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

1. Request Information

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

B. Program Title:
Community Waiver Program

C. Waiver Number:AL.1746

D. Amendment Number:AL.1746.R00.02

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

02/01/26

Approved Effective Date: 02/01/26
Approved Effective Date of Waiver being Amended: 10/21/21

2. Purpose(s) of Amendment

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

The purpose of this amendment is to update the eligibility criteria and allow relatives, including a legal liable relative, and/or a legal guardian rendering self-directed Personal Care Assistance (Home and Community) and Community Transportation to receive payment for rendering services to align with the Intellectual Disabilities (ID) and Living at Home (LAH) Waivers as long as the 1) the relative/legal guardian is otherwise qualified to provide these services and 2) the relative/legal guardian does not also serve as the same participant's representative/Employer of Record (EOR).

Appendix B:

*B-6-d: Updated eligibility criteria as it relates to the IQ test score and age of onset to align with the Intellectual Disabilities (ID) and Living at Home (LAH) Waivers.

Appendix C:

* Updated service definitions and provider specifications to allow relatives, legal liable relative and/or legal guardians to render self-directed Personal Assistance Home, Personal Assistance- Community & Community Transportation services only.
* Selected "remote/telehealth" as a service delivery option for remote supports, supported living, adult family home and community-based residential services. Additionally, minor updates were made to the service definitions of these services to provide clarity of remote supports utilization.
* C-1-d: Provided appropriate remote/telehealth safeguard descriptions
* C-2-d: Updated relatives, legal liable relative, and/or legal guardian specifications
* C-2-e: Updated relatives, legal liable relative, and/or legal guardian specifications
* Provided information in Appendix C-5

Appendix E:

* E-1-a: Updated overtime reimbursement provisions as it relates to family, legal liable relatives and/or legal guardians

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☐ **Waiver Application**	
☐ **Appendix A - Waiver Administration and Operation**	
☒ **Appendix B - Participant Access and Eligibility**	B-6-d
☒ **Appendix C - Participant Services**	C-2-d; C-2-e
☐ **Appendix D - Participant Centered Service Planning and Delivery**	
☒ **Appendix E -**	E-1-a

Component of the Approved Waiver	Subsection(s)
Participant Direction of Services	
☐ Appendix F - Participant Rights	
☐ Appendix G - Participant Safeguards	
☐ Appendix H	
☐ Appendix I - Financial Accountability	
☐ Appendix J - Cost-Neutrality Demonstration	

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

- ☐ **Modify target group(s)**
- ☒ **Modify Medicaid eligibility**
- ☐ **Add/delete services**
- ☒ **Revise service specifications**
- ☒ **Revise provider qualifications**
- ☐ **Increase/decrease number of participants**
- ☐ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☐ **Other**

Specify:

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*):

Community Waiver Program

C. Type of Request: amendment

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

○ **3 years** ◉ **5 years**

Waiver Number:AL.1746.R00.02
Draft ID: AL.033.00.03

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 10/01/21
Approved Effective Date of Waiver being Amended: 10/21/21

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:

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:

Community Waiver

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

This waiver, operated concurrently with 1115 authority, provides a range of HCBS to individuals with intellectual disabilities (ID), ages 3 and above. It has deeming options for children at home with families and adults with unearned income of up to 300% of the SSI maximum. There are 5 distinct enrollment groups in the Community Waiver Program (CWP), each with its own budget cap and set of services. Four enrollment groups will serve individuals with ID who meet institutional level of care and, per the 1115 authority, the fifth will be the sole enrollment group for the Section 1115 Group 5 HCBS program.
1.Children with ID, ages 3-13, that are living with family or other natural supports.
2.Transition-age youth with ID, ages 14-21, who are living with family or other natural supports, or living independently (18-21).
3.Working-age and older adults with ID, ages 22 and older, who are living with family or other natural supports, living independently or able to live in a non-intensive supported living arrangement.
4.Individuals ages 3 and older with ID who are not able to live with family or other natural supports, not able to live independently, or not able to live in a non-intensive supported living arrangement.
5. Individuals with ID, ages 22 +, who have a minimum of one substantial functional limitation.

The CWP will operate in 5 demonstration areas of the state, including 1 from each existing service delivery region: Region 1 (Madison, Morgan and Limestone Counties); Region 2 (Tuscaloosa and Walker Counties); Region 3 (Mobile and Baldwin Counties); Region 4 (Montgomery, Elmore and Houston Counties); Region 5 (Jefferson County). Per the 1115 authority, Support Coordination will be provided exclusively by the Alabama Department of Mental Health, Division of Developmental Disabilities (ADMH/DDD) in Regions 1, 3, 4 and 5, and in Region 2, provided by local 310 Board(s) or if none are willing and qualified, by ADMH/DDD. The CWP offers services and supports for waiver participants and their families, customized to the participant's living situation, identified goals and assessed needs related to these goals, including health and safety needs and risk planning and mitigation needs. The goals for this waiver include:(1) preserving an individual's existing living arrangement, including preserving family living arrangements where both the family and the individual desire this but need supports to achieve this;(2) increasing access to competitive integrated employment opportunities and effective services and supports to enable waiver participants to obtain and maintain competitive integrated employment;(3) for individuals who are not able to live with family, providing opportunities for individuals to reside in their own home as the first option; increasing opportunities for self-direction while ensuring appropriately trained self-direction workers;(5) providing other innovative supportive services that individuals and their families say they need most including transportation, peer-to-peer and family assistance with navigating systems and accessing community resources, a breaks & opportunities service (respite), and personal assistance and/or skill-building services available both at and in the community. The waiver design and service array also assist the state in ensuring compliance with the HCBS Settings Rule, the Americans with Disabilities Act and other applicable federal laws and regulations.

The waiver will be operated by the ADMH/DDD through an MOU/operating agreement with the Alabama Medicaid Agency (AMA) which will oversee ADMH/DDD is carrying out all aspects of waiver administration. Service delivery will be through a provider network contracted by ADMH/DDD which will have responsibility for recruitment, certification or verification of required qualifications through other means, contracting, and ongoing quality monitoring and quality assurance activities. ADMH/DDD shall also have responsibility for development of rate methodologies and payment rates for services, and ongoing review of such methodologies and rates for appropriateness to achieve the goals of the waiver and ensure an adequate, quality provider network. ADMH/DDD shall be responsible for receiving, approving, processing and paying all claims from providers with administrative oversight from AMA.

Two existing 1915(c) waivers for people with ID (Alabama Home and Community-Based Waiver for Persons with Intellectual Disabilities AL.0001 (ID waiver) and Alabama HCBS Living at Home Waiver for Persons with Intellectual Disabilities AL.0391 (LAH waiver)) will remain open for those enrolled as of the date this new 1915(c) waiver opens. 0001 and 0391 services will be supplanted by Community Waiver Program (CWP) services in the counties where the CWP is implemented. The state will transfer any attrition slots from the ID and LAH Waivers to the CWP. After this new 1915(c) waiver operates for 2 calendar years, the state will allow voluntary transitions of individuals enrolled in the LAH or ID waiver, with the enrollment slots and associated funding to follow each individual who transfers to this new 1915(c) waiver.

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. Statewideness. 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:

This waiver will operate in five demonstration areas of the state, including one from each existing service delivery region: Region 1 (Madison, Morgan and Limestone Counties); Region 2 (Tuscaloosa and Walker Counties); Region 3 (Mobile and Baldwin Counties); Region 4 (Montgomery, Elmore and Houston Counties); Region 5 (Jefferson County).

☐ **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:

ADMH/DDD, in partnership with the Alabama Medicaid Agency, utilizes a Public Comment period for all waiver amendments & renewals. The public comment period is announced on both the Alabama Department of Mental Health & the Alabama Medicaid Agency websites along with an email blast to the Medicaid LTC listserve & electronic news article posting on the Medicaid Agency website. Hardcopies of the waiver amendments &/or renewals are also made available (upon request) at the Medicaid Central Office, Medicaid District Offices, ADMH-DDD Central Office & Regional Offices. As directed by the Tribal Consultation section 1902(a)(73) of the Social Security Act and Federal Regulation, a 30-day tribal notice notifying Alabama's Tribal Government about the public comment period is sent via certified mail and electronic mail (e-mail). The Tribal Notice informs the Tribal Government about how to review waiver amendments/renewals on the Medicaid Agency website, impacts to the Tribal Government and the Medicaid address to send their input.

The 30-day public comment notice requesting public input of this waiver renewal was announced on 9/11/2025 electronically via listserve email blast, Alabama Medicaid & ADMH agency websites & a electronic news article on Medicaid Agency website. The notice and drafted renewals were made available by non-electronic means via hard copies at Medicaid District Offices & Medicaid's Central Office, upon request. A summary of the comments received are submitted to CMS with amendments/renewals. ADMH responds to comments not pertaining to the waiver renewal individually. Only one comment was received during the input period. A stakeholder expressed interest in assisting with the implementation of a nutrition program. ADMH reviewed the concern and determined that the comment was not relative to the proposed amendment. Additionally, the Division will not move forward with the implementation at this time.

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: Carmack

First Name: Ginger

Title: Deputy Commissioner, Program Administration

Agency:

Alabama Medicaid Agency

Address:

501 Dexter Avenue

Address 2:

P. O. Box 5634

City:

Montgomery

State: **Alabama**

Zip:

36103-5624

Phone:

(334) 242-5007 **Ext:** ☐ **TTY**

Fax:

(334) 353-4182

E-mail:

ginger.carmack@medicaid.alabama.gov

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

Last Name:

Johnson-Groves

First Name:

Angela

Title:

Director, LTC Healthcare Reform Development Division

Agency:

Alabama Medicaid Agency

Address:

501 Dexter Avenue

Address 2:

P.O. Box 5634

City:

Montgomery

State: **Alabama**

Zip:

36130-5624

Phone:

(334) 353-4361 **Ext:** ☐ **TTY**

Fax:

(334) 353-4182

E-mail: angela.johnson-groves@medicaid.alabama.gov

8. Authorizing Signature

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

Signature: Monica Abron

State Medicaid Director or Designee

Submission Date: Jan 9, 2026

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

Last Name: Offord, Jr.

First Name: Timothy

Title: Commissioner

Agency: Alabama Medicaid Agency

Address: 501 Dexter Avenue

Address 2: P.O. Box 5624

City: Montgomery

State: **Alabama**

Zip: 36104

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

Fax: (334) 242-5600

E-mail: timothy.offord@medicaid.alabama.gov

Attachments

Attachment #1: Transition Plan

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

☐ **Replacing an approved waiver with this waiver.**

☐ **Combining waivers.**

☐ **Splitting one waiver into two waivers.**

☐ **Eliminating a service.**

☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**

☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**

☐ **Reducing the unduplicated count of participants (Factor C).**

☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**

☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**

☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

N/A

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 Mental Health, Division of Developmental Disabilities

In accordance with 42 CFR § 431.10, the Medicaid agency exercises administrative discretion in the administration

and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

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

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

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

Through a memorandum of understanding (MOU) Medicaid designates the Alabama Department of Mental Health (ADMH) as its agent responsible for all of the functions identified in Appendix A.7. of this application. As the Oversight agency, the Alabama Medicaid Agency ensures that the:
*Operating agency adheres to all federal guidelines described in the approved waiver document
*Health and safety of the client is protected
*Client has been given freedom of choice between institutional care and community care
*Direct service providers meet the qualifications as outlined in the approved waiver document; and signs all subcontracts of qualified direct service providers enrolled with the operating agency.
*Individuals served are aware of their rights to express concerns regarding service provision and/or direct service providers.

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

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

Appendix A: Waiver Administration and Operation

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

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

In order to implement self-directed services, two Financial Management Services Agencies (FMSA) are utilized. These contracted entities provide fiscal intermediary and other services to participants who choose to self-direct some of their services. The two FMSAs were selected by a competitive RFP process. They are Allied Group and PCG/Public Partnerships. The services of the FMSA are described in detail in Appendix A.7. and Appendix E, which will include assuring "Qualified Provider Enrollment" and "Execution of Medicaid Provider Agreements."

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

Appendix A: Waiver Administration and Operation

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

◉ **Not applicable**

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

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

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

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

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

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:

The Department of Mental Health Division of DD, as the Operating Agency, has responsibility for monitoring of FMSAs including contract and performance monitoring. The DDD Regional Office fiscal managers, with oversight from Central Office, monitor to ensure FMSA contract compliance and self-direction is implemented according to waiver requirements.

Appendix A: Waiver Administration and Operation

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

The following methodologies are used to assess performance of contracted entities: (i.e FMSA):
1. Division of Developmental Disabilities staff pulls a scientifically calculated random sample of recipients at the 95% confidence level +/- 5% and reviews the pertinent records for these individuals. Alabama Medicaid Agency Waiver Quality Assurance staff also pulls a random sample 90% confidence level +/- 5% in order to review the required records.

2. On a quarterly basis, the FMSA will provide reports and documentation to the Central office and the Support Coordinator, and the self-directing participants, that will identify the amounts paid to and on behalf of employees and include copies of the signed time sheets for those employees for each pay period. If this process shows there has been any error in timecard submissions, then the error will be corrected by the following pay period. The Support Coordinator will be responsible for all follow-up conversations with participants or the representative to 1) notify them of any change to compensation and 2) ensure that time keeping processes are clearly understood. The Support Coordinator closely monitors units paid and remaining as well as account balances to ensure there are sufficient funds in each account to cover the cost of payroll. Goods and Services will be authorized through the Support Coordinator and receipts for items paid for up front by the FMSA will be reconciled. A receipt for each item purchased is required for reimbursement.
3. Also on a quarterly basis, in addition to the submission of timecards as described above, the FMSA is required to submit training documentation, license documentation, and a complete employee packet to the Operating Agency for review.

