provider is a Home Health Agency, the provider must also hold a Certificate of Need (CON) issued in accordance with Ala. Code § 22-21-260 et seq., and must be licensed as a Home Health Agency pursuant to Ala. Code § 22-21-20 et seq., and applicable Alabama Department of Public Health regulations.

Agencies that are not licensed as Home Health Agencies are not required to obtain a Certificate of Need unless otherwise required under Alabama law. These providers require a Waiver of Certificate of Need approved by the Alabama Medicaid Agency.

Other Standard (specify):

This service will be performed by a Registered Nurse (RN) with an active license from the Alabama State Board of Nursing and preferably with at least two (2) years experience as a RN in public health, hospital, home health, or long term care nursing. Nurse also must have:
national background checks required by law and regulation
references which are verified and documented; and
comply with Alabama Medicaid's current tuberculosis (TB) testing policy.

Verification of Provider Qualifications
Entity Responsible for Verification:

Frequency of Verification:

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Service:

Alternate Service Title (if any):

HCBS Taxonomy:**Category 1:**

09 Caregiver Support

Sub-Category 1:

09012 respite, in-home

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

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

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

Service Definition (Scope):

Unskilled Respite Care is provided to participants unable to care for themselves and is furnished on a short-term basis because of the absence of or need for relief of those persons normally providing the care. Unskilled Respite Care may be provided through either the traditional waiver service delivery model or as a self-directed service, consistent with the approved 1915(j) State Plan.

Unskilled Respite Care is provided for the benefit of the participant and to meet participant's needs in the absence of the primary caregiver(s) rather than to meet the needs of others in the participant's household.

Unskilled Respite Care is based on the needs of the individual participant as reflected in the PCCP.

Unskilled Respite Care is provided in the participant's home or private place of residence.

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

The unit of service is fifteen (15) minutes of direct Unskilled Respite Care provided in the participant's residence. The amount of time does not include the Respite Care Worker's (RCW) transportation time to or from the participant's residence or the RCW's break or mealtime.

Service Delivery Method (check each that applies):

- ☒ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

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

- ☒ Legally Responsible Person
- ☒ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health or Home Care Agency
Individual	Self-Directed In Home Unskilled Respite

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Unskilled Respite

Provider Category:

Agency

Provider Type:

Home Health or Home Care Agency

Provider Qualifications

License (specify):

Agency providers must hold all required business or privilege licenses issued by the applicable local (county or municipal) authority, as required under Alabama law as authorized under Ala. Code §§ 11-51-90 et seq. and 40-12-1 et seq.

Nurse supervisors must maintain a license in good standing in accordance with applicable Alabama licensing statutes and regulations, including the Alabama Nurse Practice Act (Ala. Code § 34-21-1 et seq.).

If the provider is a Home Health Agency, the provider must also hold a Certificate of Need (CON) issued in accordance with Ala. Code § 22-21-260 et seq., and must be licensed as a Home Health Agency pursuant to Ala. Code § 22-21-20 et seq., and applicable Alabama Department of Public Health regulations.

Certificate (specify):

Agencies that are not licensed as Home Health Agencies are not required to obtain a Certificate of Need unless otherwise required under Alabama law. These providers require a Waiver of Certificate of Need approved by the Alabama Medicaid Agency.

Other Standard (specify):

Workers are employed by a Medicare/Medicaid Certified Home Health Agency or other health care agencies under a Waiver approved by Alabama Medicaid must also meet:

national background checks required by law and regulation
references which are verified and documented; and
comply with Alabama Medicaid's current tuberculosis (TB) testing policy.

All Unskilled Respite workers must comply with Alabama Medicaid's current tuberculosis (TB) testing policy.

Unskilled Respite workers are required to complete initial training and orientation prior to providing services. In addition, a minimum of twelve (12) hours of relevant in-service training per calendar year is required. Annual in-service training plans must be pre-approved by ADSS.

Basic training elements provided prior to service delivery include, but are not limited to:

- Procedures and expectations related to the Personal Care worker role, including compliance with the Person-Centered Care Plan;
- Rights and responsibilities of the worker and the participant;
- Reporting, documentation, and record-keeping requirements;
- Procedures for arranging backup coverage when needed;
- Identification of appropriate supervisory and agency contacts;
- Assisting with activities of daily living (ADLs) and instrumental activities of daily living (IADLs);
- Training specific to abuse, neglect, and exploitation and DHR reporting requirements;
- Incident identification and incident reporting requirements; and
- Universal precautions, including TB.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Operating Agency
Area Agency on Aging

Frequency of Verification:

Requirements verified at initial contract execution, annually, during audits and as needed.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Statutory Service

Service Name: Unskilled Respite

Provider Category:

Individual

Provider Type:

Self-Directed In Home Unskilled Respite

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

Self-directed workers are individual providers selected and employed by the participant or their representative under the approved 1915(j) authority.

Self-directed workers must:

Be at least 18 years of age;

Completed the 10th grade;

Must have no physical or mental impairment that would prevent providing the needed oversight and care to the person;
Pass required background checks in accordance with state law, including screening for crimes related to violence, abuse, neglect, exploitation, or other disqualifying offenses;

Demonstrate the ability to read, write, and follow instructions sufficient to safely perform assigned tasks, as determined by the participant or representative;

Complete training appropriate to the tasks performed, as determined by the participant and documented in the Person-Centered Care Plan (PCCP).

Training includes, as applicable, instruction on the participant's specific needs and preferences, assistance with activities of daily living and supervision necessary to ensure the participant's health and safety, emergency procedures, incident recognition and reporting requirements, and respect for participant rights, including confidentiality and cultural preferences.

A relative, including a legally responsible relative, and/or legal guardian may serve as a provider, provided all applicable qualifications are met and the individual does not serve as the participant's representative/Employer of Record (EOR).

Services are provided according to the PCCP to relieve the primary caregiver and are not duplicative of other services.

Verification of Provider Qualifications**Entity Responsible for Verification:**

The Financial Management Services Agency (FMSA) is responsible for verifying and maintaining documentation of provider qualifications prior to service delivery, including background checks and required documentation.

The participant or representative is responsible for ensuring the selected provider is capable of performing assigned tasks and that required training is completed prior to service delivery.

The FMSA maintains records of provider qualifications and supports compliance with employment and documentation requirements. The State maintains oversight through case management monitoring and review of service delivery to ensure services are delivered in accordance with the PCCP and waiver requirements.

The State maintains records of qualified providers and ensures this information is available to participants upon request.

Frequency of Verification:

Provider qualifications are verified prior to initial service delivery.

Ongoing monitoring is conducted through case management activities, including review of service delivery and documentation to ensure continued compliance with waiver requirements.

Background checks and exclusion screenings are conducted in accordance with state policy, including periodic rechecks as required.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Medical Supplies

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14032 supplies

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service Definition (Scope):

Medical supplies are in the Plan of Care, and enable waiver participants to increase their ability to perform activities of daily

living, to maintain health and safety in the home environment. All waiver medical supplies must be prescribed by a physician, and be specified in the Plan of Care.

Providers of this service will be those who have a signed provider agreement with the Alabama Medicaid Agency. The case manager must provide the participant with a choice of vendors in the local area of convenience.

Description Of Services To Be Provided

1. Medicaid will pay for a service when the service is covered under the ACT Waiver and is physician prescribed. The service is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. The OA records on each participant must substantiate the need for services, and must detail all treatment provided.

2. Medical supplies are necessary to maintain the participants health, safety and welfare and to prevent further deterioration of a condition such as decubitus ulcers. This service is necessary to prevent institutionalization.

3. These supplies do not include common over-the-counter personal care items such as toothpaste, mouthwash, soap, cotton swabs, Q-Tips, etc.

4. Items reimbursed with waiver funds shall be in addition to any medical supplies furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the participant.

5. All items shall meet applicable standards of manufacture, design and installation.

Supplies are limited to \$1800.00 per recipient per year. Providers must maintain documentation of items purchased for recipient which is specific to the recipients.

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

All waiver medical supplies must be prescribed by a physician, and be specified in the Plan of Care.

These supplies do not include common over-the-counter personal care items such as toothpaste, mouthwash, soap, cotton swabs, Q-tips, etc. Items reimbursed with waiver funds shall be in addition to any medical supplies furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

Medical Supplies are limited to \$1800.00 per recipient per year. The OA must maintain documentation of items purchased for recipient.

EPSDT/State Plan Benefits will be exhausted prior to use of waiver services.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

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

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Certified Waiver Provider

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Medical Supplies

Provider Category:

Individual

Provider Type:

Certified Waiver Provider

Provider Qualifications**License (specify):**

Business License

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

Providers of this service will be those who have signed provider agreements with the Alabama Medicaid Agency, and the OA. The case manager must provide the participant with a choice of vendors in the local area of convenience.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Operating Agency

Frequency of Verification:

Prior to contract approval, annually or bi-annually for approved providers based on previous score, or more often if needed based on service monitoring concerns.

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Other Service

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

Service Title:

Adult Companion Service

HCBS Taxonomy:**Category 1:**

08 Home-Based Services

Sub-Category 1:

08040 companion

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

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

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

Service Definition (Scope):

Companion Service is non-medical assistance, observation, supervision and socialization, provided to a functionally impaired adult. Companions may provide limited assistance or supervise the participant with such tasks as activities of daily living, meal preparation, laundry and shopping, but do not perform these activities as discrete services. The Companion may also perform housekeeping tasks which are incidental to the care and supervision of the waiver participant. Companion Service is provided in accordance with a therapeutic goal as stated in the Plan of Care, and is not purely diversional in nature. The therapeutic goal may be related to participant safety and/or toward promoting participant independence or toward promoting the mental or emotional health of the client.

Companion Service is provided based on the needs of the individual waiver participant as reflected in the Plan of Care.

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

The unit of service will be 15 minutes of direct Companion Service provided to the participant. The number of units per visit must be indicated on the Plan of Care and the Service Authorization Form. The amount of time authorized does not include the Companion Workers transportation time to or from the participants home, or the Companion Worker's break or mealtime. A unit of service will be 15 minutes of direct Companion Service provided to the participant.

Service Delivery Method (check each that applies):

- ☒ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

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

- ☒ Legally Responsible Person
- ☒ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health or Home Care Agency
Individual	Adult Companion Worker

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Adult Companion Service

Provider Category:

Agency

Provider Type:

Home Health or Home Care Agency

Provider Qualifications

License (specify):

Agency providers must hold all required business or privilege licenses issued by the applicable local (county or municipal)

08/20/2026

authority, as required under Alabama law as authorized under Ala. Code §§ 11-51-90 et seq. and 40-12-1 et seq. Nurse supervisors must maintain a license in good standing in accordance with applicable Alabama licensing statutes and regulations, including the Alabama Nurse Practice Act (Ala. Code § 34-21-1 et seq.).

Certificate (specify):

If the provider is a Home Health Agency, the provider must also hold a Certificate of Need (CON) issued in accordance with Ala. Code § 22-21-260 et seq., and must be licensed as a Home Health Agency pursuant to Ala. Code § 22-21-20 et seq., and applicable Alabama Department of Public Health regulations.

Agencies that are not licensed as Home Health Agencies are not required to obtain a Certificate of Need unless otherwise required under Alabama law. These providers require a Waiver of Certificate of Need approved by the Alabama Medicaid Agency.

Other Standard (specify):

Workers are employed by a Medicare/Medicaid Certified Home Health Agency or other health care agencies under a Waiver approved by Alabama Medicaid. Minimum qualifications are as follows:

- Must have national background checks required by law and regulation;
- Must be at least 18 years of age;
- Must have references which are verified and documented; and
- Must be able to read and write and understand instructions.

All Companion workers must comply with Alabama Medicaid's current tuberculosis (TB) testing policy.

Companion workers are required to complete initial training and orientation prior to providing services. In addition, a minimum of twelve (12) hours of relevant in-service training per calendar year is required. Annual in-service training plans must be pre-approved by ADSS.

Basic training elements provided prior to service delivery include, but are not limited to:

- Procedures and expectations related to the worker role, including compliance with the Person-Centered Care Plan;
- Rights and responsibilities of the worker and the participant;
- Reporting, documentation, and record-keeping requirements;
- Procedures for arranging backup coverage when needed;
- Identification of appropriate supervisory and agency contacts;
- Assisting with activities of daily living (ADLs) and instrumental activities of daily living (IADLs);
- Training specific to abuse, neglect, and exploitation and DHR reporting requirements;
- Incident identification and incident reporting requirements; and
- Universal precautions, including TB.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency

AAA

Home Health or Home Care Agency

Frequency of Verification:

Verified initially and bi-annually thereafter

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Adult Companion Service

Provider Category:

Individual

Provider Type:

Adult Companion Worker

Provider Qualifications

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

Self-directed workers are individual providers selected and employed by the participant or their representative under the approved 1915(j) authority.

Self-directed workers must:

Be at least 18 years of age;

Completed the 10th grade;

Must have no physical or mental impairment that would prevent providing the needed oversight and care to the person;
Pass required background checks in accordance with state law, including screening for crimes related to violence, abuse, neglect, exploitation, or other disqualifying offenses;

Demonstrate the ability to read, write, and follow instructions sufficient to safely perform assigned tasks, as determined by the participant or representative;

Complete training appropriate to the tasks performed, as determined by the participant and documented in the Person-Centered Care Plan (PCCP).

Training includes, as applicable, instruction on the participant's specific needs and preferences, assistance with activities of daily living and supervision necessary to ensure the participant's health and safety, emergency procedures, incident recognition and reporting requirements, and respect for participant rights, including confidentiality and cultural preferences.

A relative, including a legally responsible relative, and/or legal guardian may serve as a provider, provided all applicable qualifications are met and the individual does not serve as the participant's representative/Employer of Record (EOR).

Services are provided according to the PCCP and are not duplicative of other services.

Verification of Provider Qualifications**Entity Responsible for Verification:**

The Financial Management Services Agency (FMSA) is responsible for verifying and maintaining documentation of provider qualifications prior to service delivery, including background checks and required documentation.

The participant or representative is responsible for ensuring the selected provider is capable of performing assigned tasks and that required training is completed prior to service delivery.

The FMSA maintains records of provider qualifications and supports compliance with employment and documentation requirements. The State maintains oversight through case management monitoring and review of service delivery to ensure services are delivered in accordance with the PCCP and waiver requirements.

The State maintains records of qualified providers and ensures this information is available to participants upon request.

Frequency of Verification:

Provider qualifications are verified prior to initial service delivery.

Ongoing monitoring is conducted through case management activities, including review of service delivery and documentation to ensure continued compliance with waiver requirements.

Background checks and exclusion screenings are conducted in accordance with state policy, including periodic rechecks as required.

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Other Service

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

Service Title:

Assistive Technology

HCBS Taxonomy:**Category 1:**

14 Equipment, Technology, and Modifications

Sub-Category 1:

14031 equipment and technology

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

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

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

Service Definition (Scope):

Assistive Technology includes devices, pieces of equipment or products that are modified, customized and used to increase, maintain or improve functional capabilities of individuals with disabilities. It also includes any service that directly assists an individual with a disability in the selection, acquisition or use of an Assistive Technology device. Such services may include acquisitions, selection, design, fitting, customizing, adaptation, application, etc. Items reimbursed with waiver funds shall be in addition to any medical equipment furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the participant. This service is necessary to prevent institutionalization or to assist an individual to transition from an institution to the ACT Waiver. All items shall meet applicable standards of manufacture, design and installation.

Description Of Services To Be Provided:

1. The ACT Waiver program will pay for equipment when it is not covered under the regular State Plan and is medically necessary. Medically necessary means that the service is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. A providers medical records on each participant must substantiate the need of services, must include all findings and information supporting medical necessity, and must detail all treatment provided. Vehicle modifications can only be authorized if it can be demonstrated that all Non-Emergency Transportation (NET) Services have been exhausted or is not feasible.
2. Assistive Technology includes pieces of equipment or products that are modified, customized and used to increase, maintain or improve functional capabilities individuals with disabilities.
3. The amount for this service is \$15,000.00 per waiver recipient per lifetime. Any expenditure in excess of \$15,000.00 must be approved by the ACT Coordinator and the designated Medicaid Agency personnel.
4. The service may also be provided to assist an individual to transition from an institutional level of care to the home and community based waiver.

Assistive Technology must be ordered by the physician. It must be documented in the Plan of Care and case narrative. The case manager must have the prescription for Assistive Technology.

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

The amount for this service is \$15,000.00 per waiver participant. Any expenditure in excess of \$15,000 (per participant per lifetime) must be approved by the ACT Coordinator and the designated Medicaid Agency personnel. EPSDT/State Plan Benefits will be exhausted prior to use of waiver services.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

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

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Vendor with a Business License

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Assistive Technology

Provider Category:

Individual

Provider Type:

Vendor with a Business License

Provider Qualifications

License (specify):

Business

Certificate (specify):

Other Standard (specify):

Vendor is responsible for orientation to the equipment

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency

Frequency of Verification:

As needed

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Delivered Meals

HCBS Taxonomy:

Category 1:

06 Home Delivered Meals

Sub-Category 1:

06010 home delivered meals

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service Definition (Scope):

Home Delivered Meals are provided to an eligible waiver participant who is unable to meet his or her nutritional needs. It must be determined that the nutritional needs of the participant can be addressed by the provision of home-delivered meals.

When specified in the Plan of Care, this service may include seven (7) or fourteen (14) frozen meals per week. In addition, the service may include the provision of two (2) or more shelf-stable meals to meet emergency nutritional needs when authorized on the participant's Plan of Care.

During times of the year when the state is at an increased risk of disaster from either hurricanes, tornados or ice/snow conditions, the Meals Coordinator will coordinate with the vendor to implement a Disaster Meal Services Plan.

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

Home Delivered Meals are not an entitlement. Provision is based on the needs of the individual, and the unit(s) of service needed will be specified in the Plan of Care. The unit of service is one (1) package of seven meals. For shelf-stable meals, the unit of service is two (2) meals, packaged as individual meals and delivered to the participants residence. This service does not make up a participant's full daily regiment for nutrition.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

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

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Driver of Delivery Truck
Agency	Registered Dietician

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Driver of Delivery Truck

Provider Qualifications

License (specify):

Valid driver's license

Certificate (specify):

None

Other Standard (specify):

Should receive initial and on-going training in the proper service, handling, and delivery of food

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency

Frequency of Verification:

Verified initially and monitored on an on-going basis

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Registered Dietician

Provider Qualifications**License (specify):**

State of Alabama license

Certificate (specify):

None

Other Standard (specify):

Current dietician registration

Verification of Provider Qualifications**Entity Responsible for Verification:**

Operating Agency

Frequency of Verification:

Verified initially and monitored on an on-going basis

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Modifications

HCBS Taxonomy:**Category 1:**

14 Equipment, Technology, and Modifications

Sub-Category 1:

14020 home and/or vehicle accessibility adaptations

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

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

- ☒ Service is included in approved waiver. There is no change in service specifications.

- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Those physical adaptations to the home, required by the participants plan of care, which are necessary to ensure the health, welfare and safety of the participants, or which enables the participants to function with greater independence in the home and without which, the participant would require institutionalization. Such adaptations may include the installation of ramps and grab-bars and/or the widening of doorways in order to accommodate the medical equipment and supplies which are necessary for the welfare of the participant. Excluded are those adaptations or improvements to the home which are not of direct medical or remedial benefit to the waiver participant, such as floor covering, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home, any type of construction affecting the structural integrity of the home, changes to the existing electrical components of the home, are also excluded from this benefit. All services shall be provided in accordance with applicable state or local building codes.

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

This service is necessary to assist an individual to transition from an institution to a home and community based waiver. Additionally, this service is used to maintain a participant in the community once transitioned. Limits on Home Modifications are \$5,000 per recipient per lifetime. Any expenditure in excess of \$5,000 must be approved by the ACT Waiver Coordinator and the Medicaid Agency designated personnel. The service should not be billed until the first day the participant is transitioned and has begun to receive waiver services in order to qualify as waiver funds. If the individual fails to transition to the ACT Waiver, reimbursement will be at the administrative rate.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

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

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed Contractor

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Home Modifications****Provider Category:**

Individual

Provider Type:

Licensed Contractor

Provider Qualifications**License (specify):**

Any construction/installation completed must be in accordance with state and local building code requirements, American with Disabilities Act Accessibility Guidelines (ADAAG) and done by a licensed contractor.