All training material used by the FMSA, employment forms, information packets, brochures and manuals will have the approval of the Alabama Medicaid Agency prior to implementation. Additionally, there is a RFP process every two years for the FMSA to ensure all required tasks set forth by the Operating Agency can be fully implemented.

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
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	☒	☒	☒

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
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:
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):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:
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 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**

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

Performance Measure:
Number and percent of waiver/1115 Group 5 program records reviewed by the Medicaid Agency that were compliant with program requirements Percentage = NUMERATOR [Number of waiver/ 1115 Group 5 program records reviewed by the Medicaid Agency that were compliant with program requirements] / DENOMINATOR [Number of waiver / 1115 Group 5 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*(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 = 90% with a margin of error of +/-10%
☐ **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	**Frequency of data**	**Sampling Approach***(check*

collection/generation*(check each that applies):*	**collection/generation***(check each that applies):*	*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:

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:
 # & % programmatic operating procedures pertaining to the waiver/1115 Group 5 issued by the OA that were approved by AMA prior to being issued by the OA
%=N[#programmatic operating procedures pertaining to the waiver/1115 Group 5 issued by the OA that were approved by AMA prior to being issued by the OA]/D[#programmatic operating procedures pertaining to the waiver/1115 Group 5 issued by the OA]

Data Source (Select one):
Other
If 'Other' is selected, specify:
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:
1115 Group 5 participants reside in a family member or other natural caregiver's home, their own home, or in a leased unit they lease from a landlord that is not a provider of HCBS. Percentage=NUMERATOR [Number of enrolled 1115 Group 5 participants who reside in a family member or other natural caregiver's home, their own home, or in a leased unit they lease from a landlord that is not a..

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
...cntnd from above..provider of HCBS]/DENOMINATOR[Number of enrolled 1115

Group 5 participants] Case Manager Monitoring Reports

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**

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

Performance Measure:
Number and percent of 1115 Group 5 participants for whom all service settings are integrated in, and support full access to, the community. Percentage = NUMERATOR [Number of enrolled 1115 Group 5 participants for whom all service settings are integrated in, and support full access to, the community]/ DENOMINATOR [Number of enrolled 1115 Group 5 participants]

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

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

Data Aggregation and Analysis:

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

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

The Alabama Medicaid Agency has an established methodology for aggregating data from multiple sources and weighting it to rate performance within a specific domain. The methodology was designed through a collaborative effort between the AMA and consultants at Navigant.

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.

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

ii. Remediation Data Aggregation

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

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **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 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**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☒ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	Developmental Disability			☐
	☒	Intellectual Disability	3		☒
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

Through authority granted in concurrent 1115 demonstration waiver, the State will establish enrollment categories for enrollment of individuals from the target group defined above in Appendix B-1.a, based on the program goals and objectives described in Part 2 of this application and Part 4 of the 1115 application, which align with stakeholder input, the goals of the federal Medicaid program and the objectives of the 1115 demonstration program. The enrollment categories are:

1. Children with ID, ages 3-13, that are living with family or other natural supports.
2. Transition-age youth with ID, ages 14-21, who are living with family or other natural supports, or living independently (18-21).
3. Working-age and older adults with ID, ages 22 and older, who are living with family or other natural supports, living independently or able to live in a non-intensive supported living arrangement.
4. Individuals ages 3 and older with ID who are not able to live with family or other natural supports, not able to live independently, or not able to live in a non-intensive supported living arrangement.
5. Individuals with ID, ages 22 and older, who have a minimum of one substantial functional limitation

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

◉ **Not applicable. There is no maximum age limit**

○ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

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

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

○ **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

○ **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

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

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

Specify the percentage:

○ **Other**

Specify:

◉ **Institutional Cost Limit.** Pursuant to 42 CFR § 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

○ **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

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

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

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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:

a. Cost limits for the waiver enrollment groups are implemented based on eligibility for each respective enrollment group, as follows:
- Enrollment Group 1: Cost Limit = $12,000
- Enrollment Group 2: Cost Limit = $15,000
- Enrollment Group 3: Cost Limit = $30,000 (living with family/natural supports) OR $45,000 (living independently in home/apartment owned/rented by the person)
- Enrollment Group 4: Cost Limit = $65,000 OR $100,000 (if exceptional behavioral/needs)
- Enrollment Group 5: Cost Limit = $22,000

b. The prioritization used for the waiting list indicates the services which the person is likely to need and gives an initial indication of who is likely not to need to exceed the cost limit.
c. The education done prior to enrollment lays out the various services available and how they can be used to meet people's needs in the most cost-effective ways, thus ensuring needs can be addressed both effective and cost-effectively, allowing most all individuals to be served within the cost limit.
d.The planning team understands the limitation and will not proceed, without requesting prior authorization for services in excess of the cost limit (as described in section B.2.c below), if the cost of the most cost-effective services necessary to meet an individual's needs will exceed the limit. There is also flexibility for specific services selected, and the scope of the coverage most often will allow the planning team develop a plan within the individual cost limit.
e.The PCP is assessed for cost and assistance with appropriately revising the plan in a way that is acceptable to the individual will be provided to the planning team if it exceeds the limit.
f.For individuals with plans that include services subject to rate increases in a future waiver renewal or amendment application, if the individual cost limit will be exceeded due to the rate increases, and not because additional services are added or additional units of service for services already in the plan are added, the cost limit may be exceeded by the amount of the calculated rate increases to accommodate the impact of these rate increases for as long as this continues to be necessary to ensure no reduction in service utilization must occur if there has been no reduction in assessed need.
g. To prevent institutionalization, the planning team can request prior authorization for services in excess of the cost limit (as described in section B.2.c below) if those services are both effective and the most cost-effective in meeting the individual's needs. An individual may request a fair hearing if denied waiver entrance or if denied a service due to a cost limit.

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

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

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

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

The assigned Support Coordinator for the individual, who conducts all assessments and assists and facilitates the work of the person-centered planning team, is responsible for submitting a Preliminary Notification of Needs Potentially Exceeding Individual Cost Limit form to their Regional Office Supervisor and to the Central Office Waiver Director. This will trigger involvement and consultation with the planning team by the Regional Office Supervisor and/or the Central Office Waiver Director who will do a comprehensive review of the individual's record, including all history, assessments and person-centered planning information. Should the conclusion be reached that the cost for the cumulative total of needed effective and most cost effective services will exceed the individual cost limit, a PCP including these services, in appropriate amount, frequency and duration will be developed with the individual. The PCP will be submitted to the Assistant Commissioner for the Division of Developmental Disabilities who will review and approve the PCP for a one-year period, including the amount by which it exceeds the individual cost limit. For the purposes of preventing institutionalization, a PCP that exceeds the individual cost limit can be approved with services in an amount that does not exceed 24/7 provision of an appropriate intensity of supports, 365 days per year, if needed.

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	500
Year 2	1097
Year 3	1447
Year 4	1797
Year 5	2147

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Purpose(s) the state reserves capacity for:

Purposes	
Outplacements from Nursing Homes or Institutions	
Emergency Placements	
Transitions from LAH Waiver	
Children in State Care/Custody	

Appendix B: Participant Access and Eligibility

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

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

Outplacements from Nursing Homes or Institutions

Purpose *(describe):*

Institutionalized individuals, including those leaving in-patient psychiatric facilities, have a right, with some limitations, to be placed in the community, in accordance with the Olmstead Decision. This reserve capacity is to ensure state has sufficient "slots" to serve people who wish to move to the community.

Describe how the amount of reserved capacity was determined:

Because the State has eliminated state run institutions for individuals with intellectual disabilities, the demand for outplacement is currently solely based on Skilled Nursing Facilities, in-patient psychiatric facilities and occasional transition from another type of institution where placement may occur. The State projects it needs to reserve 10 slots each year, on a statewide basis. The proposed demonstration area for this waiver is estimated to cover 50% percentage of the state's total need; therefore, 5 slots are reserved in this waiver for this category of enrollees. The remainder of necessary state capacity is reserved in the ID waiver.

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

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

Appendix B: Participant Access and Eligibility

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

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

Emergency Placements

Purpose *(describe):*

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

Describe how the amount of reserved capacity was determined:

ADMH/DDD continues to encounter emergency situations, however, based on the average number over the last 4 years, the number has been decreased based on utilization. Since this time we have made updates in our process to serve people in a high risk situation. Due to this adjustment the State projects a need to reserve 35 slots per year, statewide, for individuals in this category.
The proposed demonstration area for this waiver is estimated to cover 50% percentage of the state's total need; therefore, 18 slots are reserved in this waiver for this category of enrollees. The remainder of necessary state capacity is reserved in the ID waiver.

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

Waiver Year	Capacity Reserved
Year 1	18
Year 2	18
Year 3	18
Year 4	18
Year 5	18

Appendix B: Participant Access and Eligibility

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

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

Transitions from LAH Waiver

Purpose *(describe):*

Participants Transferring from the Living at Home Waiver when their needs can no longer be safely and appropriately met in that waiver.

Describe how the amount of reserved capacity was determined:

Data for several years has indicated an average of 25 transfers per year from the Living at Home Waiver to the ID Waiver. With programming changes at the Medicaid Fiscal Agent and a waiver amendment, Disabled Adult Children (DACs) are now able to remain on the Living at Home Waiver with income up to 300% above of the SSI FBR. This has significantly reduced the number of individuals who have to transfer out of the LAH waiver. The statewide reserved capacity has been reduced accordingly to 15 slots.
The proposed demonstration area for this waiver is estimated to cover 50% percentage of the state's total need; therefore, 8 slots are reserved in this waiver for this category of enrollees. The remainder of necessary state capacity is reserved in the ID waiver.

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

Waiver Year	Capacity Reserved
Year 1	8
Year 2	8
Year 3	8
Year 4	8
Year 5	8

Appendix B: Participant Access and Eligibility

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

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

Children in State Care/Custody

Purpose *(describe):*

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

Describe how the amount of reserved capacity was determined:

The number of children entering from this source has been consistent for several years, averaging 25/year statewide. The proposed demonstration area for this waiver is estimated to cover 50% percentage of the state's total need; therefore, 12 slots are reserved in this waiver for this category of enrollees. The remainder of necessary state capacity is reserved in the ID waiver.

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

Waiver Year	Capacity Reserved
Year 1	12
Year 2	12
Year 3	12
Year 4	12
Year 5	12

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:

Standard Operating Procedures for enrolling functionally and financially eligible individuals into this waiver have been developed and involve the use of the following steps and enrollment priority categories, consistent with the goals of this waiver, the overall Community Waiver program of which this waiver is part, and the state legislature's intent in funding the Community Waiver program including this waiver:
Enrollment Priority Category #1: On waiting list, live in demonstration area where this waiver is operating, age 22+ (no access to birth-to-three, public school/special education, EPSDT, ADRS pre-employment transition services); goal to preserve current family/independent living situation *and* goal to obtain/maintain competitive integrated employment if under age 65.
Enrollment Priority Category #2: On waiting list, live in demonstration area where this waiver is operating, age 22+ (no access to birth-to-three, public school/special education, EPSDT, ADRS pre-employment transition services); goal to preserve current family/independent living situation.
Enrollment Priority Category #3: Not on waiting list but apply through ADMH/DDD, live in demonstration area where this waiver is operating, age 22+ (no access to birth-to-three, public school/special education, EPSDT, ADRS pre-employment transition services); goal to preserve current family/independent living situation *and* goal to obtain/maintain competitive integrated employment if under age 65.
Enrollment Priority Category #4: Not on waiting list but apply through ADMH/DDD, live in demonstration area where this waiver is operating, age 22+ (no access to birth-to-three, public school/special education, EPSDT, ADRS pre-employment transition services); goal to preserve current family/independent living situation.
Enrollment Priority Category #5: On waiting list; live in demonstration area where this waiver is operating; transition age 16-21 (EPSDT, public education/special education, ADRS pre-employment transition services still available); goal to preserve current family/independent living situation *and* goal to obtain/maintain competitive integrated employment at exit from high school.
Enrollment Priority Category #6: Not on waiting list but apply through ADMH/DDD; live in demonstration area where this waiver is operating; transition age 16-21 (EPSDT, public education/special education, ADRS pre-employment transition services still available); goal to preserve current family/independent living situation *and* goal to obtain/maintain competitive integrated employment at exit from high school.
Additional enrollment priority categories will be developed, with stakeholder input and as needed, if slots remain after the above categories are implemented.

Reserve capacity slots are available to enroll any functionally and financially eligible individual into this waiver, who lives in the demonstration area where this waiver is operating, when that individuals makes him/herself known to ADMH/DDD and is determined to meet the definition of a reserve capacity category.

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:

435.110- Parents and Other Caretaker Relatives- MAGI pdf S25 435.116- Pregnant Women- MAGI pdf S28
435.118- Infants and Children under Age 19 – MAGI pdf S30
435.227- Children with Non IV-E Adoption Assistance MAGI pdf S53 435.150- Former Foster Care pdf S33
435.110 Attachment 2.2A pg 1
435.145 Attachment 2.2A pg 14
435.222 Reasonable Classification of Individuals under Age 21- pdf S52, S11
435.134
435.135
435.137
435.138

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

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

Select one:

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

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

Specify percentage:

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

Specify dollar amount:

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

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

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

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

Select one:

○ **100% of FPL**

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the period beginning January 1, 2014 and extending through September 30, 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 that is placed in a miller trust.

○ **The following dollar amount**

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

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

Specify:

○ **Other**

Specify:

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

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

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

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

Specify:

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

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

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

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

Specify:

○ **Other**

Specify:

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

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

Select one:

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

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

○ **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time 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 includes income that is placed in a miller trust.
- ( ) **The following dollar amount**

  Specify dollar amount: [ ] If this amount changes, this item will be revised.
- ( ) **The following formula is used to determine the needs allowance:**

  Specify:

○ **Other**

Specify:

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

○ **Not Applicable**

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

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 that is placed in a miller trust.

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

Select one:

- ◉ **Allowance is the same**
- ○ **Allowance is different.**

  Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR § 435.726 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: 1

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

○ **The provision of waiver services at least monthly**

◉ **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

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

Quarterly.

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:

A QIDP employed by the Operating Agency's Regional Office makes the determination of eligibility and level of care. The QIDP qualifications are as follows: Master's degree in Social Work, Psychology, or a human services field, plus experience (24 months or more) in a human services field, OR Bachelor's degree in Social Work, Psychology, or a human services field, plus considerable experience (48 months or more) working specifically with persons with intellectual and/or developmental disabilities, or extensive experience (72 months or more) in a human services field. QIDPs performing these evaluations also must complete training on the eligibility determination and level of care instrument(s) used by the Operating Agency.

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

Level of Care requires documentation of a full-scale IQ of 72 and below; a diagnosis of Intellectual Disabilities with an age of onset prior to age 22, and significant functional limitations in three of six areas of life activities (Self Care; Receptive and Expressive Language; Learning; Mobility; Self Direction; Capacity for Independent Living). The full-scale IQ is obtained from a psychological evaluation, and the age of onset is obtained, if not from the evaluation, from ancillary documentation such as a previous psychological or school record. The limitations in adaptive functioning are determined from the ICAP (Inventory for Client and Agency Planning, Riverside Press) completed by a Regional Office QDDP. If necessary to support a conclusive determination, an Adaptive Behavior Scale (ABS) will be required, but only when maladaptive behavior appears to be the only factor causing the ICAP to qualify an otherwise borderline individual. Although persons as young as three years of age can be admitted to the waiver, available state plan and EPSDT services must be utilized for all participants who are under 21 years of age. For a new applicant for waiver services, in the event that a qualifying evaluation is not possible, and substantiating documentation of all eligibility criteria is not available, the State will accept, on a case-by-case basis, limited sources of substantiated data, including the most recent IQ test prior to age 22 with an IQ score of 72 and below, an ID diagnosis without an adaptive assessment prior to age 22, or a physician's statement verifying an ID diagnosis prior to age 22 that directly causes an adaptive impairment. Persons that qualify for the expansion are eligible to be served in an ICF/IID if they choose to do so. An individual requires ICF/IID level of care after verification the individual has: 1. a diagnosis of an intellectual disability or a closely related condition as defined in 42 CFR §435.1010; 2. a significant impairment in adaptive behavior and requires training and support similar to an individual with an intellectual disability (only required if the individual is qualifying based on a closely related condition); and 3. substantial functional limitations in three or more areas of major life activity, as identified by CMS in the definition of persons with related conditions in 42 CFR §435.1010 (self-care; understanding and use of language; learning; mobility; self-direction; and capacity for independent living.)

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

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

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

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

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:

Evaluation:
An individual wishing to apply for waiver services contacts the Call Center to start the process. The person is then referred to the local 310 Board which assists the individual to complete the application and gather/complete the necessary information for determination of eligibility and level of care. The application and supporting information are then submitted to the Operating Agency's Regional Office Waiting List Coordinator (qualified QIDP) for determination of eligibility and level of care. 310 Board staff are trained by the Operating Agency to administer the ICAP and are monitored by the Operating Agency to ensure validity and reliability.

The Operating Agency's Regional Office Waiting List Coordinator (qualified QIDP) processes applications for enrollment in the Community Waiver. Either the Waiting List Coordinator or the Psychological/Behavioral Evaluator (also a qualified QIDP) reviews the application and supporting information to determine eligibility and level of care. If the submitted information is not complete or is inconclusive regarding the type of disabilities of the individual, the Regional Office QIDP will request additional tests/assessments. Notification of need for additional tests, assessments or other information stops the eligibility and level of care determination process until the additional information has been received and intellectual disability can be confirmed. Once confirmed, the Regional Office QIDP reviews the results of all test and assessment information accompanying the application (including the ICAP (ABS if necessary) and a criticality assessment) and makes a final determination of initial eligibility and level of care for individuals seeking Community Waiver services.

Applicants who are determined eligible and meeting level of care criteria are placed on the statewide ID HCBS waiting list. When an enrollment slot exists in the Community Waiver, individuals on the waiting list are contacted by the Regional Office Waiting List Coordinator in order, based on length of time waiting. Using the enrollment priority categories for this waiver discussed in section B.3.f, if a person confirms they meet an eligibility priority category, enrollment is completed. The enrollment process includes education on choice to ensure a person wishes to receive HCBS (signature on Choice Form), education on due process to educate the applicant of his her right to due process (signature on Due Process Rights Form), and completion of the Individual and Family History. The individual also signs an initial PCP that includes Support Coordination and the person is assigned, or as far as possible is able to select, a Support Coordinator. Additional forms are required if the applicant is not already Medicaid eligible.

Reevaluations:
Annual re-evaluations must include, along with the Comprehensive Assessment, Person-Centered Plan, information to re-determine eligibility and level of care:
(a) Written reference to and update of the original psychological evaluation which documented the applicant's intellectual disabilities or of a more recent full assessment.
(b) An updated ICAP completed by the Support Coordinator who is trained by the Operating Agency to administer the ICAP and are monitored by the Operating Agency to ensure validity and reliability.
(c) An annual medical report must be on file.
(d) An Individual and Family History updated within 90 days of re-evaluation.

A QIDP from the Operating Agency's Regional Office reviews the required documentation and submits the finding regarding waiver redetermination of eligibility and level of care to the Central Office of the Operating Agency. Central Office submits the information electronically to AL Medicaid's fiscal intermediary to maintain the person in the long-term care system as a recipient of waiver services and retrieves the enrollment dates. This reevaluation is good for 12 full months and then reevaluation of eligibility and level of care must occur.

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

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**

Specify the other schedule:

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

- (●) **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ( ) **The qualifications are different.**
  Specify the qualifications:

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

The initial Level of Care Evaluation is effective for 12 full months, but then Level of Care must be re-evaluated. Without re-evaluation and corresponding electronic resubmission and registration, claims for subsequent service dates will fail. Support Coordinators and Regional Office QIDPs maintain a schedule for when they have to submit eligibility redetermination and Level of Care re-evaluation packets in order to assist individuals to remain eligible for the waiver.

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

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

Records are maintained by the Operating Agency's Regional Offices.

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:
 # and % of participants who have a level of care(LOC) evaluation/an Assessment of Need for the 1115 Group 5 eligibility completed prior to entry into the HCBS waiver/1115 Group 5. % = NUMERATOR[# of participants who have a level of care (LOC) evaluation/an Assessment of Need for 1115 Group 5 eligibility completed prior to entry into the HCBS waiver / 1115 Group 5]/DENOMINATOR[# 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:
 # & % of applicants for whom there is reasonable indication that services may be needed in the future who have a LOC evaluation completed/ an Assessment of Need for 1115 Group 5. %=N[#applicants for whom there is reasonable indication that services may be needed in the future who have a level of care evaluation completed/an Assessment of Need for 1115 Group 5 eligibility]/...

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
cntnd from above...D[# 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	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. ***Sub-assurance: The 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:
 # & % LOC/initial Assessment of Need for 1115 Group5 eligibility determinations where the LOC/1115 Group5 instruments & processes were appropriately applied & according to the approved description in the approved waiver/1115 Group5 needs criteria % =N[#LOC/initial Assessment of Need for 1115 Group5 eligibility determinations where the LOC/1115 Group5 instruments & processes were appropriately..

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
..applied & according to the approved description in the approved waiver/1115 Group 5]/D[#LOC/initial Assessment of Need for 1115 Group 5 eligibility determinations] Initial Assessment of Need

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

Data Aggregation and Analysis:

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

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

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 Operating Agency trains and monitors 310 Board personnel and Support Coordinators responsible for completing level of care assessments (ICAPs). Monitoring includes, on a quarterly basis, random sampling of ICAPs completed by trained individuals, to evaluate for validity and inter-rater reliability, and observation, on a quarterly basis, of a sample of trained individuals completing the ICAP process.

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.

Individual problems regarding performance of level of care evaluations and 1115 Group 5 evaluations of need are currently handled by Regional Office staff of the Operating Agency. Resolution of these problems involves, as appropriate, re-training, enhanced monitoring for a period of time, a performance improvement plan, corrective action plan or other appropriate action steps. There is no Medicaid funding paid for someone not in active status with the Medicaid Fiscal Agent as of the date of service and no individual will be enrolled without a LOC, so there is never an issue of payments made incorrectly.

The Regional Office has designated staff (QIDPs) trained and experienced in administering LOC instruments and who are trained on the strategies employed by the state to discover/identify problems/issues and trained to review all supporting documentation that feeds into the level of care evaluation. An assessment in the information system will capture review results. A report will aggregate the data results to reveal patterns where success is less than 86%. Intervention, in general, will consist of:

a. Bringing the data to the attention of the 310 Board staff and/or Support Coordinators responsible for the discovered areas of weakness.

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

c. If no improvement is seen in the next quarter after the intervention, a performance improvement plan or corrective action plan will be required. The regional offices will ensure that any designated QIDPs who do not demonstrate full competence following implementation of the corrective action plan will not be allowed to perform LOC evaluations thereafter, until and unless the QIDP can demonstrate full competence.

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**

Responsible Party*(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:

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

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

As part of initial and annual assessment, person-centered planning and updating of the PCP, participants (and their legal representatives, if applicable) are provided with adequate information on the full range of services available under the Community First Waiver program, the services offered through Support Coordination and through other generic programs and public systems with which Waiver services are coordinated. Rights protections and opportunities assured through the HCBS Settings Rule are explained including the choice of settings where services can be delivered. This process enables the individual (and their legal representative if applicable) to make an informed decision regarding the choice to receive home and community-based services. This process may also include opportunities to meet and talk with Waiver service providers and sharing of information on satisfaction with Waiver services among those already enrolled in the Waiver. All individuals are provided choice among service providers in the area. If any needs cannot be met, these also are discussed with the individual and his family to ensure they are fully informed and are aware of other ways to get these needs met, if such alternatives exist. Individuals indicate they have received this information by signing the Freedom of Choice form.

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

Each person enrolled in the Waiver must indicate in writing their choice of institutional or home and community-based services, which will remain in effect until such time as the client changes his/her choice. The only exception to making a written choice would occur when the person is not capable of signing (or making his/her mark) on the Freedom of Choice and PCP form and has no legal or responsible party who can sign. In such a case, the Support Coordinator must document the reason(s) for absence of a signed Freedom of Choice and PCP form and attest to the above process having been undertaken with the person.

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

Records are maintained by the Operating Agency's Regional Offices.

Appendix B: Participant Access and Eligibility

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

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

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

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	**Breaks and Opportunities (Respite)**		
Statutory Service	**Community-Based Residential Services**		
Statutory Service	**Integrated Employment Path Services**		
Statutory Service	**Personal Assistance - Home**		
Statutory Service	**Support Coordination**		

Service Type	Service		
Other Service	Adult Family Home		
Other Service	Assistive Technology and Adaptive Aids		
Other Service	Co-Worker Supports		
Other Service	Community Integration Connections and Skills Training		
Other Service	Community Transportation		
Other Service	Family Empowerment and Systems Navigation Counseling		
Other Service	Financial Literacy and Work Incentives Benefits Counseling		
Other Service	Housing Counseling Services		
Other Service	Housing Start-Up Assistance		
Other Service	Independent Living Skills Training		
Other Service	Individual Directed Goods and Services		
Other Service	Minor Home Modifications		
Other Service	Natural Support or Caregiver Education and Training		
Other Service	Occupational Therapy		
Other Service	Peer Specialist Services		
Other Service	Personal Assistance-Community		
Other Service	Physical Therapy		
Other Service	Positive Behavior Supports		
Other Service	Remote Supports		
Other Service	Skilled Nursing		
Other Service	Speech and Language Therapy		
Other Service	Supported Employment Individual		
Other Service	Supported Employment Small Group		
Other Service	Supported Living 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:

Respite

Alternate Service Title (if any):

Breaks and Opportunities (Respite)

HCBS Taxonomy:

Category 1:

09 Caregiver Support

Sub-Category 1:

09011 respite, out-of-home

Category 2:

09 Caregiver Support

Sub-Category 2:

09012 respite, in-home

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

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

Service Definition *(Scope):*

Enrollment Group(s): Essential Family Preservation Supports
Seamless Transition to Adulthood Supports
Family, Career and Community Life Supports

Definition:
A service provided to a waiver participant that lives with family or other natural supports who are providing support, care and supervision to the waiver participant. The Breaks and Opportunities service is provided for time-limited periods when the family or other natural supports are temporarily unable to continue to provide support, care and supervision to the waiver participant. This service can be provided in the waiver participant's home or the pre-approved private home of the Breaks and Opportunities service provider. The Breaks and Opportunities service is provided with two equally important goals which include: (1) sustaining the family/natural support living arrangement and support-giving arrangement; and (2) providing the waiver participant with opportunities to continue his/her regular activities and relationships and/or to explore new opportunities and meet new people with the Breaks and Opportunities service provider.