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency

Frequency of Verification:

Prior to contract approval, annually or bi-annually for approved providers based on meeting previous requirements, or more often if needed based on service monitoring concerns.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Assistant Service (PAS)

HCBS Taxonomy:

Category 1:

03 Supported Employment

Sub-Category 1:

03021 ongoing supported employment, individual

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service Definition (Scope):

PAS are a range of services provided by one or more persons designed to assist an individual with a disability to perform daily activities (on the job). These activities would be performed by the individual if that individual did not have a

disability. Such services shall be designed to increase the individuals independence and ability to perform every day activities (on the job).

This service will support that population of individuals with physical disabilities who need services beyond personal care and primarily those in competitive employment either in their home or in an integrated work setting. An integrated work setting is defined as a setting typically found in the community which employs individuals and there is interaction with non-disabled individuals who are in the same employment setting.

This service will be sufficient to support the competitive employment of people with disabilities of at least 40 hours per month. The service will also be sufficient in amount, duration, and scope so that an individual with a moderate to severe level of disability would be able to obtain the support needed maintain employment.

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

The amount of time should be the number of hours sufficient to accommodate individuals with disabilities to work. The unit of service will be per 15 minutes increments of direct PAS provided to the recipient. The amount of time authorized does not include the personal assistant's transportation time to or from the recipient's home or place of employment.

This service is mostly an employment support. This service must not be duplicative of Personal Care services. PAS in the home should be directly related to the individual's employment either home based or in preparing for work outside the home.

EPSDT/State Plan Benefits will be exhausted prior to use of waiver services.

Service Delivery Method (check each that applies):

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Care Agency or Home Health Agency
Individual	Personal Assistant Worker

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Personal Assistant Service (PAS)

Provider Category:

Agency

Provider Type:

Home Care Agency or Home Health Agency

Provider Qualifications

License (specify):

Agency providers must hold all required business or privilege licenses issued by the applicable local (county or municipal) authority, as required under Alabama law as authorized under Ala. Code §§ 11-51-90 et seq. and 40-12-1 et seq. Nurse supervisors must maintain a license in good standing in accordance with applicable Alabama licensing statutes and regulations, including the Alabama Nurse Practice Act (Ala. Code § 34-21-1 et seq.).

Certificate (specify):

If the provider is a Home Health Agency, the provider must also hold a Certificate of Need (CON) issued in accordance with Ala. Code § 22-21-260 et seq., and must be licensed as a Home Health Agency pursuant to Ala. Code § 22-21-20 et seq., and applicable Alabama Department of Public Health regulations.

Agencies that are not licensed as Home Health Agencies are not required to obtain a Certificate of Need unless otherwise required under Alabama law. These providers require a Waiver of Certificate of Need approved by the Alabama Medicaid Agency.

Other Standard (specify):

Workers are employed by a Medicare/Medicaid Certified Home Health Agency or other health care agencies under a Waiver approved by Alabama Medicaid. Minimum qualifications are as follows:

- Must have national background checks required by law and regulation;
- Must be at least 18 years of age;
- Must have references which are verified and documented; and
- Must be able to read and write and understand instructions.

All PAS workers must comply with Alabama Medicaid's current tuberculosis (TB) testing policy.

PAS workers are required to complete initial training and orientation prior to providing services. In addition, a minimum of twelve (12) hours of relevant in-service training per calendar year is required. Annual in-service training plans must be pre-approved by ADSS.

Basic training elements provided prior to service delivery include, but are not limited to:

- Procedures and expectations related to the worker role, including compliance with the Person-Centered Care Plan;
- Rights and responsibilities of the worker and the participant;
- Reporting, documentation, and record-keeping requirements;
- Procedures for arranging backup coverage when needed;
- Identification of appropriate supervisory and agency contacts;
- Assisting with activities of daily living (ADLs) and instrumental activities of daily living (IADLs);
- Training specific to abuse, neglect, and exploitation and DHR reporting requirements;
- Incident identification and incident reporting requirements; and
- Universal precautions, including TB.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency

AAA

Home Health or Home Care Agency

Frequency of Verification:

Annually upon initial approval and biannually thereafter if no compliance concerns exist.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Personal Assistant Service (PAS)

Provider Category:

Individual

Provider Type:

Personal Assistant Worker

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Self-directed workers are individual providers selected and employed by the participant or their representative under the

approved 1915(j) authority.

Self-directed workers must:

Be at least 18 years of age;

Completed the 10th grade;

Must have no physical or mental impairment that would prevent providing the needed oversight and care to the person;

Pass required background checks in accordance with state law, including screening for crimes related to violence, abuse, neglect, exploitation, or other disqualifying offenses;

Demonstrate the ability to read, write, and follow instructions sufficient to safely perform assigned tasks, as determined by the participant or representative;

Complete training appropriate to the tasks performed, as determined by the participant and documented in the Person-Centered Care Plan (PCCP).

Training includes, as applicable, instruction on the participant's specific needs and preferences, assistance with activities of daily living and supervision necessary to ensure the participant's health and safety, emergency procedures, incident recognition and reporting requirements, and respect for participant rights, including confidentiality and cultural preferences.

A relative, including a legally responsible relative, and/or legal guardian may serve as a provider, provided all applicable qualifications are met and the individual does not serve as the participant's representative/Employer of Record (EOR).

Services are provided according to the PCCP and are not duplicative of other services.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Financial Management Services Agency (FMSA) is responsible for verifying and maintaining documentation of provider qualifications prior to service delivery, including background checks and required documentation.

The participant or representative is responsible for ensuring the selected provider is capable of performing assigned tasks and that required training is completed prior to service delivery.

The FMSA maintains records of provider qualifications and supports compliance with employment and documentation requirements. The State maintains oversight through case management monitoring and review of service delivery to ensure services are delivered in accordance with the PCCP and waiver requirements.

The State maintains records of qualified providers and ensures this information is available to participants upon request

Frequency of Verification:

Provider qualifications are verified prior to initial service delivery.

Ongoing monitoring is conducted through case management activities, including review of service delivery and documentation to ensure continued compliance with waiver requirements.

Background checks and exclusion screenings are conducted in accordance with state policy, including periodic rechecks as required.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Emergency Response Systems (PERS)-Installation/Monthly Fee

HCBS Taxonomy:**Category 1:**

14 Equipment, Technology, and Modifications

Sub-Category 1:

14010 personal emergency response system (PERS)

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

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

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

Service Definition (Scope):

This service will cover the installation and monthly fee after the system has been installed.

PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in the event of an emergency. The participant may also wear a portable help button to allow for mobility. The system is connected to the participants phone and programmed to signal a response center once a help button is activated. The response center is staffed by trained professionals.

By providing immediate access to assistance, PERS serves to prevent institutionalization of those individuals.

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

Price quotation from the vendor providing the service specifying the description of personal emergency requested.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

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

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Business Vendor

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Personal Emergency Response Systems (PERS)-Installation/Monthly Fee

Provider Category:

Individual

Provider Type:

Business Vendor

Provider Qualifications

License (specify):

Business License

Certificate (specify):

Other Standard (specify):

Set-up will be provided by individuals who are trained to install this device for specific consumers for whom services are being provided

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency

Frequency of Verification:

At initial enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Pest Control Service

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

17010 goods and services

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service Definition (Scope):

Pest Control Service is the chemical eradication of pests by a professional in a waiver participant's primary residence, the presence of which may limit or prevent the service providers from entering the setting to deliver other critical waiver services.

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

Pest control services may be provided in a waiver participant's primary residence, which is limited to

- a) a participant living in his/her own private house or apartment and who is responsible for his/her own rent or mortgage; or
- b) a participant living with a primary caregiver.

Pest Control services include the following activities:

- a) assessment or inspection
- b) application of chemical-based pesticide
- c) Follow up visit

Pest control services is limited to one series of treatments per lifetime by a licensed and certified pest control company and excludes lodging during the chemical eradication process, all associated preparatory housework, and the replacement of household items. Additional treatments may be approved if the lack of such treatments would jeopardize the participant's ability to live in the community. If additional treatments are needed, the State will evaluate that participant's living situation to determine if the community arrangement is appropriate and supports their health and safety.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

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

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Pest Control Company

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Pest Control Service

Provider Category:

Agency

Provider Type:

Pest Control Company

Provider Qualifications

License (specify):

State of Alabama Business License

Licensed and Certified

Certificate (specify):

Code of Alabama, 1975, § 40-12-40

Possess licensure and certification approved through the Alabama Department of Agriculture and Industries.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver Operating Agency

Frequency of Verification:

Initially; then annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Skilled Nursing RN

HCBS Taxonomy:

Category 1:

05 Nursing

Sub-Category 1:

05020 skilled nursing

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service Definition (Scope):

The Skilled Nursing Service is a service which provides skilled medical observation and nursing services performed by a Registered Nurse who will perform their duties in compliance with the Alabama Nurse Practice Act and the Alabama State Board of Nursing. Skilled Nursing Services is provided based upon the needs of the ACT Waiver participant.

The Skilled Nursing Service is to provide skilled medical monitoring, direct care, and intervention for an individual with skilled nursing needs to maintain him/her through home support. This service is necessary to avoid institutionalization.

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

A unit of service is one hour of direct skilled nursing care provided to the client. If a waiver participant meets the criteria to receive the home health benefit, home health should be used in conjunction with Skilled Nursing under the waiver. The combination provides a more robust care plan.

EPSDT/State Plan Benefits will be exhausted prior to use of waiver services.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

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

- ☐ Legally Responsible Person
- ☒ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Care Agency

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

Service Name: Skilled Nursing RN

Provider Category:

Agency

Provider Type:

Home Care Agency

Provider Qualifications**License (specify):**

Agency providers must hold all required business or privilege licenses issued by the applicable local (county or municipal) authority, as required under Alabama law as authorized under Ala. Code §§ 11-51-90 et seq. and 40-12-1 et seq. Nurse must maintain a license in good standing in accordance with applicable Alabama licensing statutes and regulations, including the Alabama Nurse Practice Act (Ala. Code § 34-21-1 et seq.).

Certificate (specify):

If the provider is a Home Health Agency, the provider must also hold a Certificate of Need (CON) issued in accordance with Ala. Code § 22-21-260 et seq., and must be licensed as a Home Health Agency pursuant to Ala. Code § 22-21-20 et seq., and applicable Alabama Department of Public Health regulations.

Agencies that are not licensed as Home Health Agencies are not required to obtain a Certificate of Need unless otherwise required under Alabama law. These providers require a Waiver of Certificate of Need approved by the Alabama Medicaid Agency.

Other Standard (specify):

This service will be performed by a Registered Nurse (RN) with an active license from the Alabama State Board of Nursing and preferably with at least two (2) years experience as a RN in public health, hospital, home health, or long term care nursing. Workers are also have:
national background checks required by law and regulation
references which are verified and documented; and
comply with Alabama Medicaid's current tuberculosis (TB) testing policy.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Operating Agency

AAA

Home Health or Home Care Agency

Frequency of Verification:

Annually upon initial approval; biannually thereafter if no compliance concerns exist

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Other Service

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

Service Title:

Skilled Nursing-LPN

HCBS Taxonomy:**Category 1:**

05 Nursing

Sub-Category 1:

05020 skilled nursing

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

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service Definition (Scope):

The Skilled Nursing Service is a service which provides skilled medical observation and nursing services performed by a Licensed Practical Nurse who will perform their duties in compliance with the Alabama Nurse Practice Act and the Alabama State Board of Nursing. Skilled Nursing Services is provided based upon the needs of the ACT Waiver participant.

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

The Skilled Nursing Service is to provide skilled medical monitoring, direct care, and intervention for an individual with skilled nursing needs to maintain him/her through home support. This service is necessary to avoid institutionalization.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

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

- ☐ Legally Responsible Person
- ☒ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health or Home Care Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Skilled Nursing-LPN

Provider Category:

Agency

Provider Type:

Home Health or Home Care Agency

Provider Qualifications**License (specify):**

Agency providers must hold all required business or privilege licenses issued by the applicable local (county or municipal)

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authority, as required under Alabama law as authorized under Ala. Code §§ 11-51-90 et seq. and 40-12-1 et seq.

Nurse supervisors must maintain a license in good standing in accordance with applicable Alabama licensing statutes and regulations, including the Alabama Nurse Practice Act (Ala. Code § 34-21-1 et seq.).

Certificate (specify):

If the provider is a Home Health Agency, the provider must also hold a Certificate of Need (CON) issued in accordance with Ala. Code § 22-21-260 et seq., and must be licensed as a Home Health Agency pursuant to Ala. Code § 22-21-20 et seq., and applicable Alabama Department of Public Health regulations.

Other Standard (specify):

This service will be performed by a Licensed Practical Nurse (LPN) with an active license from the Alabama State Board of Nursing preferably with at least two (2) years' experience as a LPN in public health, hospital, home health, or long term care nursing. The LPN must work under the supervision of an RN. Nurses also must have:
national background checks required by law and regulation
references which are verified and documented; and
comply with Alabama Medicaid's current tuberculosis (TB) testing policy.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency

AAA

Home Health or Home Care Agency

Frequency of Verification:

Annually upon initial approval; biannually thereafter if no compliance concerns exist

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Transitional Assistance Services

HCBS Taxonomy:

Category 1:

16 Community Transition Services

Sub-Category 1:

16010 community transition services

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service Definition (Scope):

Transitional assistance services and expenses can consist of the following items, when appropriate and necessary for the participants discharge from a nursing facility and safe transition to the community:

1. Security deposits that are required to obtain a lease on an apartment or home;
2. Essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens;
3. Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;
4. Household services necessary for the individuals health and safety, such as pest eradication and one-time cleaning prior to occupancy;
5. Moving expenses
6. Other expenses as approved by the Alabama Medicaid Agency or its designee

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

Conditions of Payment: To qualify for payment as transitional assistance under the ACT Waiver, expenses must be:

1. Authorized and included in the participants service plan;
2. Incurred within 60 days before a participants discharge form a nursing facility or hospital or another provider-operated living arrangement or within 90 days post-transition; and
3. Necessary for the participants safe transition to the community.
4. Transitional Assistance Services can not exceed \$3,500.

Nonpayable Services and Expenses: Transitional assistance does not include expenses:

1. For monthly rental or mortgage expense; regular utility charges; and/or household appliances or items that are intended for pure diversion or recreational purposes;
2. That are not necessary for the participants safe transition to the community.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

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

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Business Vendor
Individual	Business Vendor

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service**Service Name: Transitional Assistance Services**

Provider Category:**Provider Type:****Provider Qualifications****License (specify):****Certificate (specify):****Other Standard (specify):****Verification of Provider Qualifications****Entity Responsible for Verification:****Frequency of Verification:**

Appendix C: Participant Services

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

Service Type: Other Service**Service Name: Transitional Assistance Services**

Provider Category:**Provider Type:****Provider Qualifications****License (specify):****Certificate (specify):****Other Standard (specify):****Verification of Provider Qualifications****Entity Responsible for Verification:****Frequency of Verification:**

Appendix C: Participant Services

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

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ☐ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ☒ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☒ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management).** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants and the requirements for their training on the HCBS settings regulation and person-centered planning requirements:

d. Remote/Telehealth Delivery of Waiver Services. Specify whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely/via telehealth.

No services selected for remote delivery

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (*select one*):

- ☐ **No. Criminal history and/or background investigations are not required.**
- ☒ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

All positions (registered nurses (RN), license practical nurses (LPN), personal care workers, case managers, office staff that require participant contact shall have a background investigation. The scope of the background investigation is statewide. It is up to the direct service provider (DSP) to select a vendor to conduct the background investigation.

During the annual audit of the DSP's, the OA shall check for background investigations on all employees who are in direct or indirect contact with any Waiver participant.

The OA shall check for criminal history and/or background investigations for nurses providing nursing services. Additionally, the OA shall check each nursing license to ensure that it is showing a current active date. The OA shall look for verification that the direct service provider contacted the ABN to "obtain primary source verification, either through an official Verification, the ABN Subscription Service, or the License Lookup system, all of which is available on the ABN website".

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

- ☐ **No. The state does not conduct abuse registry screening.**
- ☐ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; (c) the process for ensuring that mandatory screenings have been conducted; and (d) the process for ensuring continuity of care for a waiver participant whose service provider was added to the abuse registry. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

Note: Required information from this page is contained in response to C-5.

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law or regulations to care for another person (e.g., the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child). At the option of the state and under extraordinary circumstances specified by the state, payment may be made to a legally responsible individual for the provision of personal care or similar services. *Select one:*

- ☐ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ☐ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the types of legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) the method for determining that the amount of personal care or similar services provided by a legally responsible individual is "*extraordinary care*", exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization; (c) the state policies to determine that the provision of

services by a legally responsible individual is in the best interest of the participant; (d) the state processes to ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made; (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services; and, (g) the procedures that are used to implement required state oversight, such as ensuring that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

Only as prescribed in Appendix E related to the 1915j

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

- ☐ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**
- ☐ **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the types of relatives/legal guardians to whom payment may be made, the services for which payment may be made, the specific circumstances under which payment is made, and the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or legal guardian, and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that the provision of services by a relative/legal guardian is in the best interests of the individual. When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, specify the state's process for ensuring that the relative/legal guardian uses substituted judgement on behalf of the individual. Specify the procedures that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- ☒ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

Relatives and/or friends may be paid for providing waiver service whenever that individual is qualified to provide services through a DSP. Relatives that are legally obligated to provide care to the participant can not be paid for their services:

(A) Services provided by relatives or friends may be covered only if relatives or friends meet the same qualifications as other direct care providers and are employed by an approved provider of service. Relatives who are providers of services cannot be a parent/guardian of a minor or spouse of participant receiving services, when the services are those that these persons are legally obligated to provide. There must be justification as to why the relative or friend is the provider of care and documentation in the Case Managers file showing the lack of other qualified providers.

(B) The strict controls to assure that payment is made to relatives or friends as providers in return for authorized services include the following:

- 1) The relative or friend must be employed by a Direct Service Provider (DSP) Agency.
- 2) Meet the qualifications outlined in the scope of service as any other personal care, respite, homemaker, or companion worker employed by a DSP agency.
- 3) Complete a service log reflecting the type of service provided including the number hours of service, the date and time of service.
- 4) Have the participant/or representative sign the service log at each visit. If the relative or friend normally acts as a representative another individual must sign the service log.
- 5) The service log is reviewed by a DSP supervisor at least once biweekly.
- 6) Supervisory visits to the participants residence at 60 day intervals.
- 7) Direct on-site supervision of the DSP worker providing the authorized service at least once every 6 months and more frequently if warranted.
- 8) Monthly visits by the case managers to address participant satisfaction with the provision of services and to question the client confidentially about the adequacy of the services received and their needs are met as well as to observe the client or friend as services are provided.

(C) While each service may be offered by a relative the state will ensure that no conflict of interest will occur because the relative providing the direct service will not be involved in the development of the care plan or allowed to sign service logs which serve as documentation that the authorized services have been provided when the participant is unable to do so. When the primary caregiver or authorized representative for the participant must also act as the direct service provider worker, another individual must be assigned the aforementioned responsibilities as well as assume responsibility for any other functions which could potentially result in a conflict of interest. The case manager must be available during the monthly visits to observe the provision of the direct service by the guardian and question the participant confidentially about their satisfaction with those services.

(D) Personal Choices participants (Cash and Counseling Pilot Project, 1915 (j)) may hire legally liable relatives as paid providers of personal care services. However, restrictions do apply on participant living arrangements, when homes or property are owned, operated or controlled by a provider of services, not related by blood or marriage to the participant.

● **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR § 431.51:

When a prospective provider calls and expresses interest in providing waiver services, a contracting package is prepared and mailed. After the package is returned it is reviewed for completeness of information. The OA or designee will conduct an initial on-site visit to verify that the provider is in compliance with Medicaid Waiver standards and regulations before approval as a direct service provider is made. Each new provider is also required to attend a waiver training conducted by the OA.

When all information from the potential provider has been reviewed and verified, a financial amount is established and a contract is signed by the appropriate authorities. If the provider is not a certified home health agency, a letter is prepared requesting the Commissioner of the Alabama Medicaid Agency to exempt the provider from the certification requirement allowing the ACT Waiver provider to provide unskilled services. This request is based on the OAs (or designee) review of the provider. Once the exemption is granted, the contract may be signed.