This service is provided during specific periods of time in a day, week or month when the unpaid family/natural support-givers typically provide support, care and supervision to the waiver participant. This service is provided in a way that ensures the individual's typical routine and activities are not disrupted and the individual's goals and needs, as set forth in the PCP, are attended to without disruption.

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

- This service shall be limited to 30 days of service per person per calendar year or to 216 hours per person per calendar year, depending on the needs and preferences of the individual as reflected in the Person-Centered Plan. (The 2 limits cannot be combined in a calendar year.) If hours are elected, no more than 8 hours can be used on a calendar day.
- This service shall be provided in non-institutional settings that meet the federal HCBS regulatory standards and which promote community involvement and inclusion. Breaks and Opportunities may not be provided in a group home of more than four (4) beds. Group homes are considered the most restrictive, least integrated setting option for this service.
- This service may be authorized to cover specific periods of time when a primary caregiver is temporarily unable to continue to provide support, care and supervision to the waiver participant.
- This service is typically scheduled in advance, but it can also be provided in an unexpected situation. If the unexpected situation is a crisis, this service is used to allow time and opportunity for assessment, planning and intervention in order to prevent the loss of the family/natural support living arrangement and support-giving arrangement as the first priority. If all efforts and strategies to sustain the family/natural support living arrangement and support-giving arrangement have been exhausted and have proven unsuccessful, this service can be used to identify and establish an alternative living arrangement for the waiver participant, focusing on the least restrictive, most integrated living arrangement possible while ensuring institutionalization can be avoided.
- The relief needs of paid direct support staff, including staff hired through self-direction, who are not family or natural support-givers will be accommodated by staffing substitutions and/or service delivery schedule adjustments; but not by this service. Respite cannot be used to provide replacement staffing when a paid direct support worker cancels. Respite can only be used to provide a replacement for natural supports who are providing unpaid support to the participant.
- With relevant substantiating documentation and DDD central office approval, a Community Services Director (CSD) may authorize services in excess of the benefit limit, if the benefit limit has been exhausted in a waiver year, as a cost-effective alternative to other medically necessary covered benefits, transition to an enrollment group with a higher expenditure cap, or to avoid institutional placement.

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	Respite Worker
Agency	DDD Certified Provider Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Breaks and Opportunities (Respite)

Provider Category:

Individual

Provider Type:

Respite Worker

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

None

Other Standard *(specify):*

Age 18;
Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense;
Must pass a pre-employment drug screen;
TB skin test as required by Alabama Medicaid Agency;

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).An individual respite worker can be hired through the FMSA or through a provider agency approved to provide this service.

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Breaks and Opportunities (Respite)

Provider Category:

Agency

Provider Type:

DDD Certified Provider Agency

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

DDD Provider Certification

Other Standard *(specify):*

The Executive Director/owner/operator must possess a Bachelor's degree from an accredited institution in Public Health, Special Education, Social Work, Business Administration, Public Administration, Psychology, or other Human Services field, or must be a Registered Nurse.

The Executive Director/owner/operator must possess, or be eligible to qualify for, licensure or certification in their particular field, if applicable.

The Executive Director/owner/operator must have considerable experience (5 or more years) working with individuals with intellectual and developmental disabilities in community settings.

The Agency must be Certified Community Provider in good standing with DDD including:

No placement on Provisional status within the past 24 months; and no substantiated findings of abuse, neglect, mistreatment or exploitation within the past 12 months.

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

Community-Based Residential Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02031 in-home residential habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Enrollment Group(s): Supports to Sustain Community Living
Unit of Authorization: Per Day

Definition:
Community-Based Residential Services enable an individual to avoid institutionalization and live in a community setting that provides services to:

- Support the person's maximum independence, autonomy and full integration in their community;
- Ensure each person's rights and abilities to make choices; and
- Support each person in a manner that complies fully with HCBS Settings Rule standards, including standards for provider-owned or controlled homes.

Community-Based Residential Services are provided for up to four individuals in a dwelling which may be rented, leased, or owned by the provider. The person has the right to a legally enforceable lease or rental agreement with the provider that offers the same appeal rights and eviction protections as is required under state landlord-tenant law.
This service offers individualized services and supports that enable the person supported to acquire, retain, and improve skills necessary to reside in the least restrictive residential setting possible. The setting in which the service is provided must be an ADMH-certified, community-based residential setting which supports each person's independence and full integration into the community and ensures each person's basic needs (e.g., food, clothing, etc.), choice, rights, safety and security.
Community-Based Residential Services provide care, supervision, and skills training in activities of daily living, home management and community integration.
The service includes the following:

- Assistance, including hands-on assistance only as needed by the individual, with activities of daily living as needed, such as bathing, dressing, personal hygiene and grooming, eating, toileting, transfer, and mobility;
- Training focused on enabling the person to acquire, retain, or improve skills needed for independently performing activities of daily living;
- Assistance, including hands-on assistance only as needed by the individual, with instrumental activities of daily living such as household chores, meal planning, shopping, preparation and storage of food, and managing personal finances;
- Training focused on enabling the person to acquire, retain, or improve skills needed for independently performing instrumental activities of daily living;
- Overseeing/assisting with managing self-administered medication and/or medication administration, as permitted under Alabama's Nurse Practice Act;
- Performing other non-complex health maintenance tasks, as needed and as permitted by state law;
- Scheduling and attending appropriate medical services appointments with transportation reimbursement through Non-Emergency Medical Transportation under the Medicaid State Plan;
- Assistance with achievement of health and wellness goals and related activities;
- Managing acute or chronic health conditions, including nurse oversight and monitoring, and skilled nursing services, only as needed, for routine, ongoing health care tasks, such as blood sugar monitoring and management, oral suctioning,

tube feeding, bowel care, etc.;

- Travel training and support and/or assistance with arrangement of transportation by a third party, and/or provision of transportation as needed by the individual to support the person's employment and community involvement, participation and/or contribution;
- Assistance with building interpersonal and social skills through assistance with planning, arranging and/or hosting social opportunities with family, friends, neighbors and other members of the broader community with whom the person desires to socialize;
- Developing and maintaining positive relationships with neighbors;
- Assistance to participate fully in community life, including faith-based, social, and leisure activities selected by the person;
- Coordinating with other service providers for the person if the person is receiving other services, regardless of funding source, to pursue employment or educational goals and opportunities;
- Assistance with exercising civil and statutory rights (e.g. voting);
- Implementation of behavioral support plans developed by a qualified behavioral specialist;
- Ensuring home and community safety is addressed including emergency preparedness planning;
- Assistance with effectively using police, fire, and emergency help available in the community to the general public;
- Supervision and companionship only if needed by the individual.

All individual goals/objectives for Community-Based Residential Services, along with a description of needed services and supports to achieve them, shall be established via the Person-Centered Planning process and documented in the Community-Based Residential Services Plan. The Community-Based Residential Services Plan and the corresponding goals/objectives, must consider:

- The person's current level of independence
- Ability to utilize technology
- Ability to rely on natural supports
- Other services the person may be receiving regardless of funding source

A fraction of this service may be delivered remotely via remote supports/monitoring if: (1) appropriate for the participant as determined by the PCP team; (2) if all requirements for this service as outlined in this service definition are met; and (3) all requirements in Appendix C-1-d are met. In these situations, the provider of this service is expected to contract with a remote support/remote monitoring provider that is paid for its technology and services by the service provider. On a case-by-case basis, ADMH staff will evaluate the provider's use of remote support/remote monitoring with a participant(s) to determine the impact on the provider's cost to deliver the service and determine if a rate adjustment is needed.

If the person-centered planning team, in collaboration with the provider, determine that use of remote supports for overnights is appropriate, this will be documented in the person-centered plan and Community-Based Residential Services Plan. The provider is responsible for contracting with and paying a remote supports vendor that otherwise meets the qualifications and requirements for providing the Remote Supports service included this waiver. The authorization for Community-Based Residential Services and rate paid to the provider will reflect the use of overnight remote supports.

Training, mentoring and supervision of the provider's direct support staff shall ensure the staff is prepared to carry out the necessary support and training functions to achieve the goals in the Community-Based Residential Services Plan, which supports the individual to have the lifestyle, routine and opportunities they desire. Progress toward these goals will be documented by the provider, with corresponding adjustments to the Plan implemented accordingly, as determined by the person and his/her Person-Centered Planning team.

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

- The provider's home must be integrated in the greater community and not isolate the person from the opportunity to interact with members of the broader community and participate fully in community life. The provider shall ensure they meet all of the requirements of the HCBS Settings Rule which includes but is not limited to supporting full access to the greater community, opportunities to 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.
- A person receiving Community-Based Residential services shall not be eligible to receive Personal Assistance-Home, Independent Living Skills Training, Personal Assistance-Community, Adult Family Home or Breaks and Opportunities

(Respite) as separate services.

- Community Integration Connections and Skills Training shall not duplicate any supports included as part of Community-Based Residential services.
- Transportation: Medical and non-medical transportation support will be determined as part of the assessment process. Medical transportation is covered separate from the waiver under Non-Emergency Medical Transportation available through the Medicaid State Plan. Transportation covered under this service may not duplicate transportation provided through the Community Transportation service. If individual non-medical transportation needs exceed a 20-mile radius and more than five trips per month, this would be considered excessive transportation and can be captured as such on the assessment. Service workers may transport consumers in their own vehicles as an incidental component of this service.
- Family members (i.e., parents, grandparent, siblings, children, or spouse, whether the relationship is by blood, marriage or adoption) are not eligible providers of Community-Based Residential services.
- As a part of the Person-Centered Plan, the Community-Based Residential services must be reviewed at least semi-annually, or more frequently, in the event of changes in needs or circumstances that require changes to the Community-Based Residential Services Plan.
- Community-Based Residential services shall be provided in a manner which ensures the person's rights of privacy, dignity, respect, and freedom from coercion and restraint. Any rights restrictions must be implemented in accordance with DMH/DDD policy, Federal Law 42 CFR 441.301(a)(2)(xiii), and procedures for rights restrictions.
- Reimbursement for this service does not include the cost of maintenance of the dwelling.
- The person's appropriate portion of room and board expenses shall be paid by the person supported and, as applicable, other residents of the home, through mutual agreement.
- The provider shall provide and execute with the person, a legally enforceable lease or rental agreement that meets HCBS Settings Rule standards.

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	Certified DDD Provider
Individual	Direct Support Personnel

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Community-Based Residential Services

Provider Category:

Agency

Provider Type:

Certified DDD Provider

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

DDD Provider Certification

Other Standard *(specify):*

The Executive Director/owner/operator must possess a Bachelor's degree from an accredited institution in Public Health, Special Education, Social Work, Business Administration, Public Administration, Psychology, or other Human Services field, or must be a Registered Nurse.

The Executive Director/owner/operator must possess, or be eligible to qualify for, licensure or certification in their particular field, if applicable.

The Executive Director/owner/operator must have considerable experience (5 or more years) working with individuals with intellectual and developmental disabilities in community settings.

The Agency must be Certified Community Provider in good standing with DDD including:

No placement on Provisional status within the past 24 months; and no substantiated findings of abuse, neglect, mistreatment or exploitation within the past 12 months.

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Community-Based Residential Services

Provider Category:

Individual

Provider Type:

Direct Support Personnel

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

None

Other Standard *(specify):*

Age 18;
Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense;
Must pass a pre-employment drug screen;
TB skin test as required by Alabama Medicaid Agency;

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

Integrated Employment Path Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03010 job development
Category 2:	**Sub-Category 2:**
04 Day Services	04010 prevocational services
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Service Title: Integrated Employment Path Services

Enrollment Group(s): Seamless Transition to Adulthood Supports
Family, Career and Community Life Supports
Supports to Sustain Community Living

Definition:
The provision of time-limited learning and work experiences, including volunteering opportunities, where a person can develop general, non-job-task-specific strengths and skills that contribute to employability in individualized integrated employment or self-employment. Services are expected to specifically involve strategies that facilitate a participant's successful transition to individualized integrated employment or self-employment.
Persons receiving Integrated Employment Path Services must have a desire to obtain some type of individualized integrated

employment or self-employment and this goal must be documented in the PCP as the goal that Integrated Employment Path Services are specifically authorized to address.

Services should be customized to provide opportunities for increased knowledge, skills and experiences specifically relevant to the person's specific individualized integrated employment and/or self-employment goals and career goals. If such specific goals are not known, this service can also be used to assist a person to identifying his/her specific individualized integrated employment and/or self-employment goals and career goals.

The expected outcome of this service is measurable gains in knowledge, skills and experiences that contribute to the individual achieving individualized integrated employment or self-employment, including (but not limited to):

- Ability to communicate effectively with supervisors, co-workers and customers;
- Generally accepted community workplace conduct and dress;
- Ability to follow directions;
- Ability to attend to tasks;
- Workplace problem solving skills and strategies; and
- General workplace safety and mobility training.