After the contract is finalized, the provider is mailed a confirmation letter.

g. State Option to Provide HCBS in Acute Care Hospitals in accordance with Section 1902(h)(1) of the Act. Specify whether the state chooses the option to provide waiver HCBS in acute care hospitals. *Select one:*

- ☒ **No, the state does not choose the option to provide HCBS in acute care hospitals.**
- ☐ **Yes, the state chooses the option to provide HCBS in acute care hospitals under the following conditions. By checking the boxes below, the state assures:**
 - ☐ **The HCBS are provided to meet the needs of the individual that are not met through the provision of acute care hospital services;**
 - ☐ **The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;**
 - ☐ **The HCBS must be identified in the individual's person-centered service plan; and**
 - ☐ **The HCBS will be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.**

And specify: (a) The 1915(c) HCBS in this waiver that can be provided by the 1915(c) HCBS provider that are not duplicative of services available in the acute care hospital setting; (b) How the 1915(c) HCBS will assist the individual in returning to the community; and (c) Whether there is any difference from the typically billed rate for these HCBS provided during a hospitalization. If yes, please specify the rate methodology in Appendix I-2-a.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

- a. Sub-Assurance:** *The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:

Number and percentage of new contracted providers that met initial licensure and/or certification standards, other standards established by Medicaid, and any applicable requirements of state laws prior to service provision. Percentage = NUMERATOR [Number of new contracted providers that met initial licensure and/or certification standards, other standards established by Medicaid and

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Cntnd from above...applicable requirements of state laws] / DENOMINATOR [All new contracted providers] Initial Certification Surveys

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

	☐ Other Specify: 	
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Data Aggregation and Analysis:

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

Performance Measure:

Number and percentage of existing contracted providers that continued to meet licensure and/or certification standards, other standards established by Medicaid and any applicable requirements of state law. Percentage = NUMERATOR [Number of existing contracted providers that continued to meet licensure and/or certification standards and other standards established by Medicaid] /

Data Source (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

Cntnd from above...DENOMINATOR [Number of existing contracted providers]

Certification Surveys

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

☒ Operating Agency	☒ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☒ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Specify: 100% of provider training verification records are reviewed over a two year cycle.

b. Sub-Assurance: The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:

Number and percentage of enrolled self-directed employees who continue to meet waiver training requirements. Percentage = NUMERATOR [Number of currently enrolled self-directed employees that continue to meet waiver training requirements]/ DENOMINATOR [Number of currently enrolled self-directed employees]

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Training verification records

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

	☒ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

Number and percentage of self-directed employees/staff that meet state and waiver requirements. Percentage = NUMERATOR [Number of self -directed employees that meet state and waiver requirements]/DENOMINATOR [Number of self-directed employees/staff]

Data Source (Select one):**Other**

If 'Other' is selected, specify:

FMSA employee enrollment packet

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

Data Aggregation and Analysis:

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

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

Performance Measure:

Number and percentage of non-licensed/non-certified providers that meet waiver requirements and any applicable requirements of state law. Percentage =
NUMERATOR [Number of non-licensed/non-certified providers that met waiver] /
DENOMINATOR [Number of non-licensed/non-certified providers]

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Provider records on-site and off site

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

	☐ Other Specify: 	

Data Aggregation and Analysis:

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

c. Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:

Number and percentage of new self-directed employees that meet waiver training requirements. Percentage = NUMERATOR [Number of new self-directed employees that meet waiver training requirements]/ DENOMINATOR [Number of new self-

directed employees]

Data Source (Select one):**Record reviews, off-site**

If 'Other' is selected, specify:

Training verification records; New Employee Enrollment packet

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly

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

Performance Measure:

Number and percentage of providers that meet training requirements in accordance with state requirements and the approved waiver. Percentage = $\frac{\text{NUMERATOR}}{\text{DENOMINATOR}}$
[Number of providers that meet training requirements in accordance with state requirements and the approved waiver] / DENOMINATOR [Number of providers]

Data Source (Select one):

Other

If 'Other' is selected, specify:

Training verification records

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

	☒ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☒ Quarterly
☐ Other Specify: 	☐ Annually
	☒ Continuously and Ongoing
	☒ Other Specify: 100% of provider training verification records are reviewed over a two year cycle.

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

The Alabama Medicaid Agency (AMA) has granted the Operating Agency authority to determine the qualifications of providers. The AMA reviews annually the Operating Agency's training documentation for compliance with state requirements.

The AMA conducts quarterly Quality Assurance meetings which includes staff from LTC and representatives from staff of the ACT (and other) waivers. These meetings are designed to inform, educate, discuss matters of concern, etc.

The AMA has Nurses Reviewers that conduct monthly and quarterly reviews of admissions and reevaluations.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

The AMA is available to assist the Operating Agency as needed. If problems arise, AMA will send a letter to the OA addressing the issue(s) at hand and require a response as to their follow-up plan of correction and corrective measures to resolve any/all problems found.

The ACT Waiver Coordinator and the OA meet regularly to discuss the ACT Waiver general operations. If there are particular trends, changes to policy and procedures will ensue to accommodate the needs of the waiver population. As individual problems arise, decisions are made as a cooperative effort between the Case Manager, the ADSS Program Manager, and the ACT Waiver Coordinator.

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

☒ No

☐ Yes

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

Appendix C: Participant Services**C-3: Waiver Services Specifications**

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services**C-4: Additional Limits on Amount of Waiver Services**

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- ☒ **Not applicable-** The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ☐ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- ☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

- ☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

- ☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

- ☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 §§ CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings in which 1915(c) HCBS are received. (*Specify and describe the types of settings in which waiver services are received.*)

Services under the ACT Waiver are furnished exclusively in home and community-based settings that meet the requirements at 42 CFR §441.301(c)(4). ACT waiver services are provided only in the following settings:

Participants' private homes or residences; and private businesses, when necessary to support the delivery of authorized services.

The ACT Waiver does not authorize services in provider-owned or provider-controlled residential settings (e.g., group homes, assisted living facilities, or congregate residential settings). Services are also not delivered in general community locations such as parks, libraries, or public gathering spaces. As a result, provisions related to leases, lockable doors, or heightened scrutiny of residential provider-owned settings do not apply. All services are authorized based on individual need, participant choice, and the person-centered planning process.

Certain ACT Waiver services may be furnished in private businesses when necessary to support the authorized delivery of services and as specified in the PCCP. These locations are limited to private business settings and do not include general community locations.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and in the future as part of ongoing monitoring. *(Describe the process that the state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring across residential and non-residential settings in which waiver HCBS are received.)*

Ongoing Monitoring of HCBS Settings Compliance

The State ensures ongoing compliance with HCBS settings requirements through a combination of person-centered planning, provider oversight, and state-level monitoring, including:

- Person-Centered Care Planning as the primary safeguard.
- Each participant's PCCP reflects individual needs, preferences, strengths, goals, and choice of services and settings. PCCPs are reviewed at least every 60 days and updated at annual redetermination or sooner if the participant's needs or circumstances change.

Private Homes

Case Management monitoring

Case Managers monitor service delivery to ensure services are furnished as authorized, participant rights are upheld, and health and welfare are protected. Issues related to access, service quality, or setting appropriateness are addressed through PCCP updates and follow-up.

Provider oversight and review

ACT providers are not licensed through a separate state licensing board. Provider oversight is conducted through:

- ADSS provider qualification, enrollment, and reverification processes; and
- Alabama Medicaid Quality Assurance audit and review activities.

Providers are monitored no less frequently than every two years, and annually or more often as needed based on identified risk, complaints, service issues, or quality concerns.

Oversight activities include review of provider qualifications, required documentation, operational practices, and service delivery records to ensure services are furnished in compliant home-based settings.

Monitoring Contacts with Participants

Participants' services and outcomes are monitored through the Case Management process, including:

- Required PCCP reviews at least every 60 days;
- Additional contacts as needed due to changes in condition, identified risks, incidents, or participant concerns; and
- Annual redetermination and reassessment activities.

These contacts support ongoing verification that services continue to be delivered in settings that meet HCBS requirements and align with participant choice.

Participant Concerns, Complaints, and Corrective Actions

Participants and/or their representatives may raise concerns related to service delivery, setting characteristics, access, or rights through their Case Manager or ADRS. Identified concerns are addressed through:

- Documentation and updates to the PCCP when appropriate;
- Increased monitoring or follow-up;
- Corrective action with providers when indicated; and
- Referral to Alabama Medicaid Quality Assurance when warranted.

Private Businesses

Ongoing Monitoring of HCBS Settings Compliance

Compliance with HCBS settings requirements in private business locations is ensured through:

- Documentation of the service location and justification in the PCCP;
- Case Management monitoring of service delivery and participant outcomes; and
- Provider oversight and state-level monitoring activities described above.

Monitoring Contacts with Participants

Case Managers monitor services delivered in private business settings through required PCCP reviews and additional contacts as needed to ensure participant health, welfare, and rights are maintained.

Participant Concerns, Complaints, and Corrective Actions

Participants may report concerns regarding services furnished in private business settings through Case Management or

ADSS. Issues are addressed through PCCP updates, provider corrective actions, and increased monitoring when necessary.

3. By checking each box below, the state assures that the process will ensure that each setting will meet each requirement:

- ☒ The setting is integrated in and supports full access of individuals receiving Medicaid HCBS 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 setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board. (see Appendix D-1-d-ii)
- ☒ Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
- ☒ Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
- ☒ Facilitates individual choice regarding services and supports, and who provides them.
- ☒ Home and community-based settings do not include a nursing facility, an institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting.

Provider-owned or controlled residential settings. (Specify whether the waiver includes provider-owned or controlled settings.)

- ☐ No, the waiver does not include provider-owned or controlled settings.
- ☒ Yes, the waiver includes provider-owned or controlled settings. (By checking each box below, the state assures that each setting, in addition to meeting the above requirements, will meet the following additional conditions):
 - ☐ The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.
 - ☐ Each individual has privacy in their sleeping or living unit:
 - ☐ Units have entrance doors lockable by the individual.
 - ☐ Only appropriate staff have keys to unit entrance doors.
 - ☐ Individuals sharing units have a choice of roommates in that setting.
 - ☐ Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
 - ☐ Individuals have the freedom and support to control their own schedules and activities.
 - ☐ Individuals have access to food at any time.
 - ☐ Individuals are able to have visitors of their choosing at any time.
 - ☐ The setting is physically accessible to the individual.
 - ☐ Any modification of these additional conditions for provider-owned or controlled settings, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan(see Appendix D-1-d-ii of this waiver application).

Appendix D: Participant-Centered Planning and Service Delivery

State Participant-Centered Service Plan Title:

Plan of Care (POC)

a. Responsibility for Service Plan Development. Per 42 CFR § 441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals. Given the importance of the role of the person-centered service plan in HCBS provision, the qualifications should include the training or competency requirements for the HCBS settings criteria and person-centered service plan development. *(Select each that applies):*

- ☒ **Registered nurse, licensed to practice in the state**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☒ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

- ☐ **Social Worker**

Specify qualifications:

- ☐ **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for service plan development except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

- ☒ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ☐ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant. Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan:**

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in service plan development. *By checking each box, the state attests to having a*

process in place to ensure:

- ☐ Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;
- ☐ An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;
- ☐ Direct oversight of the process or periodic evaluation by a state agency;
- ☐ Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and
- ☐ Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

- c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The Case Manager, the participant and/or a family of legal representative or other persons designated by the participant will all meet to develop the plan of care. During the meeting all parties will discuss the needs of the participant, informal supports provided by family or other community resources, identify the gaps in supports, and are informed by the Case Manager of waiver services which may fill those gaps. The participant decides which personal representative will be involved in development of the plan of care.

Developing a Plan of Care for Case Management will include a comprehensive review of the participants problems, strengths and weaknesses. Based on identified needs, mutually agreed upon goals are set. The Plan of Care development includes participation by the participant and/or family/primary caregiver, and Case Manager. The Plan of Care development process provides involved persons with the information necessary to make an informed choice regarding the location of care and services to be utilized.

Development of the Plan of Care for all individuals transitioning from the institution is based on individual needs. Development of the Plan of Care should include participation by the client, the individuals family/sponsor and Case Manager. This process will provide information for all individuals to make informed choices regarding available community services and support. During the transition period, special emphasis will be put on discussion of the clients current health/impairment status, appropriateness of the Plan of Care, and verification that all formal and informal providers included on the Plan of Care are delivering the amount and type of services that were committed. The Plan of Care must be reviewed every 60 days in the presence of the participant to ensure services are appropriate for participants needs. Informal supports are crucial in supplementing the Plan of Care. Waiver services cannot be provided 24/7, therefore informal supports are used to ensure health and safety when waiver services are not in the home.

The Plan of Care development must include exploration of the resources currently utilized by the participant, both formal and informal, as well as those additional services which may be available to meet the participants needs. Service planning includes a visit with the participant and contact with the family members and/or existing potential community resources.

Service Coordination - will be accomplished by the Case Manager along with input from the participant/family/caregiver, and other involved agencies/parties as needed. All services needed by the participant will be included in the Plan of Care implemented by the Case Manager.

Through careful monitoring, needed changes in the existing services shall be promptly identified. Providers will be contacted, as necessary, to discuss the appropriate amount of service to be delivered. The Plan of Care and service contracts will be updated to reflect any changes in service needs.

Monitoring - each case will be monitored monthly through contacts and at least one face-to-face visit monthly with the participant. Special emphasis will be put on discussion of the participants current health/impairment status, appropriateness of the Plan of Care, and verification that all formal and informal providers included on the Plan of Care are delivering the amount and type of services that were committed. The Plan of Care must be reviewed every 60 days in the presence of the participant to make sure services are appropriate for participants needs.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

- d. **i. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; (g) how and when the plan is updated, including when the participant's needs changed; (h) how the participant engages in and/or directs the planning process; and (i) how the state documents consent of the person-centered service plan from the waiver participant or their legal representative. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The participant-centered plan of care is developed collaboratively with the participant, Case Manager, family or legal representative, and other persons designated by the participant. The plan of care is developed as a part of the initial assessment for all applicants for available waiver services and revised periodically as the needs of the participant changes.

With input from the participant, the Case Manager will schedule a meeting with all interested parties to secure information about the participant's needs, preferences, goals, other non-waiver services or community supports. The Case Manager completes a needs assessment to assist with the development of the plan of care. The participant and/or their family member or legal representative are informed of all of the services available through the waiver. Medical information obtained from the participant's physician is considered. The care plan is then developed and is based upon the participant's functional capacity, limitations, health care needs, formal and informal supports from the family, caregiver(s) and community. Care plans are individualized for each participant and seek to balance the participant's rights, values and preferences.

Non-waiver services and community supports are a crucial part of the Plan of Care development. Waiver services are not permitted to be provided 24/7, therefore non-waiver services are needed to ensure an individual's health and safety.

When the plan of care is developed with the necessary waiver services, the participant is given a choice of qualified and willing providers of waiver services. The participant/and or their family or legal representative must complete a freedom of choice form to document that they were given a choice of qualified providers of waiver services. The amount, duration and frequency of all waiver services are documented in the plan of care to avoid duplication of services and to establish complete coordination of care. Services contained in the plan of care are those services the participant is willing to accept, for which the participant has a justifiable unmet need, and there is a qualified provider of direct services available to provide the designated services. The Case Manager completes a Service Authorization Form which is forwarded to the direct service provider to ensure services are provided in accordance with the plan of care. After the plan of care is completed and implemented, it will be evaluated for its effectiveness. The time frame for this evaluation will depend on numerous factors and will vary, but will always be completed at least annually corresponding with the participant's waiver eligibility dates.

The care plan must be reviewed and initialed every 60 days by the Case Manager and participant. During the 60-day review, the Case Manager will review the Plan of Care with the participant, responsible party, and/or knowledgeable other. Additions, deletions, or other changes are written in by the Case Manager, to be later updated. A copy of the plan of care remains in the participant's home. Services may be initiated or changed at any time within a contract period to accommodate a participant's changing needs. Any change in waiver services necessitates a revision of the plan of care. When a plan of care is revised, as warranted by changes in the participant's condition, the participant/and or their family member or legal representative must be issued a written notice at least ten days prior to any adverse actions that may result from the change.

The participant actively participates in the service plan development. The service plans are evaluated every 60 days to ensure participant's goals, outcomes, and preferences are being met.

ii. HCBS Settings Requirements for the Service Plan. *By checking these boxes, the state assures that the following will be included in the service plan:*

- ☐ **The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.**
- ☐ **For provider owned or controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan and the following will be documented in the person-centered service plan:**
 - ☐ **A specific and individualized assessed need for the modification.**
 - ☐ **Positive interventions and supports used prior to any modifications to the person-centered service plan.**
 - ☐ **Less intrusive methods of meeting the need that have been tried but did not work.**
 - ☐ **A clear description of the condition that is directly proportionate to the specific assessed need.**
 - ☐ **Regular collection and review of data to measure the ongoing effectiveness of the modification.**
 - ☐ **Established time limits for periodic reviews to determine if the modification is still necessary or can be**

terminated.

- ☐ **Informed consent of the individual.**
- ☐ **An assurance that interventions and supports will cause no harm to the individual.**

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

- e. Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Potential risks to participant's safety are addressed in the development of the plan of care. Plans are individualized and should take into consideration participant's rights, values and preferences as related to any potential risks to health and safety. During the monthly face-to-face case management visit, the participant's health and welfare is reviewed and the plan of care is adjusted accordingly and evaluated for appropriateness. Also during the monthly visit, the Case Manager assesses the home to ensure the participant is safe, questions the participant regarding satisfaction with services and providers, as well as makes observations to ensure the health needs are met, and notes any changes that may require modifications to the POC. The Case Manager also documents, addresses and monitors any health and safety concerns.

When the participant is considered at "high" risk, the Case Manager may visit more often to monitor the situation to ensure the participant's health and safety is not jeopardized. "High Risk" participants are participants who are totally dependent on waiver and/or non waiver services for their daily care needs. These participants' backup plan is vital to their health and safety. When there is a situation that delays or prohibits services being delivered, this participant will have to use their backup plan to satisfy their health and safety needs. Situations which may affect the delivery of services are: (but not limited to) weather emergencies, natural disasters, missed visits from the DSP, and participants who have highly complicated medical needs. When a risk has been reported or identified, a home visit to monitor the health and safety of the participant is required as soon as it can be arranged. Case Managers will review and modify the POC if necessary to address the concerns.

Additionally, DSP staff must visit the participant's home as ordered on the POC. DSPs are trained and expected to observe and report any concerns about a participant's health and welfare to the case manager and in writing to the supervisor at the DSP agency.

Waiver applicant or participants are also informed of procedures necessary to file a formal complaint or grievance regarding availability, delivery or quality of services at application, readmission, redetermination, reinstatement or transfer of eligibility.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

- f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

As the plan of care is developed, the Case Manager discusses and documents the participant's freedom to choose a direct service provider from the list of approved contract providers that are qualified, available and willing to provide the services. The Case Manager presents a list of all qualified providers listed in alphabetical order for all waiver services available in the area. The list includes the services the DSP is approved to provide and the hours the DSP is available to provide those services. The participant then ranks the providers by choice with a minimum of three providers chosen, or more if the participant selects additional providers. A written choice should be made for each waiver service that the participant desires to access. The Freedom of Choice Provider List form is kept in the participant's record to serve as evidence of individual choice.

The participant can change providers at any time by notifying the Case Manager. Each month the Case Manager discusses freedom of choice of service providers with the participant to ensure proper delivery of services, participant's choice, and participant satisfaction.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR § 441.301(b)(1)(i):

The Medicaid Agency performs a retrospective review of a random 10% sample, depending on waiver enrollment, equaling 2-3 of approved applications' service plans on a monthly basis. The purpose of this review is to ensure compliance with both state and federal guidelines. During this review process the service plan is subject to the approval of the Medicaid Agency. Random participants' names are chosen using monthly report showing enrollment data. If the 10% sample indicates concerns with the service plan development process, additional service plans are reviewed with the OA. This joint review provides the opportunity to discuss any issues that have been discovered.