This service is limited to no more than one year. One extension of up to one year can be allowed only if the person is actively pursuing individualized integrated employment or self-employment in an integrated setting and has documentation that a service(s) (i.e. ADRS Individualized Plan for Employment in place or Job Development or Self-Employment Start-Up funded by the Waiver) is concurrently authorized for this purpose. The one-year extension may be repeated only if a person loses individualized integrated employment or self-employment and is seeking replacement opportunities.

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

- Integrated Employment Path Services shall not be provided or reimbursed if the person is receiving Job Coaching (for individualized integrated employment or self-employment), Co-Worker Supports or is working in individualized integrated employment or self-employment without any paid supports. Integrated Employment Path Services are only appropriate for individuals who are not yet engaged in individualized integrated employment or self-employment.
- The provider is expected to conduct this service in integrated, non-disability-specific business, industry or community settings that meet all HCBS setting standards and do not isolate participants from others who do not have disabilities. These settings cannot be provider-owned, leased or operated settings.
- Transportation of the person to and from this service is not included in the rate paid for this service.
- This service will not duplicate other services provided through Medicaid state Waiver plan services and may not be billed for during the same period of time (e.g., the same hour) as other such services.
- The combination of services the person is eligible to receive that occur outside of the home and in the broader community shall be limited to a combined maximum of 40 hours per week. Expenditure caps also apply. Depending on enrollment group and age, the services the person is eligible to receive that occur outside of the home may include Supported Employment-Individual services, Supported Employment — Small Group, Community Integration Connections and Skills Training, and/or Personal Assistance-Community.
- The Waiver will not cover services which are otherwise available to the person under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.). If this service is authorized, documentation is maintained that the service is not available to the person under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

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	DDD Certified Provider
Individual	Job Coach

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Integrated Employment Path Services

Provider Category:

Agency

Provider Type:

DDD Certified Provider

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

DDD Provider Certification

Other Standard *(specify):*

Employs a program manager who will supervise DSPs providing these services and who is qualified to provide Supported Employment services by holding a CESP, ACRE or Customized Employment certification, or other qualification pre-approved by DMH/DDD, and who has at least two (2) years' experience providing Supported Employment or similar employment services.

The Executive Director/owner/operator must possess a Bachelor's degree from an accredited institution in Public Health, Special Education, Social Work, Business Administration, Public Administration, Psychology, or other Human Services field, or must be a Registered Nurse.

The Executive Director/owner/operator must possess, or be eligible to qualify for, licensure or certification in their particular field, if applicable.

The Executive Director/owner/operator must have considerable experience (5 or more years) working with individuals with intellectual and developmental disabilities in community settings.

The Agency must be Certified Community Provider in good standing with DDD including:

No placement on Provisional status within the past 24 months; and no substantiated findings of abuse, neglect, mistreatment or exploitation within the past 12 months.

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Integrated Employment Path Services

Provider Category:

Individual

Provider Type:

Job Coach

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

See Other

Other Standard *(specify):*

Age 18;
Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense;
Must pass a pre-employment drug screen;
TB skin test as required by Alabama Medicaid Agency;

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Personal Assistance - Home

HCBS Taxonomy:

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

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

Service Definition *(Scope):*

Enrollment Group(s): Essential Family Preservation Supports
Seamless Transition to Adulthood Supports
Family, Career and Community Life Supports
Supports to Sustain Community Living

Definition:
A range of services and supports designed to complement but not supplant natural supports and assist an individual with a disability to perform, in his/her home, activities of daily living, including instrumental activities of daily living that the individual would typically do for themselves if they did not have a disability. Personal Assistance-Home services are provided in the person's home and outside the home on the property where the home is located. Participant goals and support needs, as documented in the Person-Centered Plan, shall be addressed by the Personal Assistance-Home provider in a manner that supports and enables the individual to acquire, retain and maximize skills and abilities to achieve the highest level of independence possible.

Personal Assistance-Home may be used to support the person in preparing for competitive integrated employment (i.e. getting ready for work) and in being transported to this employment.
Eligible Personal Assistance-Home services include the following:

- Assistance, support and partial participation, as appropriate to the individual, with eating, toileting, personal hygiene and grooming, dressing and other activities of daily living or instrumental activities of daily living, as appropriate and needed to sustain community living.
- Meal preparation, homemaker tasks, and home chore services, specific and necessary for the waiver participant, involving the waiver participant to the greatest extent possible; other instrumental activities of daily living (e.g. assistance with managing finances (when not managed by a representative payee, legal guardian, financial power of attorney); home-based support for communication including phone, internet use); and other appropriate activities falling under instrumental activities of daily living, as described in the participant's Person-Centered Plan.

Services, if needed, to support goals and needs related to instrumental activities of daily living that occur outside the home (e.g. shopping; banking), competitive integrated employment and community participation, involvement and contribution must also be addressed in the Person-Centered Plan using Personal Assistance-Community, other appropriate services, or available natural supports. Natural supports must be documented in the Person-Centered Plan and confirmed by the Support Coordinator. This service may not be used to cover the cost of rental or purchase of furnishings, purchased maintenance services, home maintenance equipment or supplies, and utilities.

Training:

There are no requirements for a certain number of training hours for agency or self-directed workers. There is a state-sponsored course that must be completed by agency workers. For continuing education, only state-sponsored Incident Prevention and Management Training is required for all workers.

Note: The State does not maintain a listing of qualified PCA/PCS staff that is made available to individuals and families for this waiver.

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

● This service never replaces natural supports available to the waiver participant but rather augments these natural supports, as needed, to ensure these natural supports can continue to be sustained over time.
● The services under the CWP waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.
● This service is not available when another covered service is being provided and the assistance available through Personal Assistance-Home is a component part of this covered service. Support Coordinator monitors will review service delivery records to ensure that Personal Assistance-Home is not delivered concurrent with Employment Supports, Breaks and Opportunities (Respite), Supported Living Services, Adult Family Home, or Community-Based Residential Services.
● Authorization based on individual assessment results which account for the availability of sustainable natural supports; 243 hours/month (972 units) maximum and expenditure cap for enrollment group also applies.

● Using self-direction, this service can be provided by a natural caregiver(s) or relative(s) living in the same residence with the person if all of the following are true:
o The participant is twenty-one (21) years of age or older;
o A relative, including a legal liable relative, and/or a legal guardian may serve as a personal assistance- home self-directed worker as long as the 1) the relative/legal guardian is otherwise qualified to provide these services and 2) the relative/legal guardian does not also serve as the same participant's representative/Employer of Record (EOR).The FMSA shall ensure these requirements are documented.

If the above requirements are met, this service shall not supplant natural supports provided by the natural caregiver(s) or relative(s) living in the same residence with the person. To ensure such natural supports are not supplanted, the following limitations apply to Personal Assistance-Home, when provided by a natural caregiver(s) or relative(s) living in the same residence with the person:
o Actual units authorized shall be based on Personal Care Assessment results
o Exception: If all natural caregivers or relatives living in the same residence with the person are disabled, infirmed, or age 65 or older, Personal Assistance-Home that is self-directed may be provided by both natural caregiver(s) or relative(s) living in the same residence with the person (who meet the above requirements) and a worker(s) employed through self-direction. ADMH/DDD Administrative Code 580-5-30 (Chapter 580-5-30.pdf) defines natural supports as unpaid services by family, friends, community entities, groups and other community networks. If a person lives with another person (i.e. natural support or relative) and the roommate/partner/relative is unwilling or unable to provide care (i.e. they work outside the home), or the waiver participant does not want them to be a caregiver, the participant may access the full number of hours their Personal Care Assessment determines is needed by utilizing a provider other than the natural support(s) they live with.
● With relevant substantiating documentation and DDD central office approval, a Community Services Director (CSD) may authorize services in excess of the benefit limit (for up to 90 days) as a cost-effective alternative to institutional placement, other medically necessary covered benefits, or transition to an enrollment group with a higher expenditure cap. Reauthorization for additional periods of time is possible with re-assessment and CSD and DDD central office approval.

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	Personal Assistance Worker

Provider Category	Provider Type Title
Agency	DDD Certified Provider Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Assistance - Home

Provider Category:

Individual

Provider Type:

Personal Assistance Worker

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

None

Other Standard *(specify):*

Self-Directed workers must:

i. Be at least age 18;
ii. Pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense;
iii. Pass a pre-employment drug screen;
iv: Complete a TB skin test as required by Alabama Medicaid Agency;

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).

The FMSA shall ensure these requirements are documented. A relative, including a legal liable relative, and/or a legal guardian may serve as a personal assistance- home self-directed worker as long as the 1) the relative/legal guardian is otherwise qualified to provide these services and 2) the relative/legal guardian does not also serve as the same participant's representative/Employer of Record (EOR).

Supervision:

The EOR is responsible for the supervision, training and general oversight of each Self-Directed Personal Assistance- Home worker.

Training:

The State also requires self-directed workers to complete Incident Prevention and Reporting training prior to serving a participant and annually thereafter through use of a free, state-sponsored online course.

First Aid and CPR certifications and Infection Control training are only required for self-direction workers if the employer of record (EOR) requires these trainings. Training specific to the person and their person-centered plan is provided by the EOR and participant for self-directed workers.

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Services Agency (FMSA)

Frequency of Verification:

Annually;

The EOR is responsible for assuring the minimum qualifications are met prior to submission of the worker application to the FMSA. The FMSA is responsible for conducting the background checks and also verifying minimum hiring qualifications are met. The FMSA checks exclusion lists monthly.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Assistance - Home

Provider Category:

Agency

Provider Type:

DDD Certified Provider Agency

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

DDD Provider Certification

Other Standard *(specify):*

The Executive Director/owner/operator must possess a Bachelor's degree from an accredited institution in Public Health, Special Education, Social Work, Business Administration, Public Administration, Psychology, or other Human Services field, or must be a Registered Nurse.

The Executive Director/owner/operator must possess, or be eligible to qualify for, licensure or certification in their particular field, if applicable.

The Executive Director/owner/operator must have considerable experience (5 or more years) working with individuals with intellectual and developmental disabilities in community settings.

The Agency must be Certified Community Provider in good standing with DDD including:

No placement on Provisional status within the past 24 months; and no substantiated findings of abuse, neglect, mistreatment or exploitation within the past 12 months.

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).

Training:

Agency workers have most of all the required courses offered free-of-charge through state-sponsored learning management systems. This includes Incident Prevention and Reporting training which is required prior to serving a participant and annually thereafter.

First Aid and CPR certifications and Infection Control training are the responsibility of the provider agency (for provider staff). Training specific to the person and their person-centered plan is provided by the agency for agency-employed workers.

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Support Coordination

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Enrollment Group(s):
Essential Family Preservation Supports
Seamless Transition to Adulthood Supports
Family, Career and Community Life Supports
Supports to Sustain Community Living

Definition:
A case management and comprehensive supports/services coordination role involving direct assistance with gaining access to waiver program services that are desired by and selected by the individual, from among available services that are effective options for meeting one or more assessed needs. Support Coordination also involves the effective coordination of waiver program services with other Medicaid-funded services, other publicly-funded services and programs (e.g. ADRS, school, workforce and generic community services), and other generic community services and resources (e.g. social, educational, religious, etc.) available to the individual, and family as applicable, regardless of the funding source.
Support Coordinators are responsible for:

- Conducting a comprehensive assessment of the individual, using both strengths and needs-based assessment tools provided by DDD, in collaboration with the individual and others that know the individual well;
- Engaging with the individual (and legal representative/involved family members, as applicable) to accurately identify

the individual's vision for his/her life and key goals/outcomes the individual wants to achieve;

- Providing education to individuals (and legal representatives/involved family as applicable) about the various services and supports available through the waiver that are effective options for enabling the individual to achieve each of the key goals/outcomes identified by the individual (and legal representative/involved family members, as applicable);
- Providing education to individuals (and legal representatives/involved family as applicable) about the option to self-direct certain services and supports that are available through the waiver;
- Providing education to individuals (and legal representatives/involved family as applicable) about the available providers for each service and support available through the waiver;
- Coordinating a person-centered planning process, consistent with the HCBS Settings Rule requirements, and developing a written person-centered plan (PCP), utilizing a template provided by DDD, which defines and documents:
  - The individual's goals/outcomes desired by the individual as part of his/her vision for a good and full life;
  - The individual's needs related to achieving his/her identified goals/outcomes necessary for achieving his/her vision for a good and full life;
  - The natural supports, other publicly funded supports and other community supports that the individual has available to assist him/her with achieving his/her identified goals/outcomes necessary for achieving his/her vision for a good and full life;
  - The types and amounts of waiver services and supports that are needed, in addition to the natural supports, other publicly funded supports and other community supports that the individual has available to assist him/her, in order to ensure the individual can achieve his/her identified goals/outcomes which are considered necessary for achieving his/her vision for a good and full life;
  - The setting in which the individual chooses to receive each waiver service, chosen from among setting options that are also documented in the PCP, including at least one non-disability specific setting option for each service;
  - The individual's choices regarding the option to self-direct certain services and supports that are included in the PCP;
  - The individual's choice of provider for each service and support included in the PCP that will not be self-directed;
  - Ensuring the person is aware of their rights, including choice of providers. Secures the person's signature on the Free-Choice of Qualified and Contracted Providers form and provides the Due Process Rights Form;
  - Any modification(s) to HCBS Setting Rule requirements that may be necessary consistent with federal requirements for including such modification(s) in the PCP;
- Undertaking ongoing monitoring of the provision, adequacy, quality and effectiveness of waiver services/supports included in the person's PCP and progress toward goals/outcomes documented in the PCP;
- Undertaking ongoing monitoring of the person's health, safety and welfare;
- Providing ongoing support and information, as needed, to individuals (and legal representatives/involved family as applicable) who choose to self-direct certain services and supports that are included in the PCP;
- Coordinating services and supports over time, which preserve the individual's ability to live in a community setting;
- Gathering information and completing evaluations specified by DDD related to continued functional and financial eligibility for the waiver; and
- There is a requirement of at least one (1) face-to-face visit with the person each month during the first twelve (12) months of enrollment and then quarterly after that time period, based on the needs of the individual, in addition to any other Support Coordination activities.