The Medicaid Agency Long Term Care Division also conducts an annual review of the Operating Agency. During the annual audit, a random 10% sample, depending on waiver enrollment, equaling 20 of approved waiver applications' service plans are reviewed to ensure compliance. Random participants' names are chosen using annual reports showing enrollment data. Service plans are subject to the approval of the Medicaid Agency.

If the 10% sample indicates concerns with the service plan development process, additional service plans are reviewed with the OA. This joint review provides the opportunity to discuss any issues that have been discovered.

If discrepancies relating to the service plan or compliance with other state and federal guidelines are identified during either the review, the Operating Agency is notified in writing and is given the opportunity to resolve or clarify the discrepancies or provide a plan of correction. Results of the audit may result in recoupment of Medicaid funds.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

- h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update, when the individual's circumstances or needs change significantly, or at the request of the individual, to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ☐ Every three months or more frequently when necessary
- ☐ Every six months or more frequently when necessary
- ☒ Every twelve months or more frequently when necessary
- ☐ Other schedule

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR § 92.42. Service plans are maintained by the following (*check each that applies*):

☐ **Medicaid agency**

☐ **Operating agency**

☒ **Case manager**

☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan, participant health and welfare, and adherence to the HCBS settings requirements under 42 CFR §§ 441.301(c)(4)-(5); (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The entity responsible for monitoring the implementation of the service plan and participant health and welfare is the case management staff of the Operating Agency during the face-to-face visit. Special emphasis will be put on discussion of the participant's current health/impairment status, appropriateness of the plan of care, and verification that all formal and informal supports included on the plan of care are delivering the amount and type of services that were committed. The plan of care must be reviewed every 60 days in the presence of the participant to ensure that services are appropriate for the participant's needs. Participant's and/or responsible relatives shall be instructed to notify the Case Manager if services are not initiated as planned, or if the participant's condition changes. However, it is the responsibility of the Case Manager to promptly identify and implement needed changes in the plan of care. The OA also conducts random home visits to monitor service plan implementation and assess the health and welfare of participants.

When a participant has been approved for ACT waiver services and the plan of care (POC) implemented, or when changes are made to the POC, the Case Manager is responsible for contacting the Direct Service Provider (DSP) to discuss and coordinate the provision of services included in the plan of care. The Case Manager must ensure that waiver services requested on the Service Authorization Form include only those services contained in the approved POC. The DSP must receive documentation regarding the specific needs and desires of the participant and the specific tasks to be performed. Information included on the Service Authorization Form must be clear, specific, accurate and include the number of units or hours of service per day and the number of days per week which are authorized. DSPs are trained and expected to observe and report any concerns in a participant's health and welfare to the Case Manager and in writing to the supervisor of the DSP agency.

The supervisor of the DSP agency has a responsibility to contact case management staff immediately by telephone when services cannot be provided to an at risk participant.

Annual desk reviews are performed by the Medicaid Long Term Care Division and include case management personnel files, participant files, and visits to participants in their homes.

Medicaid is informed by the Operating Agency when there is a problem with a participant's service plan. Notification of critical situations is sent to Medicaid via "Critical Events/Incidents" forms. Less critical situations are sent to Medicaid via patient completed survey as well as discussion during home visits by the case manager. Data is evaluated for any type of trend in a participant's service plan. Negative trends could potentially be addressed by: updating the service plan, reevaluating the DSP, or updating primary caregivers and their information. Rectifying problems with a participant's service plan will be on an individual basis considering the participant's health and safety needs.

The service plans are reviewed by multiple staff at various levels. The participant and Case Manager. The Case Manager and Case Manager Supervisor. The OA Supervisor and OA Program Manager. The Medicaid ACT Waiver Coordinator and the Medicaid Waiver Quality Assurance Unit. If there are concerns at any level of review, feedback is requested from the participant and case manager. Plans are reviewed concurrently with provision of services as well as retrospectively.

b. Monitoring Safeguard. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for monitoring the implementation of the service plan except, at the option of the state, when providers are given this responsibility because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

- ☒ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.**
- ☐ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation. (Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can monitor service plan implementation).**

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential

for conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements. *By checking each box, the state attests to having a process in place to ensure:*

- ☐ Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;
- ☐ An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;
- ☐ Direct oversight of the process or periodic evaluation by a state agency;
- ☐ Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and
- ☐ Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

- a. *Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.*

Performance Measures

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

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

Performance Measure:

Number and percent of participant service plans that address all participant's assessed needs, including health and safety risk factors. Percentage = NUMERATOR [Number of participant service plans that address all participant's assessed needs, including health and safety risk factors] / DENOMINATOR [Number of participant service plans reviewed]

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Certification

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

Number and percent of participants whose service plans address all of the participant's personal goals. Percentage = NUMERATOR [Number of participants who have all of the participant's personal goals addressed in the service plan] / DENOMINATOR [Number of participant service plans reviewed]

Data Source (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

Certification i.e., Participants' Assessment Forms and person-centered service plans (PCCP))

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☒ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☒ Representative Sample Confidence Interval = 95% with a margin of error of +/- 5%
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:

	☒ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

- b. Sub-assurance: Service plans are updated/revised at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual.**

Performance Measures

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

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

Performance Measure:

Number and percent of PCCP's that include the signatures of the required participants in the development of the plan as indicated by the approved waiver.

Percentage = NUMERATOR [Number of PCCP's reviewed that include the required participant signature in the PCCP development process] DENOMINATOR [Number of plans reviewed]

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Certification

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

Data Aggregation and Analysis:

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

c. **Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.**

Performance Measures

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

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

Performance Measure:

Number and percent of participants reviewed whose service plans are updated at least annually. Percentage = NUMERATOR [Number of participants reviewed whose service plans were updated at least annually] / DENOMINATOR [Number of participants reviewed]

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Certification

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid	☐ Weekly	☐ 100% Review

Agency		
☒ Operating Agency	☒ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☒ Representative Sample Confidence Interval = 95% with a margin of error of +/- 5%
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☒ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

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

Performance Measure:

Number and percent of participants whose service plans were reviewed with the participant according to the timeframes specified in the waiver. Percentage =
NUMERATOR [Number of participants reviewed whose service plans were reviewed with the participant according to the timeframes specified in the waiver] /
DENOMINATOR [Number of participants reviewed]

Data Source (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

Certification

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

	☐ Other Specify: 	

Data Aggregation and Analysis:

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

d. Sub-assurance: Participants are afforded choice between/among waiver services and providers.**Performance Measures**

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

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

Performance Measure:

Number and percent of waiver participants that receive services and supports in the amount specified in the service plan. Percentage = NUMERATOR [Number of waiver

participants reviewed that receive services and supports in the amount specified in the service plan] / DENOMINATOR [Number of participants reviewed]

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Certification; Claims data (ADIDIS)

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

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of participants that answered "yes, all services" to being able to choose or change what kind of services they received. Percentage = NUMERATOR [Number of participants that answered "yes, all services" to being able to choose or change what kind of services they received] / DENOMINATOR [Number of participants interviewed]

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Certification

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

		95% with a margin of error of +/- 5%
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☒ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of waiver participants that receive services and supports in the scope specified in the service plan. Percentage = NUMERATOR [Number of waiver participants reviewed that receive services and supports in the scope specified in the service plan] / DENOMINATOR [Number of participants reviewed]

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Certification; Claims data (ADIDIS)

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

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of waiver participants that receive services and supports in the duration specified in the service plan. Percentage = NUMERATOR [Number of waiver participants reviewed that receive services and supports in the duration specified in the service plan] / DENOMINATOR [Number of participants reviewed]

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Certification; Claims data (ADIDIS)

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☒ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☒ Representative Sample Confidence Interval = 95% with a margin of error of +/- 5%

☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☒ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of waiver participants that receive services and supports in the type specified in the service plan. Percentage = NUMERATOR [Number of waiver participants reviewed that receive services and supports in the type specified in the service plan] / DENOMINATOR [Number of participants reviewed]

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Certification; Claims data (ADIDIS)

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly

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

Performance Measure:

Number and percent of waiver participants that receive services and supports in the frequency specified in the service plan. Percentage = NUMERATOR [Number of waiver participants reviewed that receive services and supports in the frequency specified in the service plan] / DENOMINATOR [Number of participants reviewed]

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Certification; Claims data (ADIDIS)

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

	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

e. Sub-assurance: *The state monitors service plan development in accordance with its policies and procedures.*

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the state to

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

Performance Measure:

Number and percent of service plans that document the waiver participant was offered and made a choice between traditional and self-directed care. Percentage =
NUMERATOR [Number of service plans that document the waive participant was
offered and made a choice between traditional and self-directed care] /
DENOMINATOR [Number of participant service plans reviewed]

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Certification

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

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Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of participant records reviewed that have a signed freedom of choice form that specifies that choice was offered among services and providers. Percentage = NUMERATOR [Number of participant records that have a signed freedom of choice form that specifies that choice was offered among services and providers] / DENOMINATOR [Number of participant records reviewed]

Data Source (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

Certification: Freedom of Choice forms

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

		Sample Confidence Interval = 95% with a margin of error of +/- 5%
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☒ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):

Performance Measure:

Number and percent of participants interviewed who reported the receipt of all services in the service plan. Percentage = NUMERATOR [Number of participants interviewed who reported the receipt of all services in the service plan]/ DENOMINATOR [Number of participants interviewed]

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Certification

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

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Data Aggregation and Analysis:

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

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

The AMA has granted the OA the authority to determine participant service plans. The AMA is available to assist OA in these determinations, if needed. The AMA LTC Division will conduct retrospective record reviews on a monthly basis. The AMA also reviews a percentage of case management records on a quarterly basis.

At this time, although the minimum is 10% sample size, 100% are reviewed. This waiver services individuals in the MFP program and their success is closely watched. With the total population of the waiver being so small, 100% review is appropriate. As the population increases, the appropriate sample size will be used.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

The AMA will advise the OA of any concerns detected during the monthly record review. The OA is required to submit additional information, and/or develop a corrective action plan. The AMA will evaluate the plan of correction for adequacy in addressing the area(s) of concern.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

☒ No

☐ Yes

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

Appendix E: Participant Direction of Services

Applicability (from Application Section 3, Components of the Waiver Request):

- ☒ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ☐ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

- a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

The Personal Choices Program State Plan Option will be offered to participants to afford them the opportunity to direct and manage their own services to the extent they are able. If they are unable they may appoint a representative to act on their behalf. The following processes describes the provisions of this program:

Where the POC indicates the need for services where personal direction is available, each participant will be provided a choice between the traditional vendor or the Personal Choices Option. The participant will share employer authority for the services they choose to self-direct. During the planning process, services and supports will be identified to meet the participant's individual needs and may include state plan services, generic resources and natural support networks in addition to waiver services. At the time of the planning process, the ACT Waiver Case Manager will ensure that the participant and caregiver have sufficient information available to make informed choices about participation in the Personal Choices Program. The ACT Waiver Case Manager will also ensure that the participant has the information needed to make informed selections of qualified waiver providers and notify participants about their ability to change providers if they are not satisfied with a providers performance.

Services available for Participant Direction are: Personal Care, Homemaker, Unskilled Respite, and Adult Companion.

Personal Choices Program providers must comply with the provisions within the Alabama Nurse Practices' Act.

Participants who choose to self-direct personal care services will be referred to a Financial Management Service Agency (FMSA) that will function as an intermediary between each participant and individuals who perform the self-directed services. The FMSA will assist the participant and/or representative to facilitate employment of direct service providers. The FMSA will conduct the following tasks:

- Identify and recruit individuals or agencies that can provide services;
- Development an enrollment packet for individuals or agencies that will provide services;
- Perform background checks on prospective individuals who will provide services;
- Provide information and training materials to assist in employment and training of workers;
- Facilitate meetings with the participant and the individual or agency providing services;
- Manage and monitor on a monthly basis, all invoices from individual employees who provide waiver services against the amount of services authorized in a particular plan of care;

Participants of the ACT program will be be able to access services in two ways:

Option one is the traditional ACT waiver services.

The second option is the Personal Choices Program described under 1915(j) of the Social Security Act, which provides an alternative to the traditional provision for personal care services. The Personal Choices option is available in Alabama. This option follows the agency of choice model, allowing the participant and the FMSA to act as co-employer model in the delivery of personal care services. Under this option, the waiver participant will be responsible for identifying individual to perform their services. The waiver participant will notify the FMSA of their choice of workers for consideration of employment. The FMSA will have the candidate complete an application for employment and will perform the background screening for each candidate prior to employment and provision of service. The review of timesheet will be the responsibility of the waiver participant. The worker will submit completed timesheets directly to the FMSA. The FMSA would be responsible for monitoring all invoices for services. The case manager will monitor the provision of participant-directed services through monthly home visits to ensure services are delivered and health and safety is not compromised. The case manager will also review invoices for accuracy prior to vendor payment. The FMSA will be monitored at least every two years by the OA.

- Develop fiscal accounting and expenditures reports;
- Report problems regarding participant directed services to the ACT Waiver Case Manager;
- Work on behalf of the waiver participants for the purpose of managing the payroll activities for the participant's employees;
- Withhold federal, state, and local tax payments including FICA;
- File the necessary tax forms for the IRS and the State of Alabama;
- Provide the individualwith the necessary tax information on a timely basis;
- File and withhold state unemployment insurance tax; and
- Make payments for invoices submitted by individuals or agencies providing services.

The ACT Waiver Case Manager will conduct an initial orientation that begins with a self-assessment process using the

Waiver Consumer Choices Roles and Responsibilities tool which provides a detailed description of the roles and responsibilities and support functions of the ACT Waiver Case Manager and the FMSA.

The Personal Choices Program participant may choose to manage their own personal support plans, or may appoint a representative to assist them. All participants have an option of choosing one individual to act as a representative to assume budget and care management responsibilities. Representatives may not work for the participant or be paid by the participant with monthly budget funds. The appointment of the representative will be done during the development of the personal support plans or may be appointed during the duration of the waiver. The ACT Waiver Case Manager will review the participant's request for appointing a representative to ensure that this appointment does not present a conflict of interest.

The Alabama Medicaid Agency will maintain oversight of the following FMSA activities:

- Monitor the FMSA to the degree necessary to ensure compliance with appropriate fiscal and programmatic procedures;
- Implement data gathering processes to enable the AMA to create accurate reports to identify and prevent erroneous billing;
- Provide support to the FMSA to facilitate effective training and identify efficient financial accounting methods; and
- Monitor the cost of the self-directed services by reviewing the data from the CMS 372 Report on a quarterly basis.

The AMA will collect information from participants and providers regarding the satisfaction with the FMS' performance. This process may include focus groups, phone contacts and face-to-face interviews.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver.
Select one:

- **Participant: Employer Authority.** As specified in **Appendix E-2, Item a**, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- **Participant: Budget Authority.** As specified in **Appendix E-2, Item b**, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- **Both Authorities.** The waiver provides for both participant direction opportunities as specified in **Appendix E-2**. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

- ☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy (*select one*):

- Waiver is designed to support only individuals who want to direct their services.
- The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
- The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.

Specify the criteria

Personal Choices Program participants will be allowed to direct services. Participants may choose to manage their own services or may appoint a representative to assist them. There must be strict controls to ensure that payment is made to the relatives or friends as providers only in return for personal care services.

Those who choose not to direct services will continue to receive their services through the traditional ACT Waiver program.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

- e. Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

The ACT Waiver Case Manager will conduct an initial orientation that begins with a self assessment process using the Waiver Consumer Choices Roles and Responsibilities tool. This tool provides a detailed description of the roles and responsibilities of the participant including a detailed description of the roles, responsibilities and support functions of the ACT Waiver Case Manager and the FMSA agency.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

- f. Participant Direction by a Representative.** Specify the state's policy concerning the direction of waiver services by a representative (*select one*):

- The state does not provide for the direction of waiver services by a representative.
- The state provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: (*check each that applies*):

- ☐ Waiver services may be directed by a legal representative of the participant.
- ☒ Waiver services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Participants may choose to manage their own personal support plans or may appoint a representative to assist them. All participants have the option of choosing one individual to act as representative (friend, caregiver, family member, or other person) to assume budget and care management responsibilities. Representatives may not work for the participant or be paid by the participant with monthly budget funds. The appointment of the representative will be done during the development of the personal support plans or may be appointed during the duration of the waiver. The ACT Waiver Case Manager will review the participant's request for appointing a representative to ensure that this appointment does not present a conflict of interest.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Homemaker	☒	☒
Personal Assistant Service (PAS)	☐	☐
Adult Companion Service	☒	☒
Personal Care	☒	☒
Unskilled Respite	☐	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

- ☒ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

- ☐ Governmental entities
- ☒ Private entities

- ☐ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

- ☒ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

- ☐ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

The FMSA was selected based upon the State of Alabama's procurement guidelines. The FMSA agency will enroll as a provider. The FMSA will not provide any direct services. The FMSA will operate as a Vendor Fiscal/Employer Agent. The FMSA contractor will provide services in withholding, filing and paying Federal and State income tax withholding, FICA, FUTA and SUTA in accordance with federal IRS and DOL and State of Alabama Departments of Revenue and Industrial Relations rules and regulations. The FMSA will conduct required criminal background checks for all prospective employees of the Personal Choices Program.

The FMSA will perform all FMSA tasks directly and may not delegate any FMSA tasks to a third party without expressed written permission from the operating agency.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The FMSA will receive a set monthly payment for each participant per month. This cost is estimated at 15% of the participant's budget. When a participant is enrolled for the first time, the first monthly payment is slightly higher to cover the administrative costs.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide (*check each that applies*):

Supports furnished when the participant is the employer of direct support workers:

- ☒ Assist participant in verifying support worker citizenship status
- ☒ Collect and process timesheets of support workers
- ☒ Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
- ☐ Other

Specify:

Supports furnished when the participant exercises budget authority:

- ☒ Maintain a separate account for each participant's participant-directed budget
- ☒ Track and report participant funds, disbursements and the balance of participant funds
- ☒ Process and pay invoices for goods and services approved in the service plan
- ☒ Provide participant with periodic reports of expenditures and the status of the participant-directed budget
- ☐ Other services and supports

Specify:

Additional functions/activities:

- ☒ Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
- ☒ Receive and disburse funds for the payment of participant-directed services under an agreement

- with the Medicaid agency or operating agency
- ☒ Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget
- ☐ Other

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The OA will monitor the FMSA through monthly claims submissions and reports received from the FMSA to ensure compliance with appropriate fiscal and program procedures. Problems identified will be brought to the attention of FMSA personnel within 48 hours. Remediation of the problem will be expected within 48 hours of the FMSA being notified by the operating agency. AMA will be responsible for monitoring this process annually.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

- ☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Pursuant to the 1915j:

The ACT Waiver Case Manager will play a significant role in the overall development of the participant's personal support plan. The Case Manager will continue to assess supports and needs as well as health and safety risks as required by ACT Waiver protocols. The Case Manager will perform a re-assessment of the participant's level of care needs at least semi-annually in order to resolve any identified health and safety issues.

- ☒ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (*check each that applies*):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Medical Supplies	☐
Case Management	☒
Skilled Nursing RN	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Adult Day Health	☐
Home Modifications	☐
Homemaker	☐
Personal Assistant Service (PAS)	☐
Home Delivered Meals	☐
Assistive Technology	☐
Pest Control Service	☐
Skilled Nursing-LPN	☐
Adult Companion Service	☐
Personal Emergency Response Systems (PERS)-Installation/Monthly Fee	☐
Personal Care	☐
Unskilled Respite	☐
Skilled Respite	☐
Transitional Assistance Services	☐

- ☒ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

The ACT Waiver Case Manager will provide information to the waiver participant to support their efforts to direct their own services. This will occur during the initial assessment process, during reviews and updates to the plan of care. If the individual elects to direct their own services, they will be referred to the FMSA to provide employer related services. These include:

- Identifying and recruiting individuals or agencies that can provide personal care services;
- Developing an enrollment packet for individuals or agencies that will provide personal care services;
- Performing background checks on prospective individuals who will provide personal care services;
- Providing information and training materials to assist in employment and training of workers;
- Facilitating meetings with the participant and the individual or agency providing personal care services;
- Managing, on a monthly basis, all invoices for personal care services authorized in the participants' plan of care;
- Developing fiscal accounting and expenditure reports.

The methods and frequency of the FMSA review will be as follows:

- The FMSA will provide monthly reports to the OA
- The OA and/or AMA will perform on-site administrative and operational reviews
- AMA and ADSS will monitor the FMSA, on a monthly basis during the first six months of operations and every six months thereafter.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy (*select one*).

- ☒ **No. Arrangements have not been made for independent advocacy.**
- ☐ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

- l. Voluntary Termination of Participant Direction.** Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

A program participant may elect to discontinue participation in the Personal Choices Program at any time. The AMA and the OA will initiate procedures to serve as safeguards to ensure that the reasons for discontinuance are not related to abuse, neglect or similar concerns. It is the responsibility of the participant to initiate voluntary discontinuance by notifying the Case Manager of such decision by phone, mail, or e-mail. The Case Manager will document in the participant's record, the date of notification by the participant of their decision to discontinue in the Personal Choices Program. The Case Manager will begin the process within 5 business days from the date of notification.

A face-to-face contact is required to discuss the following:

- To provide an opportunity for the Case Manager to determine if the participant's health, and welfare has been jeopardized during the process
- To identify and resolve any problems that would enable continued participation with the program or confirm that the reasons for discontinuation cannot be resolved.
- To obtain the signature of the participant to attest to his desire to discontinue participation
- To explain the processes and timeline for return to the traditional service delivery option
- To ascertain the participant's choice of direct service provider

From the receipt of the participant's request to discontinue their participation, the timeline for initiation of traditional waiver services may be from 15 to 30 days. The Case Manager will have 5 days to begin the process of reinstating traditional waiver services. Personal Choices Program services will continue until traditional services have been reinstated.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

- m. Involuntary Termination of Participant Direction.** Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

At any time that it is determined that the health, safety and well-being of the participant is compromised by continued participation in the Personal Choices Program, the participant will be returned to receiving traditional waiver services. Participants will be given advance notice in writing of their return to the traditional ACT Waiver program. Although the decision to involuntarily disenroll the participant from the Personal Choices Program may be appealed, the participant will begin to receive traditional waiver services until a decision is made on the appeal. The participant/representative has 15 days from the date of the notification of their return to the traditional waiver program to request an informal review of the decision to disenroll the participant from the Personal Choices Program. The AMA and the OA will make a decision within 30 days from receipt of the request for an informal review.

If the informal review decision is unfavorable, the participant may appeal the decision within 60 days from the date of the written decision of their return to the traditional ACT Waiver program in accordance with established Medicaid Fair Hearings provisions.

ACT Waiver participants may be involuntarily returned to traditional waiver services for the following reasons:

-Health, Safety and Well-Being: At any time that the ACT Waiver Case Manager or the AMA determines that the health, safety and well-being of the participant is compromised or threatened by continued participation in the Personal Choices Program, the participant will be returned to traditional waiver services.

-Change in Condition: If the participant's ability to direct their own care diminishes to a point where they can no longer do so and there is no responsible representative available to direct the care, then the individual will be returned to traditional waiver services.

-Under Utilization of Budget Allocation: The FMSA is responsible for monitoring on a monthly basis the use of funds received on behalf of program participants. If the participant is under utilizing the monthly allocation or is not using the allocation according to their personal support plans, the FMSA and Case Manager will discuss the issues of utilization with the participant/representative. If the health and safety of the participant may be in jeopardy because of the under-utilization of the budget allocation, the participant will be returned to traditional waiver services.

-Failure to Provide Required Documentation: If a program participant/representative fails to provide required documentation of expenditure and related items as prescribed in the Waiver Consumer Choices Roles and Responsibilities tool, a written reminder will be sent from the FMSA to the participant/representative. If the participant/representative continues to fail to provide required documentation after a written notice is given, the individual will be disenrolled from the program. The participant will receive written advance notification of disenrollment and the reasons for the actions. After disenrollment, the participant/representative cannot utilize funds allocated by the on Personal Choices Program.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1		25
Year 2		50
Year 3		75
Year 4		100
Year 5		100

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both:*

- ☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

- ☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

- ☒ **Recruit staff**
- ☒ **Refer staff to agency for hiring (co-employer)**
- ☒ **Select staff from worker registry**
- ☒ **Hire staff common law employer**
- ☒ **Verify staff qualifications**
- ☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

The cost of conducting criminal background checks will be compensated as part of the payment to the FMSA.

- ☐ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

- ☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- ☒ **Determine staff wages and benefits subject to state limits**
- ☒ **Schedule staff**
- ☒ **Orient and instruct staff in duties**
- ☒ **Supervise staff**
- ☒ **Evaluate staff performance**
- ☒ **Verify time worked by staff and approve time sheets**

- ☒ Discharge staff (common law employer)
- ☒ Discharge staff from providing services (co-employer)
- ☐ Other

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

- ☒ Reallocate funds among services included in the budget
- ☒ Determine the amount paid for services within the state's established limits
- ☒ Substitute service providers
- ☒ Schedule the provision of services
- ☒ Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3
- ☒ Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3
- ☒ Identify service providers and refer for provider enrollment
- ☒ Authorize payment for waiver goods and services
- ☒ Review and approve provider invoices for services rendered
- ☒ Other

Specify:

The Case Manager will assist the participant with their budget. A potential service plan is discussed using current waiver services. An estimate of the total cost of that service plan will be used as the budget for a Personal Choices participant. The participant can arrange their services in a manner that's consistent with their health and safety needs. The participant can not exceed the budget amount that was agreed upon in the service plan, without prior approval. The Case Manager will provide the participant with the information regarding how to request an adjustment to their budget. Participants are made aware of their appeal rights upon admission to the ACT Waiver. These appeal rights apply to any decision in which they disagree or find adverse. They are given a hard copy of their appeal rights to keep in their home. This paperwork describes, in detail, the steps to take to appeal a decision. More details of the appeal process are in Appendix F.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how

the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The State assures that the methodology used to establish budgets will meet the following criteria:

- A. Each participants budget will be established based on the current hours of traditional personal care hours received each week. Of the total monthly amount, a portion will be directed to the FMSA for administration of the participant-directed services. The primary choice for the recipient will be the decision regarding who will provide their services.
- B. The number of hours that a participant will receive is based on the individual assessment of need and will remain unchanged, unless the participants need changes. All changes will be indicated on the waiver participants plan of care (POC). Each participant will be provided a form which will assist in determining the payment methodology and rate of pay for the worker.
- Services are reviewed for appropriateness monthly during the case management home visit. Any additional factors identified during the home visit or by other means are based on the assessment of need and will be indicated on the recipients POC.
- D. Policy and procedures will describe the formula used to establish each recipients budget which will be applied consistently for each recipient who chooses the participant-directed option.
- E. Information about the budget methodology will be made available to the public through the AMA website, OA website, as well as published materials, formal and informal oral presentations.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

- iii. Informing Participant of Budget Amount.** Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The State informs each participant of the amount of their monthly budget and the procedures by which to request an adjustment in the budget amount during the development of the personal support plans. Separate orientations to participant direction are provided by the ACT Waiver Case Manager during the home visits. As a result, the potential participants are provided timely information about participant direction to allow them to make an informed decision about whether to enroll in the Personal Choices Program. For example, potential participants will be informed about the benefits and responsibilities associated with enrollment into the Personal Choices Programs.

Participants are made aware of their appeal rights upon admission to the ACT Waiver. These appeal rights apply to any decision in which they disagree or find adverse. They are given a hard copy of their appeal rights to keep in their home. This paperwork describes, in detail, the steps to take to appeal a decision. More details of the appeal process are in Appendix F.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

- iv. Participant Exercise of Budget Flexibility.** *Select one:*

- Modifications to the participant directed budget must be preceded by a change in the service plan.
- The participant has the authority to modify the services included in the participant directed budget without prior approval.

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

- v. Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The financial management activities will include:

- Identification of problems associated with the monthly allowance such as misuse or under-utilization of the funds;
- Participant/representative's failure to pay staff as required;
- Participant/representative's failure to comply with applicable state and federal laws;
- Participant/representative's failure to submit documentation of expenditures;

Theft of checks mailed to participants or other problems will be reported in writing to the AMA and the OA.

The ACT Waiver Case Manager will train, coach and provide technical assistance to participants as needed. The training and technical assistance will help participants use the budget effectively to meet their care needs, avoid overspending as well as to prevent the under utilization of their allocated budget.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

a. Description of the procedures by which eligible individuals or their representatives are informed of the feasible alternatives available under the waiver.

As part of the assessment and service coordination visit, participants and/or responsible parties are provided with adequate information to make an informed decision regarding institutional and community based care. Service coordination addresses problems and presents feasible solutions.

Service coordination also includes an exploration of all resources currently utilized by the participant, both formal and informal, as well as those waiver services that may be provided to meet the participants needs. If any needs cannot be met, these also are discussed with the individual and his family to fully inform them of the alternatives.

b. Following is a description of the States procedures for allowing individuals to choose either institutional or home and community-based services

Each person served through the waiver makes a written choice of institutional or community-based care, which will remain in effect until such time as the participant changes his/her choice. The only exception to making a written choice would occur when the participant is not capable of signing the form and has no legal or responsible party who can sign. In such situations, services will not be denied just because a written choice statement cannot be obtained. The Case Manager must carefully document the reason(s) for absence of a signed choice and the efforts to locate and encourage a responsible party who could have signed for the person.

c. Following is a description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, subpart E.

Any waiver applicant or participant has the right to request a fair hearing if denied home and community-based services or if a decision by the operating or administering agency adversely affects his/her eligibility status or receipt of service. The formal process is in accordance with 42 C.F.R. Section 431, Subpart E and Chapter 3 (560-X-3) of the Alabama Medicaid Administrative Code. A Hearing Officer appointed by the Commissioner of the Medicaid Agency conducts or arranges for a fair hearings.

When a change in the participants needs suggests a change in the waiver services and plan of care, the Case Manager discusses proposed change(s) with the participant and his family/representative prior to implementation. This discussion will include an explanation of the reason for the change, further assessment of the impact of the change, and an effort to elicit agreement on the part of the participant and/or his family/ representative.

Whenever there is a decision by the operating or administering agency to reduce, suspend, or terminate waiver services to coincide with the participants current need or the participants loss of eligibility for the service, the Operating Agency will issue a written 10 day advance notice to the participant and or family/caregiver indicating the participant's right to a fair hearing and instructions for initiating an appeal. The notice will contain all the due process information required by 42 C.F.R. Section 431, Subpart E. A copy of the notice will be forwarded to the Medicaid Agency.

The OA will be responsible for taking a lead role in the fair hearing process by preparing and conducting the fair hearing. Medicaid legal counsel and program staff will function as support staff. If the individual/guardian is still dissatisfied after the fair hearing, he/she may appeal to the Circuit Court. The OA will be responsible for defending any appeal of the administrative decision.

The participant is notified and reminded every year at redetermination about their appeal rights. When a particular decision is made, the participant receives written notice with instructions on how to request a fair hearing and how to continue receiving services in the interim.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ☐ **No. This Appendix does not apply**
- ☒ **Yes. The state operates an additional dispute resolution process**

• **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The Alabama Medicaid Agency does operate another dispute resolution process--the informal conference process, which offers participants the opportunity to appeal decisions that adversely affect their services through the Operating Agency in collaboration with the Alabama Medicaid Agency, while preserving their right to a fair hearing provided by the Alabama Medicaid Agency. An individual choosing to use the informal conference to resolve a dispute is informed in writing by the Case Manager that if the informal conference decision is not favorable, they maintain their right to have a fair hearing.

At the conference, the participant may present the information or may be represented by a friend, relative, attorney, or other spokesperson of their choice. If the dispute is not resolved through the informal conference, the participant, applicant, or his/her legal representative can submit a written request for a fair hearing within 30 days of the date of the notice of action. The document referring to the participants appeal rights is maintained in the waiver participants home for future reference.

The Alabama Medicaid Agency will provide an opportunity for a fair hearing under 42 C.F.R. Part 431 Subpart E for individuals who are dissatisfied after the above procedure has been completed. If the request for the hearing is made by someone other than the participant who wishes to appeal, the person requesting the hearing must make a definite statement that he/she has been authorized to do so by the participant for whom the hearing is being requested. Information about the hearings will be forwarded and plans will be made for the hearing and a date and place convenient to the participant will be arranged. If the person is satisfied before the hearing and wants to withdraw his/her request, he/she or his/her legally appointed representative or other authorized person should write the Alabama Medicaid Agency that he/she wishes to do so and give the reason for withdrawing.

When benefits are terminated, they can be continued if a hearing request is received within 10 days following the effective date of termination. If benefits are continued pending the outcome of the hearing and the Hearing Officer decides that termination was proper, Alabama Medicaid Agency may recover from the terminated participant, the costs of all benefits paid after the initial termination date.

Regulations found at 42 CFR 431.222 allow the State to consolidate individual requests for a hearing into a single group hearing for cases where the sole issue involved is one of Federal or State law or policy. However, the state does offer a hearing in these cases. The Alabama Medicaid Agency need not grant a request for a hearing if the sole issue is a federal or state law or policy which requires an automatic change adversely affecting some or all recipients.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. **Operation of Grievance/Complaint System.** *Select one:*

- ☐ **No. This Appendix does not apply**
- ☒ **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

• **Operational Responsibility.** Specify the state agency that is responsible for the operation of the grievance/complaint system:

The grievance/complaint system for the ACT Waiver is managed and maintained by the Operating Agency (OA), the Alabama Department of Senior Services. The OA has the responsibility of informing the participant of all rights and responsibilities and the manner in which service complaints may be registered.

The Administering Agency, The Alabama Medicaid Agency, monitors and tracks resolution of grievances and complaints. Information is transmitted to the Medicaid Agency through a complaint and grievance log maintained by the OA and submitted quarterly to the Medicaid Agency.

- **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The OA is responsible for explaining the procedures to participant for filing complaints and grievances. Participants are informed of procedures necessary to file a formal complaint or grievance regarding availability, delivery or quality of services at application, readmission, redetermination, reinstatement or transfer of eligibility. Written information about this process is maintained in the participant's home as well. The OA must have procedures in place that will assure AMA that DSPs have explained to participants the process on how to register a complaint. The DSP supervisor will investigate any complaints registered by a participant against any DSP workers. Any action taken will be documented in the participant's record. If the participant is dissatisfied with the action taken by the provider they should forward their complaint to appropriate agency and/or the Alabama Medicaid Agency (AMA).

- Complaints are submitted to the OA and a copy forwarded to the AMA and are investigated through resolution. A tracking log will be used to document the incidents and resolutions of incident. The OA will also maintain a log of complaints and grievances received.
- If complaints are received by the AMA, a copy will be forwarded to ADSS immediately. If they are received by ADSS a copy will be forwarded to AMA within two working days.
- The OA must investigate all complaints upon receipt of notification, and follow through to resolution. Appropriate parties must initiate action within 24 hours if it appears that a participant's health and safety are at risk. If necessary the complainant will be interviewed.
- A summary and plan of correction will be sent from the OA to AMA for all complaints reported within 30 days of the request for the summary or plan of correction from the AMA. The providers must forward their plan of corrections to the OA who will in turn forward to AMA. The AMA will evaluate the plan of correction within seven days of receipt. If the plan of correction is not responsive to the complaint, it will be returned to the OA within two days. The revised plan of correction will be resubmitted to the AMA within two working days. If the summary or plan of correction carried out is found not to be responsive, the OA will have up to 45 days to revise the plan and carry out the appropriate action.
- The OA will review all complaints and grievances to determine a pattern of problems in order to assure that no health and safety risk exists.
- Final determinations including any adverse findings will be reported to the AMA, LTC Division.
- ADSS will forward all grievance logs to AMA Nurse Reviewer quarterly for review, tracking, and assurance that resolutions have been completed.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

- a. Critical Event or Incident Reporting and Management Process.** Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program. *Select one:*

- ☒ **Yes. The state operates a Critical Event or Incident Reporting and Management Process** (*complete Items b through e*)
- ☐ **No. This Appendix does not apply** (*do not complete Items b through e*)

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

--

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

State Critical Event or Incident Requirements

Incident Types Timeframes

Physical Abuse	Immediate
Sexual Abuse	Immediate
Verbal Abuse	Immediate
Neglect	Immediate
Mistreatment	Immediate
Death	Immediate
Exploitation	24-hours
Moderate Injury	24-hours
Major Injury	24-hours
Natural Disaster	24-hours
Fire	24-hours
Fall	24-hours

Definitions

Physical Abuse-the infliction of physical pain, injury or the willful deprivation by a caregiver or other person of necessary services to maintain physical and mental health.

Sexual Abuse any conduct that is a crime as defined in Sections 13A-6-60 to 13A-6-70, inclusive of the Code of Alabama. Forms of sexual abuse include rape, incest, sodomy, and indecent exposure.

Verbal Abuse-the infliction of disparaging and angry outbursts such as name calling, blaming, or accusatory comments.

Neglect- the failure of a caregiver to provide food, shelter, clothing, medical services, or healthcare for the person unable to care for himself or herself; or the failure of the person to provide these basic needs for himself or herself when the failure is the result of the persons mental or physical inability.

Mistreatment-Actions that cause harm or create serious risk of harm whether intended or not, to a vulnerable person, by the caregiver or another person, or failure of a caregiver to satisfy the basic need or to protect the child or adult from harm.

Death-the permanent suspension of consciousness and the end of life.

Exploitation-the expenditure, diminution or use of the property, assets or resources of a person subject to protection under the provision of Sections 38-9-1 through 11, Code of Alabama, without the express voluntary consent of that person or legally authorized representative.

Moderate Injury-any observable and substantial impairment of a persons physical health such as temporary loss or impairment.

Major Injury-any observable and substantial impairment that results in permanent or temporary impairment, such as fractures, injury to internal organs, burns, or physical disfigurement of the body. These injuries may result in hospitalization.

Natural Disaster-the consequence of the combination of a natural hazard such as tornadoes, hurricanes, floods, power outages and winter weather.

Fire a situation in which something such as a building or an area of land is destroyed or damaged by burning.

Fall- an incident that causes a person to drop suddenly from an up-right position which may result in harm.

All Medicaid approved providers who provide home and community-based services in Medicaid recipients homes shall report incidents of abuse, neglect, and exploitation immediately to the Department of Human Resources, or law enforcement as required by the Alabama Adult Protective Services Act of 1976.

The Alabama Adult Protective Services Act of 1976 outlines the specific responsibilities of the Department of Human resources, law enforcement authorities, physicians, caregivers individuals and agencies in reporting and investigating such cases, and in providing the necessary services.

Alabama Code §§ 38-9-1-11 Adult Protective Services Act of 1976

All physicians, osteopaths, chiropractors and caregivers are required by law to report instances of suspected abuse, neglect or exploitation, sexual abuse, or emotional abuse. An oral report, either by telephone or in person must be made immediately if there is reasonable cause to believe that an adult has been subjected to abuse, neglect, or exploitation, followed by a written report to the chief of police or sheriff, the County Department of Human Resources or the Adult Protective Services Hotline (1800-458-7214).

Other incidents such as falls must be reported within 24 hours to the Provider Agency and the OA in a timely manner based upon the circumstances surrounding the incident via phone.

Child Abuse Prevention and Treatment Act 1974

Alabama law is clear on reporting abuse and neglect of children under the age of 18. For example, physicians, teachers, social workers, nurses, day care workers or anyone who comes in contact with suspected child abuse or neglect should make a report to those who can take action. An oral report, either by telephone or in person must be made immediately if there is reasonable cause to believe that a child has been subjected to abuse, neglect, or exploitation, followed by a written report to the chief of police or sheriff, the County Department of Human Resources or the State Child Abuse Reporting Hotline (334- 242-9500).

- c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The Case Manager and the direct service provider are responsible for ensuring that the participants, and/families or legal representatives are informed about their rights concerning abuse, neglect and exploitation at least annually. Case managers maintain relationships with participants to encourage them to talk about what is important to them as well as what they do not like. Each participant is informed of his/her rights and responsibilities during the initial assessment. The legal guardian and/or advocate is informed of the participant's rights, responsibilities, protections or means to enforce the protections, if the participant is not able to understand. The Case manager and the DSP are responsible for informing the participant/or responsible party of their right to lodge a complaint and how to register a complaint alleging abuse, neglect or exploitation.