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

- From the person-centered planning process, informed by the requisite assessments, the individual and the SC identify supports and services to address desired goals and outcomes. The individual and Support Coordinator first explore unpaid and natural supports, then supports and services from other systems and programs available to the individual, followed by services and support funded by the waiver program, utilizing waiver funding as the funding source of last resort. When considering waiver services, the Support Coordinator is required to assist the individual in evaluating the waiver services and supports that will most effectively meet the individual's desired goals, outcomes and needs. Support Coordinators are trained to be skilled in explaining services and supports, including those available through generic community resources and other systems and programs.
- Support Coordinators are required to document the individual's goals/outcomes, needs and preferences that are identified through a collaborative review of assessment results and exploratory discussion involving the individual's person-centered planning team. Prior to concluding the PCP development process, Support Coordinators must review their documentation of all of the planning conversations with the individual to ensure the PCP meets all of the person's identified needs and preferences related to their identified goals and outcomes.
- When an individual chooses not to address one of their needs or preferences on the PCP, the Support Coordinator

discusses this choice with the individual. If the individual elects to not address an identified need or preference through the waiver PCP, this conversation must be documented, including the Support Coordinator's effort to encourage the individual to address the need. In cases wherein the unaddressed need is related to health and safety or presents another type of risk, the Support Coordinator completes the document, "Risk Agreement – Waiver Program" with the individual to document information and resources provided to the individual.

- Support Coordination Supervisors (SCS) are required to ensure that the PCP's developed by their Support Coordinators meet the needs of the individual as required by this waiver and waiver program policy and work instructions.
- Person Centered Plans are subject to continuous revision, as needed. However, at a minimum, the PCP is reviewed by the individual and SC during a formal review at least annually. During this time, the individual's progress on the goals and outcomes identified on the previous year's PCP is reviewed as a priority. The individual and Support Coordinator collaborate to ensure the new PCP is an accurate and current reflection of the individual's goals/outcomes and needs related to these goals/outcomes, and that the PCP adequately supports the individual's goals and outcomes with waiver–funded services used to wrap around generic community services and supports and services and supports available through other programs and systems. When the cost of an individual's needs exceed the person's expenditure cap, the Support Coordinator is required to involve their Supervisor to review the PCP and assist the individual, as needed, in completing documentation for approval to exceed the expenditure cap (or receive approval for a one-time emergency expense) to avoid enrollment in an enrollment group with a higher expenditure cap, particularly to avoid residential placement if the person is living with natural supports or living independently.
- Through the SC's monthly and quarterly contacts, the SC will monitor the individual's health and welfare. Progress notes will document the contact and whether the outcomes stated in the person's plan are occurring for the individual and being effectively addressed by the person's providers of waiver services and supports.
- It is also the SC's responsibility to review the provider's submitted documentation at least monthly, and note any problems, concerns, discrepancies, dramatic changes or other occurrences that would indicate a need for review of the provider's performance or the individual's goals/outcomes or needs. The SC's review of the provider documentation will include making further inquiries and taking appropriate action if there is reason to believe the person's health or welfare is potentially at risk and/or if services are not being delivered according to the PCP.
- This service may only be provided by Support Coordinators employed by 310 Boards (in Region II demonstration counties only) and ADMH DDD (in all other Regions/demonstration counties).

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	ADMH DDD
Individual	Support Coordinator
Agency	310 Board

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Support Coordination

Provider Category:

Agency

Provider Type:

ADMH DDD

Provider Qualifications

License *(specify):*

None.

Certificate *(specify):*

None.

Other Standard *(specify):*

Operating Agency

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH

Frequency of Verification:

Ongoing

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Support Coordination

Provider Category:

Individual

Provider Type:

Support Coordinator

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

None

Other Standard *(specify):*

Bachelor’s degrees in human services field. Human Service field includes the following disciplines: Social Work, Psychology, Criminal/Juvenile Justice, Special Education, Sociology, Speech Education, Rehabilitation, Counseling, Speech Pathology, Audiology, Nursing, Physical or Occupational Therapy, and any related academic disciplines associated with the study of Human Behavior, Human Skill Development, or Basic Human Care Needs.

Completion of pre-service training provided or approved by DDD and Alabama Medicaid.

Preference should be given to those with experience working with individuals with intellectual disabilities and/or working in support coordination, case management, or roles with similar responsibilities as detailed in the service definition.

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD

Frequency of Verification:

Initially upon hire

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Support Coordination

Provider Category:

Agency

Provider Type:

310 Board

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

None

Other Standard *(specify):*

The Executive Director/owner/operator must possess a Bachelor's degree from an accredited institution in Public Health, Special Education, Social Work, Business Administration, Public Administration, Psychology, or other Human Services field, or must be a Registered Nurse.

The Executive Director/owner/operator must possess, or be eligible to qualify for, licensure or certification in their particular field, if applicable.

The Executive Director/owner/operator must have considerable experience (5 or more years) working with individuals with intellectual and developmental disabilities in community settings.

Pursuant to the concurrent 1115 authority, the Agency must be a Certified 310 Board serving counties where the Program will operate in Region 2 in good standing with DDD.

The Agency cannot provide any services other than monitoring and service plan development.

No placement on Provisional status within the past 24 months; and no substantiated findings of abuse, neglect, mistreatment or exploitation within the past 12 months.

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Adult Family Home

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02021 shared living, residential habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Enrollment Group(s): Supports to Sustain Community Living

Definition:
A community-based alternative to residential habilitation service that enables up to three persons receiving this service to live in the home of trained host family caregivers (other than the person's own family) in an adult foster care arrangement. In this type of shared living arrangement, the person(s) moves into the host family's home, enabling the person(s) to become part of the family, sharing in the experiences of a family, while the trained family members provide the individualized services that:

- Support each person's independence and full integration in their community;
- Ensure each person's choice and rights; and
- Support each person in a manner that complies fully with HCBS Settings Rule standards, including standards for provider-owned or controlled homes.

Adult Family Home services are individualized based on the needs of each person, as specified in the Adult Family Home Plan and may include supports for any of the following:

- Assistance, including hands-on assistance only as needed by the individual, with activities of daily living as needed, such as bathing, dressing, personal hygiene and grooming, eating, toileting, transfer, and mobility;
- Training focused on enabling the person to acquire, retain, or improve skills needed for independently performing activities of daily living;
- Assistance, including hands-on assistance only as needed by the individual, with instrumental activities of daily living such as household chores, meal planning, shopping, preparation and storage of food, and managing personal finances;
- Training focused on enabling the person to acquire, retain, or improve skills needed for independently performing instrumental activities of daily living;
- Overseeing/assisting with managing self-administered medication and/or medication administration, as permitted under Alabama's Nurse Practice Act;
- Performing other non-complex health maintenance tasks, as needed and as permitted by state law;
- Achieving health and wellness goals as outlined in the Person-Centered Plan;
- Scheduling and attending appropriate medical services appointments with transportation reimbursement through Non-Emergency Medical Transportation under the Medicaid State Plan;

- Managing acute or chronic health conditions, including nurse oversight and monitoring (including via the Skilled Nursing service, as outlined in that service definition), and skilled nursing services, only as needed, for routine, ongoing health care tasks, such as blood sugar monitoring and management, oral suctioning, tube feeding, bowel care, etc.;
- Travel training and support and/or assistance with arrangement of transportation by a third party, and/or provision of transportation as needed by the individual to support the person's employment and community involvement, participation and/or contribution;
- Assistance with building interpersonal and social skills through assistance with planning, arranging and/or hosting social opportunities with family, friends, neighbors and other members of the broader community with whom the person desires to socialize;
- Developing and maintaining positive relationships with neighbors;
- Assistance to participate fully in community life, including faith-based, social, and leisure activities selected by the person;
- Coordinating with other service providers for the person if the person is receiving other services, regardless of funding source, to pursue employment or educational goals and opportunities;
- Assistance with exercising civil and statutory rights (e.g. voting);
- Implementation of behavioral support plans developed by qualified behavioral specialist;
- Ensuring home and community safety is addressed including emergency preparedness planning;
- Assistance with effectively using police, fire, and emergency help available in the community to the general public;
- Supervision and companionship only if needed by the individual.

All individual goals/objectives for Adult Family Home services, along with a description of needed Adult Family Home supports to achieve them, shall be established via the Person-Centered Planning process and documented in the Adult Family Home Service Plan which is made part of the Person-Centered Plan and which determines the specific monthly rate paid for the service. The Adult Family Home Plan and the corresponding goals/objectives, must consider:

- The person's current level of independence
- Ability to utilize technology
- Ability to rely on natural supports
- Other services the person may be receiving regardless of funding source

A fraction of this service may be delivered remotely via remote supports/monitoring if: (1) appropriate for the participant as determined by the PCP team; (2) if all requirements for this service as outlined in this service definition are met; and (3) all requirements in Appendix C-1-d are met. In these situations, the provider of this service is expected to contract with a remote support/remote monitoring provider that is paid for its technology and services by the service provider. On a case-by-case basis, ADMH staff will evaluate the provider's use of remote support/remote monitoring with a participant(s) to determine the impact on the provider's cost to deliver the service and determine if a rate adjustment is needed.

Training and supervision of the host family caregivers by DMH/DDD Regional Office staff person qualified as QDDP/QIDP shall ensure the host family caregivers is prepared to carry out the necessary training and support functions to implement the Adult Family Home Service Plan and assist the individual to successfully achieve the goals/objectives identified in the Plan. Progress toward the goals/objectives will be documented by the provider, with corresponding adjustments to the Adult Family Home Service Plan implemented accordingly, as determined by the person and his/her Person-Centered Planning team.

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

- The provider's home must be integrated in the greater community and not isolate the person from the opportunity to interact with members of the broader community and participate fully in community life. The provider shall ensure they meet all of the requirements of the HCBS Settings Rule which includes but is not limited to supporting full access to the greater community, opportunities to 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.
- A person receiving Adult Family Home services shall not be eligible to receive Personal Assistance-Home, Independent Living Skills Training, or Community-Based Residential Services as separate services.
- Personal Assistance-Community and/or Community Integration Connections and Skills Training shall not duplicate any supports included as part of Adult Family Home services.
- Breaks and Opportunities (Respite), shall be available to preserve the Adult Family Home living situation for the person and shall be taken account of in the assessment that determines the reimbursement rate paid for Adult Family Home services. If Breaks and Opportunities (Respite) is authorized, it shall be authorized using day rate/unit and the number of

Adult Family Home days authorized/billable will be reduced accordingly.

- A person receiving Adult Family Home services may receive Remote Supports to maximize the use of technology supports. The Adult Family Home Plan must reflect the use of Remote Supports and the monthly rate paid for this service must take account of the use of Remote Supports and the role the Adult Family Home provider may play in the implementation of Remote Supports. Remote supports shall not be utilized for periods of time when the Adult Family Home providers are present in the home with the person receiving services unless approval from DMH/DDD central office is received in advance.
- Transportation: Medical and non-medical transportation support will be determined as part of the assessment process. Medical transportation is covered separate from the waiver under Non-Emergency Medical Transportation available through the Medicaid State Plan. Transportation covered under this service may not duplicate transportation provided through the Community Transportation service. If individual non-medical transportation needs covered under this service exceed a 20-mile radius and more than five trips per month, this would be considered excessive transportation and can be captured as such on the assessment. Service workers may transport consumers in their own vehicles as an incidental component of this service. Note that the Adult Family Home provider will not be reimbursed per mileage for their own direct transportation of the person served.
- Family members (e.g., parents, grandparent, siblings, children, or spouse, whether the relationship is by blood, marriage or adoption) are not eligible providers of Adult Family Home services. A person residing with an individual and being paid for Personal Assistance-Home services may not be an eligible provider of Adult Family Homes services.
- As a part of the Person-Centered Plan, the Adult Family Home services must be reviewed at least semi-annually, or more frequently, in the event of changes in needs or circumstances that require changes to the Adult Family Home Plan.
- Adult Family Home services shall be provided in a manner which ensures the person's rights of privacy, dignity, respect, and freedom from coercion and restraint. Any rights restrictions must be implemented in accordance with DMH/DDD policy, Federal Law 42 CFR 441.301(a)(2)(xiii), and procedures for rights restrictions.
- Reimbursement for this service does not include the cost of maintenance of the dwelling.
- The person's appropriate portion of residential expenses (e.g., telephone, cable television, internet, food, electricity, heating/cooling, water, etc.) shall be paid by the person supported and, as applicable, other residents of the home, through mutual agreement.
- The provider shall provide and execute with the person, a legally enforceable lease or rental agreement that meets HCBS Settings Rule standards.