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The OA is the entity that receives reports of critical events or incidents. Each OA will investigate the critical events reported and make a decision within seven working days. If a decision cannot be reached, additional information is requested. Resolution is reached within seven working days from receipt of the additional information with a response disseminated to all parties involved. All allegations of abuse require an investigation. If the OA determines that an incident requires follow-up, the Case Manager will monitor the situation and make referrals to the appropriate reporting agency or follow-up on referrals previously made to ensure that the issue has been satisfactorily resolved. If other services or supports are needed to resolve the situation, the Case Manager will seek available resources and arrange when appropriate. Responses to the critical events or incidents are appropriately coordinated and assigned with a completion date not to exceed 30 days based on the nature of the incident.

Depending on the nature of the incident the timeframes vary. Incidents are managed in our electronic portal. The portal tracks reporting timeframes and will provide reminders to staff until completion of the documentation to resolution. When the Department of Human Resources investigates a complaint, they advise they have "60 day" for review and completion. Medicaid and the OA are not traditionally included in the review, nor are we advised of any follow up action.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The OA is responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants through individual/family interviews. The OA will notify Medicaid's ACT Waiver Coordinator of critical incidents and events as they occur and any follow-up action taken. In addition, Medicaid is responsible for overseeing the reporting of and response to critical incidents through a review of quarterly participation satisfaction surveys, a review of complaint logs, medical record reviews, DSP personnel record reviews, and onsite home and provider visits, when deemed necessary.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. Use of Restraints.** (Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)

- **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The OA monthly monitoring of participants health and welfare and provider quality reviews.

The Department of Human Resources (ADHR): certain incidents of abuse, neglect and exploitation must be reported to ADHR by law.

The Alabama Medicaid Agency: Annual review of OA investigations.

- **The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one):*

- ☒ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The OA is responsible for detecting the unauthorized use of restrictive interventions through monthly face to face visits as well as supervisory visits every 60 days.

- ☐ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

- i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

- c. Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

- ☒ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

ADSS as the Operating Agency will be responsible for detecting unauthorized use of seclusion. The OA Case Manager is responsible for ensuring the prohibition of seclusion. The Case Manager addresses this at every monthly visit and more often if needed. The daily DSP workers are responsible for reporting to the DSP Supervisor any concerns they have related to seclusion. Additionally, the DSP supervisor makes visits at a minimum of every 60 days.

- **The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- **No. This Appendix is not applicable** (do not complete the remaining items)
- **Yes. This Appendix applies** (complete the remaining items)

• **Medication Management and Follow-Up**

Do not complete this section

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

i. Provider Administration of Medications. *Select one:*

- ☐ **Not applicable.** *(do not complete the remaining items)*
- ☐ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*
 - **State Policy.** Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- **Medication Error Reporting.** *Select one of the following:*
 - ☐ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record*:

(c) Specify the types of medication errors that providers must *report* to the state:

- ☐ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

- **State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.

i. Sub-Assurances:

- Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.*

Performance Measures

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

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

Performance Measure:

Number and percent of service providers who successfully completed the annual refresher training which includes a session on abuse, neglect, mistreatment, and exploitation. Percentage = NUMERATOR [Number of service providers who successfully completed the annual refresher training which includes a session on abuse, neglect, mistreatment, and exploitation] / DENOMINATOR [Number of providers]

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

☒ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	Specify:

Performance Measure:

Number and percent of participant records reviewed that do not identify previously unreported incidents of abuse, neglect, mistreatment, exploitation and unexplained deaths. Percentage = NUMERATOR [Total number of participant records reviewed that do not identify unreported incidents of abuse, neglect, mistreatment, exploitation, and unexplained deaths]..

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

continued from above../ DENOMINATOR [Number of participant records reviewed]

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

	Specify: 	
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Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of case managers who successfully completed the annual refresher training which includes a session on abuse, neglect, mistreatment, and exploitation. **NUMERATOR** [Number of case managers who successfully completed the annual refresher training which includes a session on abuse, neglect, mistreatment, and exploitation] / **DENOMINATOR** [Number of case managers]

Data Source (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:

Number and percent of abuse, neglect, exploitation, or unexplained death incidents reviewed/investigated within the required timeframe. Percentage = NUMERATOR [Total number of abuse, neglect and exploitation or unexplained death incidents reviewed/investigated within the required timeframe] / DENOMINATOR [Number of abuse, neglect and exploitation or unexplained death incidents]

Data Source (Select one):**Record reviews, off-site**

If 'Other' is selected, specify:

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

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Data Aggregation and Analysis:

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

Performance Measure:

Number & percent of closed cases of abuse/neglect/exploitation for which AMA verified that the investigation conducted by the provider was done in accordance with state policy. Percentage=NUMERATOR[Number of closed cases of abuse/neglect/exploitation verified that the investigation was conducted in accordance with state policy] DENOMINATOR[Number of closed cases of abuse/neglect/exploitation]

Data Source (Select one):**Other**

If 'Other' is selected, specify:

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

		Sample Confidence Interval =
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

- b. **Sub-assurance:** *The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

Performance Measures

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

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

Performance Measure:

Number and percent of critical incident trends for which systemic intervention was implemented that showed sustained improvement after three months, or the state implemented a corresponding revision to the intervention.

Percentage=NUMERATOR [Total number of critical incident trends where systemic intervention from above was implemented that showed sustained improvement after three months,

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Continued... or the state implemented a corresponding revision to the intervention] /

DENOMINATOR [Number of critical incident trends for which systemic intervention was implemented]

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

	☐ Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of critical incidents that have been resolved by AMA within 60 days of the date of the critical incident report date. Percentage = NUMERATOR [Number of critical incidents resolved by AMA within 60 days of the date of the critical incident report date] / DENOMINATOR [Number of reported critical incidents]

Data Source (Select one):**Other**

If 'Other' is selected, specify:

GCL Portal entries

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

Data Aggregation and Analysis:

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

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

Performance Measure:

Number and percent of critical incident trends where systemic intervention was implemented. Percentage=NUMERATOR [Total number of critical incident trends where systemic intervention was implemented] / DENOMINATOR [Number of critical incident trends]

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

GCL Portal

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

	☐ Other Specify: 	
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Data Aggregation and Analysis:

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

- c. *Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.*

Performance Measures

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

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

Performance Measure:

Number and percent of participant records reviewed that do not identify previously unreported incidents of unauthorized restrictive interventions or seclusion.

Percentage = NUMERATOR [Number of participant records reviewed that did not identify previously unreported incidents of unauthorized restrictive interventions or seclusion] / DENOMINATOR [Number of participant records reviewed]

Data Source (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

- d. **Sub-assurance:** The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.

Performance Measures

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

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

Performance Measure:

Number and percent of participants reviewed who had an ambulatory or preventive care visit during the year. Percentage = NUMERATOR [Number of participants who had an ambulatory or preventive care visit during the year] / DENOMINATOR [Number of participants]

Data Source (Select one):

Other

If 'Other' is selected, specify:

MMIS

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

		Sample Confidence Interval =
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☒ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of participant records reviewed that document training and education were provided to staff on how to identify and address health concerns of a participant, including any change in a participant's status that could jeopardize their health and safety in the community. Percentage=NUMERATOR[Number of participant records reviews that document training and education were provided]

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

on how to identify and address health concerns of a participant, including any change in a participant's status that could jeopardize their health and safety in the community./DENOMINATOR[Number of participant records reviewed]

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

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of people who responded that their overall health was Good, Very Good, or Excellent. Percentage = NUMERATOR [Number of people who responded that their overall health was Good, Very Good, or Excellent] / DENOMINATOR [Number of surveys containing responses regarding health reviewed]

Data Source (Select one):**Provider performance monitoring**

If 'Other' is selected, specify:

NCI-AD Survey

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

		Confidence Interval = 95% with a margin of error of +/- 9.8
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☒ Other Specify: Sample size deemed appropriate by NCI
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

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

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

The Case Manager will monitor participants through monthly home visits to observe the participant in the home and note any critical events/incidents appropriately. The Case Manager will also report any events of this nature to the waiver administrator in the approved format who will forward to AMA within the required guidelines. The Case Manager will track reports to resolution for documentation and will report the resolution to the waiver administrator to forward to AMA.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

AMA conducts participant satisfaction surveys on a quarterly basis. The results of the surveys are relayed to the Operating Agency (OA). The OA is responsible for keeping a log of complaints/grievances that must be tracked through to resolution on an on-going basis. This log is to be sent to AMA on a quarterly basis. Grievances are to be resolved in an appropriate and timely manner, or the OA will be asked to submit a Plan of Correction to ensure prevention of re-occurrence. The OA will be notified of any complaints/grievances received by AMA involving the OA or any of its providers of care. The OA performs periodic telephone interviews with waiver participants statewide to ensure services are provided appropriately and to ensure that the participant is satisfied with services received.

The OA sends a satisfaction survey to 10% of those receiving waiver services during the year. The sample is selected randomly. Responses of dissatisfaction are addressed with the waiver Case Manager who provides follow-up with the client and reports findings and resolution to the state office. For the provision of Assistive Technology, Environmental Accessibility Adaptations, and Minor Assistive Technology services, the participant signs a form prior to vendor payment to ensure satisfaction of service.

The results of the satisfaction surveys are kept on file and any comment or dissatisfaction is followed up on by the waiver Case Manager through resolution. Each waiver participant, at initial application and each year at the time of the re-evaluation of services will be provided a copy of the ACT Waiver Problem Solving Guide that provides them with directions on how to complain to the Case Manager and to the ACT Coordinator or their designee. The Case Manager will follow-up with all complaints through resolution.

ACT Administrator will review 5% of waiver participants' records periodically throughout the year to ensure compliance with the waiver document and participant satisfaction with services. Satisfaction of services is reviewed during the monthly home visits and documented in the participant record. ACT Administrators make visits to 5% of waiver participants throughout the state to review satisfaction of all services. Problems identified during the home visits are reviewed immediately with the waiver case manager and brought to resolution.

ii. Remediation Data Aggregation

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

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Specify: 	
	☐ Continuously and Ongoing
	☐ Other Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of health and welfare that are currently non-operational.

- ☒ No
☐ Yes

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under Section 1915(c) of the Social Security Act and 42 CFR § 441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver quality improvement strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a quality improvement strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the quality improvement strategy.

Quality Improvement Strategy: Minimum Components

The quality improvement strategy (QIS) that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the QIS spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the QIS. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

Description of the Quality Management Program for the ACT Waiver

The Quality Management Strategy for the ACT Waiver is:

AMA is responsible for collecting data from the OA quarterly and annually regarding the quality of services provided from various sources for the ACT Waiver program. The Quality Framework is used as a guide to assess seven Program Design Focus areas from samples of waiver participants, case management and direct service providers records, on-site home visits when deemed necessary, and onsite visits to adult day health facilities. In addition, participant satisfaction surveys and complaints and grievances logs are reviewed quarterly. Adverse responses to surveys and/or complaints received are tracked to resolution. Adverse responses are also re-tracked with targeted surveys to determine participants satisfaction with resolutions.

Data is collected through annual record reviews and the review of the OA which may include policies and procedures, contracts with subcontractors, on-going training of subcontractors, quality assurance system, and billing and service provision. More specifically, a sample of all participants approved is conducted to ensure that the processes and instruments described in the approved waiver are applied in determining the Level of Care. Additionally, a sample of the waiver population is chosen for record review to ensure coordination of care, quality of care, outcomes and billing accuracy. A sample of personnel records of Case Managers and other employees is reviewed to ensure that basic and continuing education requirements are met. Home visits may be made to ensure quality of care, health and safety, ongoing needs of the client are being met, and to gain input about the quality of the services received.

Remediation for non-compliance issues identified during data collection is handled by requesting the entity involved to submit a plan of correction within 15 days of notification. If the problem is not corrected, the entity is monitored every three months. After the third request for a plan of correction, and the entity continues to be non-compliant, a letter to terminate the Memorandum of Agreement will be issued.

The collected data is reported quarterly and annually to each Operating Agency. AMA will evaluate reports and make recommendations for improvements to the program. The AMA will determine if changes are to be made to the program.

In order to measure and improve performance, data is collected, reviewed and reported using the seven focus areas of the Quality Framework.

Participant Access

Sources of data:
Case Management Records
Home Visits
DSS Queries
Consumer Surveys

ParticipantCentered Service Planning and Delivery

Sources of data:
Consumer Surveys
Case Management Records
Site Visits
Home Visits

Provider Capacity and Capabilities

Sources of data:
Consumer Surveys
Case Management Records
Personnel and Training Records of Operating Agency and Subcontractors
Home Visits

Participants Safeguards

Sources of data:

Case Management Records
 Consumer Surveys
 Home Visits
 Site Visits

Participants Rights and Responsibilities

Sources of data:
 Consumer Surveys
 Case Management Records
 Complaint and Grievances Logs
 Targeted Surveys

Patient Satisfaction

Sources of data:
 Consumer Surveys
 Case Management Records
 Home Visits
 Site Visits

System Performance

Sources of data:
 Review of Operating Agency Quality Assurance System
 Review of Operating Agency Billing and Service Provision
 Collaborative Meeting with Operating Agency to enhance the administration of the Program
 Subcontractor Client Records

The following indicators are reported to the operating agency and Medicaid's Long Term Care Division:

Percentage of participant/family reporting satisfaction with waiver services and needs met.
 Percentage of participant/family reporting they feel safe and secure in the home and community.
 Percentage of participant/family reporting they have ready access to services and were informed of sources of support available in the community.
 Percentage of participant/family reporting knowledge of rights and responsibilities.
 Percentage of records indicating services are planned and implemented according to the participants needs and preferences.
 Evidence that the operating agency has a Quality Assurance System in place that monitors subcontractors.
 Evidence that the operating agency has a system in place to ensure only qualified providers are enrolled, credentials are verified and training of personnel is ongoing.

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
☒ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☒ Quarterly
☐ Quality Improvement Committee	☒ Annually
☐ Other Specify:	☐ Other Specify:

Responsible Party(<i>check each that applies</i>):	Frequency of Monitoring and Analysis(<i>check each that applies</i>):

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The Medicaid Agency is responsible for collecting data regarding the quality of services provided from various sources for the ACT Waiver. Data is collected using quality indicators from each of the seven Program Design Focus areas of the Quality Framework as a guide. In addition, quality indicators from adverse responses to surveys and/or complaints received are tracked to resolution. Adverse responses are also re-tracked with targeted surveys to determine participants satisfaction with resolutions.

- ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

Collected data is reported quarterly and annually to the Operating Agency and to Medicaid's LTC Division for evaluation and recommendations for program improvements. The Medicaid Agency is the administering authority over the ACT Waiver Program; therefore, recommendations for improvements will be evaluated for final determination of changes to the program.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

- a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):

- ☐ No
- ☒ Yes (*Complete item H.2b*)

- b. Specify the type of survey tool the state uses:

- ☐ HCBS CAHPS Survey :
- ☐ NCI Survey :
- ☒ NCI AD Survey :
- ☐ Other (*Please provide a description of the survey tool used*):

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the

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

The State of Alabama assures the financial accountability and integrity of waiver payments through the following activities: The Alabama Medicaid Agency serves as the administering agency for the ACT Waiver. The operating agency is the Alabama Department of Senior Services.

The Long Term Care Division monitors payments for ACT Waiver services.

The Fiscal Agent Liaison Division/Contract Monitoring Unit monitors the processing and payment of Medicaid claims through the Claims Processing Assessment System (CPAS). Periodic reviews and targeted reviews of claims are performed when potential system errors are identified. The Medicaid Management Information Systems (MMIS) performs validation edits and audits to ensure program compliance. Audits check for duplicate services, service limitations and related services are compared to Medicaid policy and guidelines.

Monthly reports of expenditures are received by the waiver coordinator in order to monitor irregular expenses. The CMS 372 report is generated annually which records cost effectiveness and cost comparisons. Provider records are audited annually or more frequently at the discretion of the Medicaid Agency.

The entity responsible for conducting the periodic independent audit of the waiver program as required by the Single State Audit Act is the Alabama Department of Examiners of Public Accounts.

Providers are required to secure an independent audit of their financial statements.

All waiver services are subject to post payment review.

The Medicaid Agency is audited, externally by the Alabama Department of Public Examiners of Public Accounts. Annually, the state submits a SEFA (Statement of Expenditures of Federal Award) to the Examiners of Public Accounts. The Waiver programs are shown in CFDA 93.778M, although 93.778M is not limited to waiver programs. Of 93.778M, programs and claims are chosen at random by a formula specific to the Examiners office.

Alabama's 1915b PCCM-E (ICN) will receive a monthly capitated payment inclusive of HCBS Case Management. The ICN will review the Case Management claims and reimburse the HCBS Case Management providers.

On October 1, 2017, the Alabama Medicaid Agency implemented an Electronic Visit Verification and Monitoring (EVVM) system to monitor visits to Home and Community Based Waiver Services clients. The EVVM system will enable more accuracy in service tracking, reporting, and billing for in-home care providers. The Electronic Visit and Verification system performs automated scheduling, time/attendance tracking and claim submission that:

- * Maintains a repository of authorized services*
- * Allows web-based scheduling of service visits*
- * Verifies a workers' location and length of service visit*
- * Automatically creates a claim record for review*
- * Identifies late or undelivered services*
- * Issues alerts for late and missed visits*
- * Automatically submits claim records for payment*
- * Provides flexible reporting in real-time*
- * Check in/out immediately reflected on the web*

Waiver services which require EVVM include Personal Care, Respite (Breaks & Opportunities) and Skilled Nursing. The Electronic Visit Verification and Monitoring system requires the worker to check-in and check-out using the worker's mobile devices to log the visit on the EVVM app or by using the recipient's phone to dial into an Interactive Voice Response system. The system provides GPS location authentication and real-time communication to view and monitor by the provider, Operating Agency, and the Alabama Medicaid Agency. This system ensures the integrity of providers billing for Medicaid payment of waiver services. The EVVM system reduces fraud and errors and is a proactive monitoring tool. Providers can monitor and review claims in real time and confirm claims for payment upon review. Additionally, the system will alert the case managers/providers when critical services are missed or late, thus preventing an overpayment for services not performed.

Service authorizations are loaded into the system from the Operating Agencies, thus preventing the provider from adding or editing the authorization for services. A claim cannot be confirmed and submitted for payment without a valid authorization. A visit can be scheduled only if there is an authorization for that service and client. A warning message pops up if the visit conflicts with another or not enough remaining units in the authorization, thus preventing fraudulent billing or an overpayment.

Every service captured by the Mobile app or IVR, or entered via the Web creates a claim. The provider has to confirm the claim before they are submitted for payment. Behind the scenes editing occurs continuously based on AL business rules and billing requirements. The provider can edit claims; however, a report can be produced to monitor if a provider has a

systemic issue with editing claims which can raise a flag of fraud.

The AAAs, under the oversight of the Operating Agency, ADSS, are responsible for conducting annual provider audits. All providers are required to secure an independent audit of their financial statements. As additional oversight, Medicaid's Networks and Quality Assurance Division takes a sample of each type of service provider (roughly about 15 types of providers across all Waivers) over a rolling three-year period to audit from all Waivers.

The AAA's schedule routine annual audits for all existing DSPs. All new DSPs receive an initial on site audit. For new DSPs, audits will be conducted at least annually but may be more frequent during the first two years to ensure compliance with the waiver requirements.

The Alabama Community Transition waiver's process consists of on-site reviews of service delivery, program administration, fiscal practices, incident and investigation reports, and person-centered planning processes. Tools utilized to gather data and measure provider performance include employee files, administrative policies and procedures, reviews of case management records, analysis of FMSA data, analysis of incident reporting data and investigation records, NCI-AD data analysis, and random sample audits of person-centered plans and claims data.

For new DSPs, the AAA audits 100% of employee files and conducts administrative and personnel reviews. For existing providers, the AAA conducts a random sample of employee files and client files that results in a confidence level of 95% with a +/- 5% margin of error.

All audits are conducted on-site as part of the AAA's annual routine audit process.

The auditor will discuss the preliminary findings with the DSP during the exit conference along with any recommendations made by the AAA; but, the DSP must be reminded that ADSS will review the audit and give final recommendations.

Depending on the nature of any discrepancies found and the seriousness of those findings, the auditor can make recommendations for corrections. On an announced audit, the DSP must have all pertinent staff present during the exit conference including the office manager, supervisory nurse and local administrator. Absences of the required staff from the exit conference could result in termination of the contract. After ADSS review/approval, the AAA shall provide the DSP a detailed/bulleted copy of the findings via letter.

For existing DSPs, depending on the nature of any discrepancies found and the seriousness of those findings, the auditor can make recommendations for corrections. When a Plan of Correction (POC) is required, the DSP has 15 working days from the receipt of the notification letter to submit the plan to the AAA. The AAA Lead Auditor must review the plan for correctness prior to forwarding it to ADSS for final review and approval. The POC must address each area of non-compliance and the plan for correcting each area, and it must identify the DSP personnel responsible for ensuring the issues are monitored/corrected. If the plan meets the waiver requirements, a letter will be mailed by the AAA to the DSP stating that it is acceptable. If the plan is unacceptable, the AAA will contact the DSP by telephone or e-mail to discuss concerns with the plan. The AAA shall offer the DSP in writing the opportunity to correct problems and submit another POC within 15 working days from the date of the telephone call or email. ADSS shall be copied on the memorandum to the DSP. Upon receipt of the second POC, a determination will be made as to whether the POC is acceptable or unacceptable. Again, this is determined by staff at ADSS. If it is acceptable, a letter stating such is sent to the AAA, and the AAA follows up with a letter to the DSP. If the plan is not received in 15 working days and/or the plan is unacceptable, ADSS shall follow agency procedures regarding non-compliance and notify the AAA of the results. Based upon official notification, the AAA shall act according to the recommendations of ADSS regarding the vendor. In order to ensure statewide uniformity in the treatment of vendors, the AAA may not act on their own without ADSS approval. ADSS recommendations may include probation, recoupment and/or withholding of payments to the AAA/DSP or termination of the DSP from waiver program participation. ADSS will review the POC, and a written response will be sent to the AAA indicating whether the POC is acceptable or unacceptable.

For new DSPs, if the DSP is out of compliance of Waiver regulations/contract requirements, the AAA shall inform the DSP of the findings and provide information/education on how the DSP can correct/improve the area(s) that are not in compliance. The Prospective DSP shall send the AAA a Plan of Correction (POC) which is forwarded to ADSS for approval. After ADSS approves the POC, the DSP shall be given the opportunity to correct the findings. When ready, the DSP notifies the AAA, and they will conduct a return audit/visit. If after the 2nd audit/visit the DSP is still out of compliance and/or has problems identified, then the process stops and the Prospective DSP is notified in writing that the contract shall not be signed at this time. If the AAA feels it is warranted, they have the option to continue to train/educate the Prospective DSP to bring them into Waiver compliance.)

If AMA finds 15 or more discrepancies (total from the administrative, personnel, training, and client tool components) between its audit findings and ADSS's audit findings for a given provider, AMA will issue a Corrective Action Plan (CAP) indicating the steps ADSS must implement within a designated timeframe to remedy the issues. If ADSS or a provider is not progressing in completing the CAP and remedying the deficiency(ies), a conference call between ADSS or the providers' Executive Leadership and the QA Director and other related parties will be scheduled. If ADSS or a provider continues to not achieve progress in completing the CAP, the issue will be escalated to AMA Executive Leadership.

Inappropriate claims are recouped from the OA and FFP is returned.

Appendix I: Financial Accountability**Quality Improvement: Financial Accountability**

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

a. Methods for Discovery: Financial Accountability Assurance:

The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.

i. Sub-Assurances:

a. Sub-assurance: The state provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

Performance Measures

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

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

Performance Measure:

Number and percent of participant records that show claims were coded correctly, and paid, only for services that were rendered. Percentage = NUMERATOR [Number of participant records reviewed that show claims were coded correctly, and paid, only for services that were rendered] / DENOMINATOR [Number of participant records reviewed]

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

MMIS

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach (check each that applies):
☒ State Medicaid Agency	☐ Weekly	☐ 100% Review
☐ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☒ Representative Sample Confidence Interval = 95% with a margin of error of +/- 5%

☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver document. Percentage = $\frac{\text{NUMERATOR [Number of claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver]}}{\text{DENOMINATOR [Number of claims paid]}}$

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Claims

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

Data Aggregation and Analysis:

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

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

- b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.**

Performance Measures

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

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

Performance Measure:

Number and percent of rates that remain consistent with the approved rate methodology throughout the five-year waiver cycle. Percentage = NUMERATOR [Number of rates that remain consistent with the approved rate methodology]/DENOMINATOR [Number of rates reviewed]

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Claims data

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

☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☒ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

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

The AMA has contracted with a fiscal agent to maintain the payment records on services received and billed under the ACT

Waiver. The OA ensures that all services and corresponding payments are coded and documented properly. The OA ensures that only those services included on the plan of care are billed for the ACT Waiver participant.

The Fiscal Intermediary has edits in the system to ensure that the participant has Medicaid financial eligibility and ACT Waiver eligibility before the claims are paid. The AMA reviews selected claim data to ensure that services are billed appropriately and according to the plan of care.

To ensure maximum reimbursement to services providers, the AMA is notified of any claims payment issues and will work with the OA and the fiscal intermediary to resolved the issues.

The AMA through the Decision Support System can generate adhoc reports to track payments and denials for each waiver participant as well as the cost for the entire waiver program.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

AMA has a Program Administrator that provides assistance to the OA to address individual problems as they are identified. All issues will be coordinated with the appropriate entity: Medicaid Eligibility Division, Fiscal Agent Liaison, etc., for resolution. If the issue cannot be resolved on that level, the issue will be reported to the Long Term Care Division Director for further intervention.

On a global level, any consistent errors or trends that could be indicative of systemic problems are reviewed with the appropriate division.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- ☒ **No**
☐ **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing

identified strategies, and the parties responsible for its operation.

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Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

The Alabama Medicaid Agency is responsible for establishing provider payment rates for ACT Waiver services. Payments made by Medicaid to ACT Waiver providers are on a fee-for-service basis and are based upon the following factors:

- Current pricing for similar services
- State-to-State comparisons
- Geographical comparisons within the state
- Comparisons of different payers for similar services

A procedure code is determined for each waiver service and a rate is assigned to each code. The Medicaid Management Information System (MMIS) pays the claim based upon the States determined pricing methodology applied to each service by provider type, claim type, recipient benefits, or policy limitations.

Rates established are reasonable and customary to ensure continuity of care, quality of care and continued access to care. Re-evaluation of pricing and rate increases are considered as warranted based upon provider inquiries, problems with service access, and changes in the Consumer Price Index. The public, Direct Service Providers and participants have the ability to provide feedback regarding rates for services. This can be accomplished via satisfaction survey and/or phone call to the OA or AMA. The Medicaid website provides fee schedules for Medicaid programs.

- Rates for ACT Waiver services are established by Medicaid and the OA. Prospective rates are based on audited historical costs with consideration given to the health care index, rates of neighboring states, surveys, and renegotiated contracts. Medicaid pays private and public contractors the same rate. For each waiver service, a HCPC code is determined with a rate assigned to each code. The Medicaid Management Information system (MMIS) pays the claim based upon the States determined pricing methodology applied to each service by provider type, claim type, recipient benefits and policy limitations. All claims submitted for adjudication must pass certain edits in the MMIS. Once a claim passes through edits, the system reviews each claim to make sure it complies with AMA policies. The MMIS then performs audits by validating claims history information against information on the current claim. Audits check for duplicate services, limited services, and related services and compare them to Alabama Medicaid policy to ensure that recipient benefits are paid according to current policies.

Rate for Case Management are managed through a concurrent 1915b PCCM_E and its procurement process. The rate is no less than the fee for service calculation would be.

Individuals participating in Self-Direction have the autonomy to choose a rate based on their need and budget.

Historical rates FY2017 to present are used to calculate any rate updates.

- Rates for all services are reviewed annually. If necessary they may be reexamined at any time. Stakeholders, participants, and providers may submit information or request information regarding the rate methodology at any time. Alabama also performs periodic evaluations and assessments to determine if the rates are consistent with efficiency, economy, and quality of care. We also periodically survey providers to request their feedback on rates.

12/22/20 A 30 day notice was mailed to Alabama's Poarch Band Indian Health Department.

1/21/2021

Comment received related to the number of Pest Control Treatments permitted

State Response:

Pest Control situations are evaluated on an individual basis based on maintaining an individual's health and safety in the community.

Alabama's public input process was completed in accordance with 42 CFR 441.304(f) in the following 3 ways:

1. 12/22/20 Public notice and the amended application was uploaded to the Alabama Medicaid Website-Waiver Version AL.0878.01.01
2. 12/22/20 A physical copy of the amended application was posted in each Alabama Medicaid District Office- Waiver Version AL.0878.01.01

12/22/2020 A link to an electronic copy was sent to the following Agencies, organizations, and Councils:

UAB Medical Center

AL Respite Organization

AARP

Nursing Home Owner/Admin

Independent Living Council

Governor's Office on Disabilities

Independent Living Council

AL Dept of Mental Health

Senior Services
AL Disabilities Advocacy Program
BCBS
State Legislator
Primary Health Care Assn (FQHCs)
Legislative Fiscal Office
AL Dept. of Mental Health
Shared Health
University of South Alabama
Alabama Community Care
Lee-Russell Council of Governments
USA Healthcare
Alabama Arise
Mercy Medical - Pace
UCP
Disability Advocates
AlaCare
UAB
AL Dept of Rehab
AL Hospital Assn.
LRCOG
State Medical Association
The Arc of Alabama
Alabama Community Care
Glenwood, Inc.
Alahealth
BCBST
Navigant
Volunteers of America Southeast, Inc.
Jackson Thornton
WellCare Health Plans, Inc.
Otsuka America Pharmaceuticals, Inc.
Alabama Tombigbee Regional Commission
Leavitt Partners, LLC
Middle Area Agency on Aging
Shared Health
Alabama Department of Senior Services
Quality Outcomes
AmeriHealth Caritas Family of Companies
Volunteers of America Southeast, Inc.
AL Dept of Rehab
UnitedHealthcare
My Care / BCBS
Answered Prayer
East AL Planning and Devel Com.
Answered
Answered Prayer
Amerihealth Caritas
TARCOG
Oxford HealthCare
Optum Healthcare
MHC of North Central AL, Inc
Addus Home Care
Grandview Health
Valentines Diabetic Supply
Otsuka America Pharmaceutical, Inc.
BCBSAL

The Arc of Shelby County
HPE
Terrace Manor Nursing and Rehab
AseraCare Hospice & Prime by AseraCare
AmeriHealth Caritas Family of Companies
West Alabama Regional Commission
Cosby Development & Service Adv.
Dept. of Rehabilitation
University of South Alabama
DHR
Blueprint Health Care
Cleburne County Nursing Home
Columbus Speech & Hearing Center
NARCOG
Post Acute Solutoins
Alabama Family Health Care, Inc
American Senior Alliance
Jackson Thornton
Health Management Associates
Perry County Nursing Home
SARCOA / AAA
Walker Rehabilitation Center
Southern Care, LLC dba Sunset Manor
krause financial services, inc
UnitedHealthcare
Alabama Hospital Association
Qualis Health
UAB Health System and USA
gilpin givhan,pc
Manatt
Community Hospital, Inc
Russell Medical
Marion Regional Nursing Home
SeniorSelect Partners, LLC
Alabama Wheelchair Specialists Inc
WellCare Health Plans, Inc.
Kindred at Home
Southern Strategy Group
LHC Hospice
Shared Health
BlueCross and Blue Shield of Alabama
Washington County Nursing Home
Coosa Valley Medical Center
VITAS Healthcare
Pharmacy Care Associates
CRI
Hospice of the Valley, Inc.
Marion Regional Nursing Home
PAYLESS PHARMACY
Panhandle Rural Health, Inc. d/b/a Jay Medical Clinic
Mediware Information Systems
My Care Alabama
Hospice of Montgomery
Turenne and Associates
Noland Health Services
AHC
CCA

VIVA Health, Inc.
Diversicare
Dayspring Hospice
Vision Partners, LLC
UAB
Diversicare of Pell City
Health Management Associates
Genesis HealthCare
Traylor Porter HealthCare
UAB Health System
HHC
AHA
UnitedHealthcare
ADT LLC
AmeriHealth Caritas
alahealth
Millennium Health LLC
HBS
Middle AL Area Agenc on Aging
AL Medicaid Business Analytics
ADCS
Health Management Associates
Genesis HealthCare
Shelton Consulting Services
East Alabama Mental Health Center
Addus HomeCare
Pharmacy Care Associates
Terrace Manor
Navigant
Poarch Creek Indians
M4A
Hospice of Marshall County
Marion Regional Nursing Home
Amerigroup
HMA
Help At Home / Oxford HealthCare
Diversicare of bessemer
NHS Management, LLC
AllHealth CHOICE
VIVA Health
Central Alabama Aging Consortium
South Central Alabama Development Commission-Area Agency on Aging
Mercer
WARC
Methodist Homes of Alabama and Northwest Florida
state analysis, inc
Optum Healthcare
Pangea Healthcare
Bradley Arant Boult Cummings
AARC
Infirmary Health System, Inc.
Performance Clinical Systems
Marion Regional Nursing Home
Genesis Health Care
Children's of Alabama
st vincent's
The Arc of Madison County, Inc.

Quality South, Inc

- Stakeholders, participants, and providers may submit information or request information regarding the rate methodology at any time

Rates are continually reviewed.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Each waiver participant, once approved, is added to the Alabama Medicaid Agency's Long Term Care Benefit Panel. This file holds approved dates of eligibility for waiver services.

Provider billing flows directly from the providers to the State's claim payment system (MMIS) through the Fiscal Intermediary, as follows:

Payments made by Medicaid to providers are on a fee-for-service basis. Each covered service is identified on a claim by procedure code.

For each participant, the claim allows span billing for a period not to exceed one month. There may be multiple claims in a month; however no single claim can cover services performed in different months.

If the submitted claim covers dates of services where a part or all of the services were covered in a previously paid claim, then the entire claim is rejected. The provider is required to make the corrections on the claim and resubmit for processing.

Payment is based on the number of units of service reported on the claim for each procedure code. There is a clear differentiation between waiver services and non-waiver services and a clear audit trail exists from the point of service through billing and reimbursement. Discrepancies are initially handled at the local level.

The ACT Waiver administrator monitors expenditures on a biannual basis or as often as needed and monitors problems with particular service providers. If costs appear to be out of line or unusual, the provider is contacted and follow-up action is taken.

Payment is based on the number of units of services reported on the claim for each procedure code.

Alabama's 1915b PCCM-E (ICN) will receive a monthly capitated payment inclusive of HCBS Case Management. The ICN will review the Case Management claims and reimburse the HCBS Case Management providers.

The ICN provides additional Medical Case Management Services to individuals. The ICN is required to comply with existing 1915c requirements related to assuring health and safety. Existing quality measures will remain.

On October 1, 2017, the Alabama Medicaid Agency implemented an Electronic Visit Verification and Monitoring (EVVM) system to monitor visits to Home and Community Based Waiver Services clients. The EVVM system will enable more accuracy in service tracking, reporting, and billing for in-home care providers. The Electronic Visit and Verification system performs automated scheduling, time/attendance tracking and claim submission that:

- * Maintains a repository of authorized services
- * Allows web-based scheduling of service visits
- * Verifies a worker's location and length of service visit
- * Automatically creates a claim record for review
- * Identifies late or undelivered services
- * Issues alerts for late and missed visits
- * Automatically submits claim records for payment
- * Provides flexible reporting in real-time
- * Check in/out immediately reflected on the web

Waiver services which require EVVM include Personal Care, Respite (Breaks & Opportunities) and Skilled Nursing. The Electronic Visit Verification and Monitoring system requires the worker to check-in and check-out using the worker's mobile devices to log the visit on the EVVM app or by using the recipient's phone to dial into an Interactive Voice Response system. The system provides GPS location authentication and real-time communication to view and monitor by the provider, Operating Agency, and the Alabama Medicaid Agency. This system ensures the integrity of providers billing for Medicaid payment of waiver services. The EVVM system reduces fraud and errors and is a proactive monitoring tool. Providers can monitor and review claims in real time and confirm claims for payment upon review. Additionally, the system will alert the case managers/providers when critical services are missed or late, thus preventing an overpayment for services not performed.

Service authorizations are loaded into the system from the Operating Agencies, thus preventing the provider from adding or editing the authorization for services. A claim cannot be confirmed and submitted for payment without a valid authorization. A visit can be scheduled only if there is an authorization for that service and client. A warning message pops up if the visit conflicts with another or not enough remaining units in the authorization, thus preventing fraudulent billing or an overpayment.

Every service captured by the Mobile app or IVR, or entered via the Web creates a claim. The provider has to confirm the claim before they are submitted for payment. Behind the scenes editing occurs continuously based on AL business rules and billing requirements. The provider can edit claims; however, a report can be produced to monitor if a provider has a systemic issue with editing claims which can raise a flag of fraud.

The AAAs, under the oversight of the Operating Agency, ADSS, are responsible for conducting annual provider audits. All providers are required to secure an independent audit of their financial statements. As additional oversight, Medicaid's Networks and Quality Assurance Division takes a sample of each type of service provider (roughly about 15 types of providers across all Waivers) over a rolling three-year period to audit from all Waivers. The AAA's schedule routine annual audits for all existing DSPs. All new DSPs receive an initial on site audit. For new DSPs, audits will be conducted at least annually but may be more frequent during the first two years to ensure compliance with the waiver requirements.

- Providers bill through the EVV system
- Providers do not typically bill Medicaid directly

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures (select one):

- ☒ No. state or local government agencies do not certify expenditures for waiver services.
- ☐ Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

- ☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-a.)

- ☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

- d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The MMIS performs validation edits to ensure the claim is filled out correctly and contains sufficient information for processing. Edits ensure the participants name matches the participant identification number; the procedure code is valid for the diagnosis; the participant is eligible and the provider is active for the dates of service; and other similar criteria are met. For electronically submitted claims, the edit process is performed several times per day; for paper claims, it is performed five times per week. If a claim fails any of these edits, it is returned to the provider.

Once claims pass through edits, the system reviews the claim history information against information on the current claim. Audits check for duplicate services, service limitation, and related services and compare them to Alabama Medicaid policy. The system then prices the claim using the State-determined pricing methodology applied to each service by provider type, claim type, recipient benefits or policy limitations.

Once the system completes claim processing, it assigns each claim status: approved to pay, denied, or suspended. Approved to pay and denied claims are processed through the financial cycle twice a month, at which time an Explanation of Payment (EOP) report is produced and checks are written, if applicable. Suspended claims must be worked by HP personnel or reviewed by Alabama Medicaid Agency personnel, as required.

Claims approved for payment are paid with a single check or electronic funds transfer (EFT) transaction according to the check writing schedule published in the Provider Insider, the Alabama Medicaid provider bulletin produced by HP. The check is sent to the providers payee address with an EOP, which also identifies all denied claims, pending claims, and adjustments. If the provider participates in electronic funds transfer (EFT), the payment is deposited directly into the providers bank account and the EOP is mailed separately to the provider.

Alabama's 1915b PCCM-E (ICN) will receive a monthly capitated payment inclusive of HCBS Case Management. The ICN will review the Case Management claims and reimburse the HCBS Case Management providers.

- e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (select one):

- ☒ **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ☐ **Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ☐ **Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):

- ☐ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- ☒ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- ☐ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- ☐ **Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:

- **No. The state does not make supplemental or enhanced payments for waiver services.**
- **Yes. The state makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or

enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. Specify whether state or local government providers receive payment for the provision of waiver services.