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	Host Family Caregiver

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Family Home

Provider Category:

Individual

Provider Type:

Host Family Caregiver

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

None

Other Standard *(specify):*

Age 18;
Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense;
Must pass a pre-employment drug screen;
TB skin test as required by Alabama Medicaid Agency;

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Assistive Technology and Adaptive Aids

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Enrollment Group(s): Essential Family Preservation Supports
Seamless Transition to Adulthood Supports
Family, Career and Community Life Supports
Supports to Sustain Community Living

Definition:
An item, piece of equipment or product system, whether acquired commercially, modified or customized, that is used to increase, maintain, or improve functional capabilities and to support the individual's increased independence in their home, in community participation, and in competitive integrated employment. The service covers purchases, leasing, shipping costs, and as necessary, repair of equipment required by the person to increase, maintain or improve his/her functional capacity to perform activities of daily living or instrumental activities of daily living independently or more cost effectively than would be possible otherwise. This service must include strategies for training the individual, natural/unpaid and paid supporters of the individual in the setting(s) where the technology and/or aids will be used, as identified in the Person-Centered Plan (PCP).
Assistive Technology and Adaptive Aids covers the following:

- The Service Coordinator facilitates evaluation and assessment of the Assistive Technology and Adaptive Aids needs of the individual by an appropriate professional, including a functional evaluation of the impact of the provision of appropriate assistive technology and adaptive equipment through equipment trials and appropriate services to him/her in all environments where the person is expected to use the specific technology or equipment, including the home, integrated employment setting(s) and integrated community locations;
- Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, updating, repairing, or replacing assistive technology devices and adaptive equipment;
- Adaptive equipment to enable the individual to complete activities of daily living or instrumental activities of daily living independently or to do so in a way that either allows natural supports to provide the human assistance still needed or allows the cost of paid supports otherwise needed to be reduced to offset the cost of the technology or aid within one (1) year. Such assistive technology or adaptive equipment includes:
  - o Adaptive switches and attachments;
  - o Adaptive equipment to enable the individual to feed him/herself and/or complete oral hygiene as indicated while at home, work or in the community (e.g. utensils, gripping aid for utensils, adjustable universal utensil cuff, utensil holder, scooper trays, cups, bowls, plates, plate guards, non-skid pads for plates/bowls, wheelchair cup holders, adaptive cups that are specifically designed to allow a person to feed him/herself or for someone to safely assist a person to eat and drink, and adaptive toothbrushes);
  - o Adaptive toileting equipment;
  - o Communication devices and aids that enable the person to perceive, control or communicate with the environment, including a variety of devices for augmentative communication;
  - o Assistive devices for persons with hearing and vision loss (e.g. assistive listening devices, TDD, large visual display services, Braille screen communicators, FM systems, volume control telephones, large print telephones and teletouch systems, and long white canes with appropriate tips to identify footpath information for people with visual impairment);
  - o Computer equipment, adaptive peripherals and adaptive workstations to accommodate active participation in the workplace (unless eligible as a reasonable accommodation by the employer) and in the community;
  - o Software, when required to operate accessories included for environmental control;
  - o Pre-paid, pre-programmed cellular phones that allow an individual, who is participating in employment or community integration activities without paid or natural supports and who may need assistance from remote sources of support or due to an accident, injury or inability to find the way home, to access such assistance independently. The person's PCP outlines the protocol that is followed for training, regular practice in using and regular checks of operability for a cellular phone including plan for when the individual may have an urgent need to request help while in the community;
  - o Such other durable and non-durable medical equipment and items that constitute non-durable medical supplies not

available under the state Medicaid plan that is necessary to address functional limitations in the community, in the workplace, and in the home.

- Training, programming, demonstrations or technical assistance for the individual and for his/her providers of support (whether paid or unpaid) to facilitate the person's use of the Assistive Technology and Adaptive Aids.
- Coordination and use of necessary therapies, interventions, or services with assistive technologies and adaptive aids, such as therapies, interventions, or other services in the PCP.
- Repairs of equipment and items purchased through this Waiver or purchased prior to Waiver participation, as long as the item is identified within this service definition, and the cost of the repair does not exceed the cost of purchasing a replacement piece of equipment. The individual must own any piece of equipment that is repaired.

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

- For children 21 years and younger, State Plan Services available through EPSDT are utilized prior to expending waiver funds.
- Items reimbursed with waiver funds shall be non-duplicative of, and to meet an assessed need(s) in addition to, any medical equipment and supplies available to the individual and furnished under the state Medicaid plan. Repairs of items purchased under the state Medicaid plan shall be covered by the state Medicaid plan.
- Items reimbursed with waiver funds shall exclude those items which are not of direct medical or remedial benefit to the recipient.
- All items must meet applicable standards of manufacture, design and installation.
- A written recommendation by an appropriate professional (most typically, the professional that completed the evaluation and assessment or a prescription from a physician) must be obtained to ensure that the equipment will meet the needs of the person. For Assistive Technology and Adaptive Aids in the workplace, the recommendation of the Alabama Department of Rehabilitative Services/Vocational Rehabilitation (ADRS/VR) can also meet the requirement of a written, professional recommendation.
- The provision of this service to support the person in competitive integrated employment is only available for an individual who is working in competitive integrated employment and only if what is needed is not otherwise available to the individual under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.). If this service is authorized, documentation is maintained that the service is not available to the individual under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.) or P.L. 94-142. Persons interested in obtaining competitive integrated employment should be referred to ADRS/VR, and the need for assistive technology and/or adaptive aids will assessed and identified in the ADRS/VR process.
- Depending upon the financial size of the employer or the employer’s status as a public entity, these employers may be required to provide some of these items as part of their legal obligations under Title I or Title III of the ADA. Federal financial participation is not claimed for accommodations that are the legal responsibility of an employer or public entity, pursuant to Title I or Title III of the ADA.

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	Authorized Equipment Vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology and Adaptive Aids

Provider Category:

Agency

Provider Type:

Authorized Equipment Vendor

Provider Qualifications

License *(specify):*

Must meet all applicable state (Alabama Board of Home Medical Equipment Services Providers) and local licensure requirements.

Certificate *(specify):*

None

Other Standard *(specify):*

None

Verification of Provider Qualifications

Entity Responsible for Verification:

DDD Fiscal Management

Frequency of Verification:

Upon selection

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:

Co-Worker Supports

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03021 ongoing supported employment, individual
Category 2:	**Sub-Category 2:**

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

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

Service Definition *(Scope):*

Enrollment Group(s): Seamless Transition to Adulthood Supports (age 16 and up)
Family, Career and Community Life Supports
Supports to Sustain Community Living

Definition:
This service involves the provider of this service (who receives a monthly service fee for their ongoing oversight and involvement) entering into an agreement with the employer to reimburse the employer who will in turn reimburse one or more co-workers and/or supervisors, agreeable to the person supported, for supports in lieu of a Job Coach.

This service can be considered at any time the individual wishes to have Co-Worker Supports rather than Job Coaching, given that Co-Worker Supports are less intrusive and expected to be less costly to implement than Job Coaching. This service can be used when an employer wants to hire an individual; but has reasons for not wanting an external job coach in the workplace. This service must be considered as an option with the individual and his/her employer if fading of Job Coaching has ceased to continue for at least six (6) months. The use of this service should also be authorized on a time limited basis (i.e., no more than 180 days) and reviewed to determine need for renewal/continuation. This service cannot include payment for the supervisory and co-worker activities rendered as a normal part of the business setting and that would otherwise be provided to an employee without a disability. The co-worker(s) and/or supervisor(s) identified to provide the support to the person must meet the minimum qualifications (e.g., training, background checks, etc.) for a legal liable relative as provider of this service. The provider is responsible for oversight and monitoring of paid Co-Worker Supports.

The actual amount of Co-Worker Supports authorized is based on individual need as determined through an on-the-job support assessment the format for which is prescribed by DMH/DDD and as outlined in a Co-Worker Supports Agreement using a template prescribed by DMH/DDD and jointly signed by the person, the provider and the employer.
The provider must ensure the following as part of utilizing Co-Worker Supports:
• A formal written agreement is in place outlining the nature and amount of the supports, above and beyond natural supports, to be provided to the member by the employer, the amount of time necessary for the supervisor(s) or co-worker(s) to provide this support and the cost to the employer for this support, which will be reimbursed by the provider. The agreement should include expectations regarding documentation and billing necessary for the employer to be reimbursed by the provider.
• The supervisor(s) and/or co-worker(s) identified to provide the support to the individual must pass background checks otherwise required for Job Coach. The provider is responsible for ensuring these checks are done (by the employer or provider) and for retaining copies of background check results on file.
• Providing an orientation training to the supervisor(s) and/or co-worker(s) identified to provide the support to the individual which includes the following content:
o Basic introduction to Supported Employment
o Explanation of the Co-Worker Supports model of support – what is covered/not covered; expected outcomes
o Overview of best practices for coaching to promote maximum independence and performance
o Training specific to the member, including support plan, communication style, learning style, support needs and specific needed related to performing and maintaining his/her job that the supervisor(s) or co-worker (s) is expected to address;
o Role and availability of the provider in supporting the member, the employer/supervisor, and co-worker(s) providing support to the member;
o Contact information for the provider, including emergency/back-up cell phone numbers;
o Documentation requirements necessary for the provider to invoice Medicaid and make payment to the employer based on the supports provided to the member.
• The provider is available to provide back-up supports and/or additional training/technical assistance for the employer and member whenever this may be needed;
• The provider completes minimum monthly check-ins with the employer and the member.

Based on all of the above expectations, the provider maintains records of each Co-Worker Supports arrangement for review

by DMH/DDD at any time or as a part of annual certification. Records should include, at minimum: current written agreement between the employer and provider as described above; valid copies of background checks; proof of completion of training for supervisor(s) and co-worker(s) providing supports to the member; evidence of monthly check-ins being completed; billing documentation submitted by the employer to support payments to the employer; record of reimbursements made to the employer and tax documents issued to the employer (e.g. 1099 forms) by the provider.

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

- The Waiver will not cover services which are otherwise available to the person under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.). If this service is authorized, documentation is maintained that the service is not timely available to the person under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).
- This service will not duplicate other services provided to the individual and face-to-face delivery of the service may not be billed for during the same period of time (e.g., the same hour or 15-minute unit) that another face-to-face service is billed.
- The Supported Employment provider overseeing the Co-Worker Supports arrangement shall be responsible for any Personal Assistance needs not met by Co-Worker Supports and shall bill this time as Job Coaching. All providers of Personal Assistance under Supported Employment—Individual shall meet the Personal Assistance provider qualifications.
- The combination of services the person is eligible to receive that occur outside of the home and in the broader community shall be limited to a combined maximum of 40 hours per week, except in instances where the person is 16+ and employed in competitive integrated employment 20 or more hours per week, in which case the person can receive up to 48 hours per week less any hours the person is working in competitive integrated employment without any waiver services. Expenditure caps also apply. Depending on enrollment group and age, the services the person is eligible to receive that occur outside of the home may include Supported Employment-Individual services, Supported Employment — Small Group, Community Integration Connections and Skills Training, and/or Personal Assistance-Community.
- Transportation of the person to and from this service is not included in the rate paid for this service.
- This service does not include support for volunteering.
- This service does not include supporting paid employment in sheltered workshops or similar facility-based settings.
- This service does not include payment for the supervisory activities rendered as a normal part of the business setting.
- An individual may receive both Ticket to Work outcome payments and receive waiver employment supports including Co-Worker Supports.
- Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
  - Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment;
  - Payments that are passed through to users of supported employment services; or
  - Payments for training that is not directly related to a person's supported employment program.

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	Co-Worker Supports Supervisor
Agency	DDD Certified Provider
Individual	Co-Worker Supports Worker

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Co-Worker Supports

Provider Category:

Individual

Provider Type:

Co-Worker Supports Supervisor

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

None

Other Standard *(specify):*

Age 18;
Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense;
Must pass a pre-employment drug screen;
TB skin test as required by Alabama Medicaid Agency;

In addition to the qualifications above, there are post-hire requirements that can be found at this link:(http://mh.alabama.gov/community-waiver-program/).

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Co-Worker Supports

Provider Category:

Agency

Provider Type:

DDD Certified Provider

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

DDD Provider Certification

Other Standard *(specify):*

Employs a program manager who will supervise DSPs providing these services and who is qualified to provide Supported Employment services by holding a CESP, ACRE or Customized Employment certification, or other qualification pre-

approved by DMH/DDD, and who has at least two (2) years' experience providing Supported Employment or similar employment services.

The Executive Director/owner/operator must possess a Bachelor's degree from an accredited institution in Public Health, Special Education, Social Work, Business Administration, Public Administration, Psychology, or other Human Services field, or must be a Registered Nurse.

The Executive Director/owner/operator must possess, or be eligible to qualify for, licensure or certification in their particular field, if applicable.

The Executive Director/owner/operator must have considerable experience (5 or more years) working with individuals with intellectual and developmental disabilities in community settings.

The Agency must be Certified Community Provider in good standing with DDD including:

No placement on Provisional status within the past 24 months; and no substantiated findings of abuse, neglect, mistreatment or exploitation within the past 12 months.