- ☐ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- ☒ **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Alabama's Area Agencies on Aging (local government) provides HCBS Case Management services for the ACT Waiver.
Alabama's 1915b PCCM-E (ICN) will receive a monthly capitated payment inclusive of HCBS Case Management. The ICN will review the Case Management claims and reimburse the HCBS Case Management providers.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- ☒ **The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.**
- ☐ **The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ☐ **The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

- ☐ **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ☒ **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Alabama's 1915b PCCM-E (ICN) will receive a monthly capitated payment inclusive of HCBS Case Management. The ICN will review the Case Management claims and reimburse the HCBS Case Management providers. Capitation payments are returned to the state if waiver participant loses eligibility. Capitation payments are not modified based on encounter data.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:

- ☐ **No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ☒ **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR § 447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

Direct Service Providers may reassign payments only to ADSS, the operating agency for the ACT Waiver. Providers may request to modify the arrangement. Direct Service Providers contract with the AAA's as delegated by ADSS.

ii. Organized Health Care Delivery System. Select one:

- ☐ **No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR § 447.10.**
- ☒ **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR § 447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- *The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.*
- *The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of section 1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.*

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- *This waiver is a part of a concurrent section 1915(b)/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.*
- *This waiver is a part of a concurrent section 1115/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.*
- *If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.*

In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:

- ☒ **Appropriation of State Tax Revenues to the State Medicaid Agency**
- ☐ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

☒ **Not Applicable.** *There are no local government level sources of funds utilized as the non-federal share.*

☐ **Applicable**

Check each that applies:

☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

☒ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

☐ **The following source(s) are used**

Check each that applies:

- ☐ **Health care-related taxes or fees**
- ☐ **Provider-related donations**
- ☐ **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** Select one:

- ☒ No services under this waiver are furnished in residential settings other than the private residence of the individual.
- ☐ As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:

Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:

- ☒ No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.
- ☐ Yes. Per 42 CFR § 441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:

- ☒ **No.** The state does not impose a co-payment or similar charge upon participants for waiver services.
- ☐ **Yes.** The state imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

- ☐ **Nominal deductible**
- ☐ **Coinsurance**
- ☐ **Co-Payment**
- ☐ **Other charge**

Specify:

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)**

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)**

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)**

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

- ☒ **No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ☐ **Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration**J-1: Composite Overview and Demonstration of Cost-Neutrality Formula**

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	15714.78	29794.00	45508.78	58874.00	4012.00	62886.00	17377.22
2	13536.68	30687.82	44224.50	60640.22	4132.36	64772.58	20548.08
3	14179.94	31608.45	45788.39	62459.43	4256.33	66715.76	20927.37
4	15436.65	32556.71	47993.36	64333.21	4384.02	68717.23	20723.87
5	14989.00	33533.41	48522.41	66263.21	4515.54	70778.75	22256.34

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (1 of 9)**

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Nursing Facility	
Year 1	675		675
Year 2	675		675
Year 3	675		675

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Nursing Facility	
Year 4	675		675
Year 5	675		675

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

- b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Average length of Stay is 265 days per year based upon the most recent CMS 372 report (Report year 2023). While the average length of stay has increased modestly in recent years, the State expects the ALOS to remain relatively stable over the five-year renewal period. The recent increase reflects short-term factors, including stabilization of services following the COVID-19 public health emergency, improved access to home and community-based services, and enhanced service continuity for individuals who would otherwise have transitioned to institutional care. Looking forward, the State does not anticipate continued growth in ALOS due to ongoing eligibility redeterminations, annual reassessments of level of care, and person-centered service planning requirements that ensure participants continue to meet waiver eligibility criteria and receive services aligned with their current needs. In addition, the waiver serves a population with ongoing functional limitations, for whom long-term community-based services are appropriate and consistent with the waiver's objective of avoiding institutionalization, resulting in a stable and predictable length of stay over time.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

- c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

Factor D is derived from data contained in the CMS-372 Reports and from Medicaid claims data for the most recent waiver years covering the same period. Claims data were extracted from the Alabama Medicaid Management Information System (MMIS) and analyzed to determine historical trends in: the number of waiver participants (users), units of service per user, and average cost per unit. These historical data were used to develop trend assumptions, which were then projected forward using an assumed annual growth factor of approximately 3.0 percent to reflect anticipated changes in service utilization and cost over the waiver renewal period. Annual trends for changes in users, units per user, and average cost per unit were determined by comparing claims utilization and expenditures from recent waiver years and applying observed utilization patterns, adjusted for approved slot increases and service availability. These trends were then projected forward for each waiver year in the renewal period.

- ii. Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' is derived from data contained in the CMS-372 Reports and from Medicaid claims data for the most recent waiver years covering the same period. Claims data were extracted from the Alabama Medicaid Management Information System (MMIS) and analyzed to determine historical trends in: -the number of waiver participants (users), -units of service per user, and -average cost per unit. Claims data from MMIS were used to calculate baseline waiver service expenditures. An annual growth trend of three percent (3%) was applied to reflect anticipated increases in service utilization and cost over time. The 3% trend was based on historical expenditure growth observed in recent waiver years and reflects conservative assumptions regarding utilization and cost growth.

- iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G is derived from data contained in the CMS-372 Report and from Medicaid claims data for the most recent waiver years covering the same period. Claims data were extracted from the Alabama Medicaid Management Information System (MMIS) and analyzed to determine historical trends in: -the number of waiver participants (users), -units of service per user, and -average cost per unit. Claims data from the Alabama Medicaid MMIS were used to establish baseline service utilization and costs. An annual growth trend of three percent (3%) was applied to project future expenditures. This trend reflects historical utilization and expenditure patterns for waiver services and incorporates anticipated changes in service demand and cost inflation.

- iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' is derived from data contained in the CMS-372 Report and from Medicaid claims data for the most recent waiver years covering the same period. Claims data were extracted from the Alabama Medicaid Management Information System (MMIS) and analyzed to determine historical trends in: -the number of waiver participants (users), -units of service per user, and -average cost per unit. Estimates of Factor G' do not include costs for prescribed drugs furnished to Medicare/Medicaid dual eligible under Medicare Part D. A three percent (3%) annual growth trend was applied to project future expenditures. The growth trend is based on historical claims experience and reflects reasonable assumptions regarding future utilization and cost growth.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “manage components” to add these components.

Waiver Services	
Adult Day Health	
Case Management	
Homemaker	
Personal Care	
Skilled Respite	
Unskilled Respite	
Medical Supplies	
Adult Companion Service	
Assistive Technology	
Home Delivered Meals	
Home Modifications	
Personal Assistant Service (PAS)	
Personal Emergency Response Systems (PERS)-Installation/Monthly Fee	
Pest Control Service	
Skilled Nursing RN	

Waiver Services	
Skilled Nursing-LPN	
Transitional Assistance Services	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							65182.75
Adult Day Health	☐	Daily	25	127.00	20.53	65182.75	
Case Management Total:							1086444.00
Case Management	☒	Per month	309	12.00	293.00	1086444.00	
Homemaker Total:							925120.00
Homemaker	☐	15 minute unit	250	896.00	4.13	925120.00	
Personal Care Total:							3393472.00
Personal Care	☐	15 Minute Unit	272	3119.00	4.00	3393472.00	
Skilled Respite Total:							4105.00
Skilled Respite	☐	15 Minute Unit	25	20.00	8.21	4105.00	
Unskilled Respite Total:							2210.00
Unskilled Respite	☐	15 Minute Unit	25	20.00	4.42	2210.00	
Medical Supplies Total:							604800.00
Medical Supplies	☐	Monthly	252	12.00	200.00	604800.00	
Adult Companion Service Total:							144000.00
GRAND TOTAL: 10607475.51 Total: Services included in capitation: 1086444.00 Total: Services not included in capitation: 9521031.51 Total Estimated Unduplicated Participants: 675 Factor D (Divide total by number of participants): 15714.78 Services included in capitation: 1610.00 Services not included in capitation: 14105.23 Average Length of Stay on the Waiver: 265							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Companion Service	☐	15 Minute Unit	75	480.00	4.00	144000.00	
Assistive Technology Total:							2250000.00
Assistive Technology	☐	Per item	150	1.00	15000.00	2250000.00	
Home Delivered Meals Total:							873600.00
Home Delivered Meals	☐	Per Packet	280	104.00	30.00	873600.00	
Home Modifications Total:							225000.00
Home Modifications	☐	Per item	45	1.00	5000.00	225000.00	
Personal Assistant Service (PAS) Total:							58200.00
Personal Assistant Service (PAS)	☐	15 Minute Unit	10	1500.00	3.88	58200.00	
Personal Emergency Response Systems (PERS)- Installation/Monthly Fee Total:							90341.76
Personal Emergency Response Systems (PERS)- Installation/Monthly Fee	☐	monthly	223	12.00	33.76	90341.76	
Pest Control Service Total:							62500.00
Pest Control Service	☐	Per Incident	25	1.00	2500.00	62500.00	
Skilled Nursing RN Total:							332500.00
Skilled Nursing RN	☐	30 Minutes	25	350.00	38.00	332500.00	
Skilled Nursing-LPN Total:							315000.00
Skilled Nursing-LPN	☐	30 Minutes	25	350.00	36.00	315000.00	
Transitional Assistance Services Total:							175000.00
Transitional Assistance Services	☐	Per Incident	50	1.00	3500.00	175000.00	
GRAND TOTAL: 10607475.51 Total: Services included in capitation: 1086444.00 Total: Services not included in capitation: 9521031.51 Total Estimated Unduplicated Participants: 675 Factor D (Divide total by number of participants): 15714.78 Services included in capitation: 1610.00 Services not included in capitation: 14105.23 Average Length of Stay on the Waiver: 265							

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							64325.50
Adult Day Health	☐	Daily	25	127.00	20.26	64325.50	
Case Management Total:							1086444.00
Case Management	☒	Per month	309	12.00	293.00	1086444.00	
Homemaker Total:							1128960.00
Homemaker	☐	15 minute unit	250	896.00	5.04	1128960.00	
Personal Care Total:							3393472.00
Personal Care	☐	15 Minute Unit	272	3119.00	4.00	3393472.00	
Skilled Respite Total:							4105.00
Skilled Respite	☐	15 Minute Unit	25	20.00	8.21	4105.00	
Unskilled Respite Total:							2210.00
Unskilled Respite	☐	15 Minute Unit	25	20.00	4.42	2210.00	
Medical Supplies Total:							604800.00
Medical Supplies	☐	Monthly	252	12.00	200.00	604800.00	
Adult Companion Service Total:							144000.00
Adult Companion Service	☐	15 Minute Unit	75	480.00	4.00	144000.00	
Assistive Technology Total:							450000.00
Assistive Technology	☐	Per item	150	0.20	15000.00	450000.00	
Home Delivered Meals Total:							873600.00
GRAND TOTAL: 9137258.26 Total: Services included in capitation: 1086444.00 Total: Services not included in capitation: 8050814.26 Total Estimated Unduplicated Participants: 675 Factor D (Divide total by number of participants): 13536.68 Services included in capitation: 1610.00 Services not included in capitation: 11927.13 Average Length of Stay on the Waiver: 265							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Delivered Meals	☐	Per Packet	280	104.00	30.00	873600.00	
Home Modifications Total:							275000.00
Home Modifications	☐	Per item	55	1.00	5000.00	275000.00	
Personal Assistant Service (PAS) Total:							75000.00
Personal Assistant Service (PAS)	☐	15 Minute Unit	10	1500.00	5.00	75000.00	
Personal Emergency Response Systems (PERS)- Installation/Monthly Fee Total:							90341.76
Personal Emergency Response Systems (PERS)- Installation/Monthly Fee	☐	monthly	223	12.00	33.76	90341.76	
Pest Control Service Total:							87500.00
Pest Control Service	☐	Per Incident	35	1.00	2500.00	87500.00	
Skilled Nursing RN Total:							332500.00
Skilled Nursing RN	☐	30 Minutes	25	350.00	38.00	332500.00	
Skilled Nursing-LPN Total:							315000.00
Skilled Nursing-LPN	☐	30 Minutes	25	350.00	36.00	315000.00	
Transitional Assistance Services Total:							210000.00
Transitional Assistance Services	☐	Per Incident	60	1.00	3500.00	210000.00	
GRAND TOTAL: 9137258.26 Total: Services included in capitation: 1086444.00 Total: Services not included in capitation: 8050814.26 Total Estimated Unduplicated Participants: 675 Factor D (Divide total by number of participants): 13536.68 Services included in capitation: 1610.00 Services not included in capitation: 11927.13 Average Length of Stay on the Waiver: 265							

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. **Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							65182.75
Adult Day Health	☐	Daily	25	127.00	20.53	65182.75	
Case Management Total:							1230600.00
Case Management	☒	Per month	350	12.00	293.00	1230600.00	
Homemaker Total:							1128960.00
Homemaker	☐	15 minute unit	250	896.00	5.04	1128960.00	
Personal Care Total:							3742800.00
Personal Care	☐	15 Minute Unit	300	3119.00	4.00	3742800.00	
Skilled Respite Total:							4926.00
Skilled Respite	☐	15 Minute Unit	30	20.00	8.21	4926.00	
Unskilled Respite Total:							2652.00
Unskilled Respite	☐	15 Minute Unit	30	20.00	4.42	2652.00	
Medical Supplies Total:							540000.00
Medical Supplies	☐	Monthly	225	12.00	200.00	540000.00	
Adult Companion Service Total:							153600.00
Adult Companion Service	☐	15 Minute Unit	80	480.00	4.00	153600.00	
Assistive Technology Total:							450000.00
Assistive Technology	☐	Per item	150	0.20	15000.00	450000.00	
Home Delivered Meals Total:							842400.00
Home Delivered Meals	☐	Per Packet	270	104.00	30.00	842400.00	
Home Modifications Total:							325000.00
Home Modifications	☐	Per item	65	1.00	5000.00	325000.00	
Personal Assistant Service (PAS) Total:							75000.00
GRAND TOTAL: 9571462.51 Total: Services included in capitation: 1230600.00 Total: Services not included in capitation: 8340862.51 Total Estimated Unduplicated Participants: 675 Factor D (Divide total by number of participants): 14179.94 Services included in capitation: 1823.00 Services not included in capitation: 12356.83 Average Length of Stay on the Waiver: 265							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Assistant Service (PAS)	☐	15 Minute Unit	10	1500.00	5.00	75000.00	
Personal Emergency Response Systems (PERS)- Installation/Monthly Fee Total:							90341.76
Personal Emergency Response Systems (PERS)- Installation/Monthly Fee	☐	monthly	223	12.00	33.76	90341.76	
Pest Control Service Total:							62500.00
Pest Control Service	☐	Per Incident	25	1.00	2500.00	62500.00	
Skilled Nursing RN Total:							332500.00
Skilled Nursing RN	☐	30 Minutes	25	350.00	38.00	332500.00	
Skilled Nursing-LPN Total:							315000.00
Skilled Nursing-LPN	☐	30 Minutes	25	350.00	36.00	315000.00	
Transitional Assistance Services Total:							210000.00
Transitional Assistance Services	☐	Per Incident	60	1.00	3500.00	210000.00	
GRAND TOTAL: 9571462.51 Total: Services included in capitation: 1230600.00 Total: Services not included in capitation: 8340862.51 Total Estimated Unduplicated Participants: 675 Factor D (Divide total by number of participants): 14179.94 Services included in capitation: 1823.00 Services not included in capitation: 12356.83 Average Length of Stay on the Waiver: 265							

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							65182.75
Adult Day Health	☐	Daily	25	127.00	20.53	65182.75	
Case Management Total:							1230600.00
Case Management	☒	Per month	350	12.00	293.00	1230600.00	
Homemaker Total:							1354752.00
Homemaker	☐	15 minute unit	300	896.00	5.04	1354752.00	
Personal Care Total:							3992320.00
Personal Care	☐	15 Minute Unit	320	3119.00	4.00	3992320.00	
Skilled Respite Total:							4926.00
Skilled Respite	☐	15 Minute Unit	30	20.00	8.21	4926.00	
Unskilled Respite Total:							2652.00
Unskilled Respite	☐	15 Minute Unit	30	20.00	4.42	2652.00	
Medical Supplies Total:							600000.00
Medical Supplies	☐	Monthly	250	12.00	200.00	600000.00	
Adult Companion Service Total:							192000.00
Adult Companion Service	☐	15 Minute Unit	100	480.00	4.00	192000.00	
Assistive Technology Total:							450000.00
Assistive Technology	☐	Per item	150	0.20	15000.00	450000.00	
Home Delivered Meals Total:							780000.00
Home Delivered Meals	☐	Per Packet	250	104.00	30.00	780000.00	
Home Modifications Total:							325000.00
Home Modifications	☐	Per item	65	1.00	5000.00	325000.00	
Personal Assistant Service (PAS) Total:							75000.00
Personal Assistant Service (PAS)	☐	15 Minute Unit	10	1500.00	5.00	75000.00	
GRAND TOTAL: 10419740.75 Total: Services included in capitation: 1230600.00 Total: Services not included in capitation: 9189140.75 Total Estimated Unduplicated Participants: 675 Factor D (Divide total by number of participants): 15436.65 Services included in capitation: 1823.00 Services not included in capitation: 13613.54 Average Length of Stay on the Waiver: 265							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Emergency Response Systems (PERS)- Installation/Monthly Fee Total:							88308.00
Personal Emergency Response Systems (PERS)- Installation/Monthly Fee	☐	monthly	223	12.00	33.00	88308.00	
Pest Control Service Total:							125000.00
Pest Control Service	☐	Per Incident	50	1.00	2500.00	125000.00	
Skilled Nursing RN Total:							465500.00
Skilled Nursing RN	☐	30 Minutes	35	350.00	38.00	465500.00	
Skilled Nursing-LPN Total:							441000.00
Skilled Nursing-LPN	☐	30 Minutes	35	350.00	36.00	441000.00	
Transitional Assistance Services Total:							227500.00
Transitional Assistance Services	☐	Per Incident	65	1.00	3500.00	227500.00	
GRAND TOTAL: 10419740.75 Total: Services included in capitation: 1230600.00 Total: Services not included in capitation: 9189140.75 Total Estimated Unduplicated Participants: 675 Factor D (Divide total by number of participants): 15436.65 Services included in capitation: 1823.00 Services not included in capitation: 13613.54 Average Length of Stay on the Waiver: 265							

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							63500.00
Adult Day Health	☐	Daily	25	127.00	20.00	63500.00	
Case Management Total:							1230600.00
Case Management	☒	Per month	350	12.00	293.00	1230600.00	
Homemaker Total:							1128960.00
Homemaker	☐	15 minute unit	250	896.00	5.04	1128960.00	
Personal Care Total:							3742800.00
Personal Care	☐	15 Minute Unit	300	3119.00	4.00	3742800.00	
Skilled Respite Total:							4926.00
Skilled Respite	☐	15 Minute Unit	30	20.00	8.21	4926.00	
Unskilled Respite Total:							2652.00
Unskilled Respite	☐	15 Minute Unit	30	20.00	4.42	2652.00	
Medical Supplies Total:							600000.00
Medical Supplies	☐	Monthly	250	12.00	200.00	600000.00	
Adult Companion Service Total:							192000.00
Adult Companion Service	☐	15 Minute Unit	100	480.00	4.00	192000.00	
Assistive Technology Total:							450000.00
Assistive Technology	☐	Per item	150	0.20	15000.00	450000.00	
Home Delivered Meals Total:							842400.00
Home Delivered Meals	☐	Per Packet	270	104.00	30.00	842400.00	
Home Modifications Total:							325000.00
Home Modifications	☐	Per item	65	1.00	5000.00	325000.00	
Personal Assistant Service (PAS) Total:							187500.00
Personal Assistant Service (PAS)	☐	15 Minute Unit	25	1500.00	5.00	187500.00	
GRAND TOTAL: 10117646.00 Total: Services included in capitation: 1230600.00 Total: Services not included in capitation: 8887046.00 Total Estimated Unduplicated Participants: 675 Factor D (Divide total by number of participants): 14989.00 Services included in capitation: 1823.00 Services not included in capitation: 13166.00 Average Length of Stay on the Waiver: 265							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Emergency Response Systems (PERS)- Installation/Monthly Fee Total:							88308.00
Personal Emergency Response Systems (PERS)- Installation/Monthly Fee	☐	monthly	223	12.00	33.00	88308.00	
Pest Control Service Total:							125000.00
Pest Control Service	☐	Per Incident	50	1.00	2500.00	125000.00	
Skilled Nursing RN Total:							465500.00
Skilled Nursing RN	☐	30 Minute Unit	35	350.00	38.00	465500.00	
Skilled Nursing-LPN Total:							441000.00
Skilled Nursing-LPN	☐	30 Minutes Unit	35	350.00	36.00	441000.00	
Transitional Assistance Services Total:							227500.00
Transitional Assistance Services	☐	Per Incident	65	1.00	3500.00	227500.00	
GRAND TOTAL: 10117646.00 Total: Services included in capitation: 1230600.00 Total: Services not included in capitation: 8887046.00 Total Estimated Unduplicated Participants: 675 Factor D (Divide total by number of participants): 14989.00 Services included in capitation: 1823.00 Services not included in capitation: 13166.00 Average Length of Stay on the Waiver: 265							