In addition to qualifications which are separate, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Co-Worker Supports

Provider Category:

Individual

Provider Type:

Co-Worker Supports Worker

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

None

Other Standard *(specify):*

Age 18;
Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense;
Must pass a pre-employment drug screen;
TB skin test as required by Alabama Medicaid Agency;

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Integration Connections and Skills Training

HCBS Taxonomy:

Category 1:	Sub-Category 1:
16 Community Transition Services	16010 community transition services
Category 2:	**Sub-Category 2:**
04 Day Services	04070 community integration
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Enrollment Group(s): Family, Career and Community Life Supports
Supports to Sustain Community Living (adults age 22+)

Definition:

Time-limited services which identify and arrange integrated opportunities for the person to achieve his/her unique goals for community participation, involvement, membership, contribution and connections, including targeted education and training for specific skill development to enable the waiver participant to develop ability to independently (or with natural supports only) engage in these integrated opportunities as specified in the person's Person-Centered Plan.

This service focuses specifically on successful participation in community opportunities that offer the opportunity for meaningful, ongoing interactions with members of the broader community. This service also focuses on ensuring the ongoing interactions with members of the broader community are meaningful and positive, leading to the development of a broader network of natural supports for the individual.

The community connections component of this service is focused on assisting the person to find and become engaged in specific opportunities for community participation, involvement, membership, contribution and connections. The service

focus on community connections includes the following:

- Connections to members of the broader community who share like interests and/or goals for community participation, involvement, membership and/or contribution.
- Connections to community organizations and clubs to increase the individual's opportunity to expand community involvement and relationships consistent with his/her unique goals for community involvement and expanded natural support networks, as documented in the Person-Centered Plan;
- Connections to formal/informal community associations and/or neighborhood groups;
- Community classes or other learning opportunities related to developing passions, interests, hobbies and further mastery of existing knowledge/skills related to these passions, interests and hobbies;
- Connections to community members, opportunities and venues that support an individual’s goals related to personal health and wellness (e.g. yoga class, walking group, etc.);
- Connections to volunteer opportunities focused primarily on community contribution rather than preparation for employment;

The provider must document weekly progress toward achieving each goal for community participation, involvement, membership, contribution and connections for which the service is specifically authorized and which is documented in the Person-Centered Plan.

This service shall be provided in a variety of integrated community settings that offer opportunities for the person to achieve their personally identified goals for community participation, involvement, membership, contribution and connections, including developing and sustaining a network of positive natural supports. The provider is expected to provide this service in the appropriate integrated community setting(s) where the opportunities take place and the skills will be used, rather than maintaining a separate service location or practicing skills in places that are not the places where they will be used by the participant.

The skills training component of this service is instructional and training-oriented, and not intended to provide substitute task performance by staff. Skill training is focused on the development of skills identified in the Person-Centered Plan that will enable the person to continue participation in integrated community opportunities without waiver-funded supports.

Community Integration Connections and Skills Training may include only education and training for skill development related to:

- Developing and maintaining positive reciprocal relationships with members of the broader community who are not other waiver participants, paid staff or family members;
- Participation in community activities, clubs, formal or informal membership groups and other opportunities for community involvement, participation and contribution (all so long as the activity clearly meets a goal(s) designated in the PCP);
- Accessing and using community services and resources available to the general public;
- Safeguarding personal financial resources in the community;
- Mobility training and travel training;
- Cell phone and/or PERS use in the community;
- Skills for personal safety in the community.

The provider must prepare and follow a plan utilizing systematic instruction and other evidence-based strategies for teaching the specific skills identified in the Person-Centered Plan. The provider must further ensure consistent teaching methods if multiple staff share responsibility for delivery of the service to a waiver participant. The provider must document weekly progress toward achieving each goal for community integration skill development and independence identified in the Person-Centered Plan.

The Community Integration Connections and Skills Training provider shall be responsible for any Personal Assistance needs during the hours that Community Integration Connections and Skills Training services are provided. However, the Personal Assistance services may not comprise the entirety of the Community Integration Connections and Skills Training.

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

- All settings where Community Integration Connections and Skills Training is provided must meet all HCBS Settings Rule standards and cannot be provider owned or controlled.
- The service amount, duration, and scope must be documented in the PCP.

- This service is provided separate and apart from the person's private (including family) residence, other residential living arrangement and/or the home of a service provider and is not provided in provider owned or controlled facilities.
- One expected result of this service is fading of the service and less dependence on paid support over time in favor of increased natural supports and skills for community involvement and participation;
- This service can be authorized on a time-limited basis to facilitate one or more community connections and/or to facilitate acquisition or mastery of one or more skills for participation in integrated community opportunities and relationships.
- This service is intended to be a "wrap-around" support to participation in individualized, competitive integrated employment, Supported Employment-Small Group services and/or Integrated Employment Path Services, or is intended for individuals of retirement age (65+) who have elected not to pursue further employment opportunities, or for individuals who, after participating in the informed choice process available through completion of the Exploration service, have decided not to pursue individualized, competitive integrated employment at this time.
- Staff-to-person ratios may vary from 1:1 to 1:3, with variable payment based on the specific ratio.
- The combination of services the person is eligible to receive that occur outside of the home and in the broader community shall be limited to a combined maximum of 40 hours per week, except in instances where the person is 16+ and employed in competitive integrated employment 20 or more hours per week, in which case the person can receive up to 48 hours per week less any hours the person is working in competitive integrated employment without any waiver services.
  - o The specific hours per week allowable to a person, and their associated employment status, will be documented in the PCP and will be verified during Support Coordinator monitoring of the service's delivery.
  - o Expenditure caps also apply.
  - o Depending on enrollment group and age, the services the person is eligible to receive that occur outside of the home may include Supported Employment-Individual services, Supported Employment — Small Group, Community Integration Connections and Skills Training, and/or Personal Assistance-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
Individual	Community Integration Worker
Agency	DDD Certified Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Integration Connections and Skills Training

Provider Category:

Individual

Provider Type:

Community Integration Worker

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

None

Other Standard *(specify):*

Must have at least one (1) year of experience working directly with individuals with intellectual disabilities or other developmental disabilities.
An Associate's degree from an accredited institution in a human services field is preferable but not required.

Age 18;
Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense;
Must pass a pre-employment drug screen;
TB skin test as required by Alabama Medicaid Agency;

In addition to the qualifications above, there are post-hire requirements that can be found at this link:(http://mh.alabama.gov/community-waiver-program/).

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Integration Connections and Skills Training

Provider Category:

Agency

Provider Type:

DDD Certified Provider

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

DDD Provider Certification

Other Standard *(specify):*

The Executive Director/owner/operator must possess a Bachelor's degree from an accredited institution in Public Health, Special Education, Social Work, Business Administration, Public Administration, Psychology, or other Human Services field, or must be a Registered Nurse.

The Executive Director/owner/operator must possess, or be eligible to qualify for, licensure or certification in their particular field, if applicable.

The Executive Director/owner/operator must have considerable experience (5 or more years) working with individuals with intellectual and developmental disabilities in community settings.

The Agency must be Certified Community Provider in good standing with DDD including:

No placement on Provisional status within the past 24 months; and no substantiated findings of abuse, neglect, mistreatment or exploitation within the past 12 months.

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Transportation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
15 Non-Medical Transportation	15010 non-medical transportation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Enrollment Group(s): Essential Family Preservation Supports
Seamless Transition to Adulthood Supports
Family, Career and Community Life Supports
Supports to Sustain Community Living

Transportation services offered in order to enable an individual to access the broader community, including competitive integrated workplaces, opportunities for integrated community participation, involvement and contribution, and community

services, resources and businesses, for purposes specified in the Person-Centered Plan. These services allow people to engage in typical day-to-day (non-medical) integrated community opportunities and activities such as going to and from paid, competitive, integrated employment, stores, bank, social opportunities with other members of the broader community, social events, clubs and associations, other community activities, and attending a worship service when public or other community-based transportation services or transportation provided by natural supports are not available. As part of the service, a natural or paid support-giver may accompany the person using Community Transportation, if the need for such supports are necessary and documented in the Person-Centered Plan.

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

- For children 21 years and younger, State Plan Services available through EPSDT are utilized prior to expending waiver funds.
- This service never replaces natural supports available to the waiver participant but rather augments these natural supports, as needed, to ensure these natural supports can continue to be sustained over time. Whenever possible, family, neighbors, co-workers, carpools or friends are utilized to provide this assistance without charge
- The planning team must ensure the most cost-effective means of transportation is utilized, while still assuring provision of reliable transportation when a waiver participant needs this transportation to access non-medical opportunities in the community.
- Actual costs (based on established reimbursement per mile of travel) for travel via a stand-alone transportation service provider must be calculated prior to authorization of the service and must not exceed the established maximum set in policy by DMH/DDD.
- If this service is not self-directed, this service is limited to 250 miles per month, except if used for individualized competitive integrated employment in which case limited to actual miles to/from individualized competitive integrated employment plus 120 miles per month.
- If this service is self-directed, a relative, including a legal liable relative, and/or a legal guardian may serve as a community transportation self-directed worker as long as the 1) the relative/legal guardian is otherwise qualified to provide these services and 2) the relative/legal guardian does not also serve as the same participant's representative/Employer of Record (EOR). This service is authorized as a monthly budget amount. Only documented transportation costs incurred will be reimbursed by the FMSA. Carry-over of unused amounts is limited to 25% and can be carried over for up to three (3) months.
- This service is not available when another covered service is being provided and transportation to/from and/or during the service is a component part of this covered service. Support Coordinator monitoring will review provision of the service to ensure no duplication of transportation components of services provided.
- Transportation for attending medical appointments is covered under Non-Emergency Medical Transportation and not included in this service. This service is in addition to the medical transportation service offered under the Medicaid State Plan, which shall not be supplanted and which includes transportation to medical appointments as well as emergency medical transportation.
- This service may not be used for transportation between the waiver participant's home and a provider owned or controlled residential or non-residential setting.
- An individual community transportation provider (e.g., a self-direction worker) can provide this service on a fee-for-service reimbursement basis (e.g., per mileage or per one-way/round trip).

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	Individual Community Transportation Provider
Agency	DDD Certified Provider
Individual	Individual Community Transportation Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transportation

Provider Category:

Individual

Provider Type:

Individual Community Transportation Provider

Provider Qualifications

License *(specify):*

Valid Alabama Driver’s License

Certificate *(specify):*

Other Standard *(specify):*

Age 18;
Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense;
Must pass a pre-employment drug screen;
TB skin test as required by Alabama Medicaid Agency;

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).

Community transportation shall not replace transportation that is already reimbursable under day or residential habilitation nor the Medicaid non-emergency medical transportation program. Transportation by a personal care attendant is not intended to replace generic transportation or to be used merely for convenience.

If providing transportation, a valid driver's license and insurance (i.e. liability) is required by State Law.

The FMSA shall ensure these requirements are documented. A relative, including a legal liable relative, and/or a legal guardian may serve as a personal care self-directed worker as long as the 1) the relative/legal guardian is otherwise qualified to provide these services and 2) the relative/legal guardian does not also serve as the same participant’s representative/Employer of Record (EOR).

A legal liable relative may only provide extraordinary care, which means care exceeding the range of activities that a legal liable relative would ordinarily perform in the household on behalf of 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.

If a relative or legal liable relative and/or legal guardian is the choice of provider for personal care under the waiver, the Support Coordinator will document that relationship in the PCP to ensure the person-centered planning team is cognizant of the need to ensure no conflict of interest occurs.

Supervision:

The EOR is responsible for the supervision, training and general oversight of each Self-Directed Personal Care worker.

Documentation:

The participant and EOR must maintain documentation of the dates and hours of service provided and provide this to the FMSA at least bi-weekly. Daily or weekly logs, signed by the worker and by the individual or EOR, which identify the individual, the worker providing the service, the date(s) of service, the time service began and the time service ended, and the activities provided within each span of work, will be required. A form will be provided by the FMSA or may be collected by an electronic visit verification system as required by federal law.

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Self Directed Community Transportation Services Financial Management Services Agency (FMSA) The self-directed Community Transportation workers will be employed by the family and participant, who will be employers of record (EOR).

Frequency of Verification:

Annually;

The EOR is responsible for assuring the minimum qualifications are met prior to submission of the worker application to the FMSA. The FMSA is responsible for conducting the background checks and also verifying minimum hiring qualifications are met. The FMSA checks exclusion lists monthly.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transportation

Provider Category:

Agency

Provider Type:

DDD Certified Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certification by ADMH/DDD

Other Standard *(specify):*

Liability insurance

The Executive Director/owner/operator must possess a Bachelor’s degree from an accredited institution in Public Health, Special Education, Social Work, Business Administration, Public Administration, Psychology, or other Human Services field, or must be a Registered Nurse.

The Executive Director/owner/operator must possess, or be eligible to qualify for, licensure or certification in their particular field, if applicable.

The Executive Director/owner/operator must have considerable experience (5 or more years) working with individuals with intellectual and developmental disabilities in community settings.

The Agency must be Certified Community Provider in good standing with DDD including:

No placement on Provisional status within the past 24 months; and no substantiated findings of abuse, neglect, mistreatment or exploitation within the past 12 months.

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transportation

Provider Category:

Individual

Provider Type:

Individual Community Transportation Provider

Provider Qualifications

License *(specify):*

Valid Alabama Driver's License

Certificate *(specify):*

Other Standard *(specify):*

Age 18;
Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense;
Must pass a pre-employment drug screen;
TB skin test as required by Alabama Medicaid Agency;

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).

Community transportation shall not replace transportation that is already reimbursable under day or residential habilitation nor the Medicaid non-emergency medical transportation program. Transportation by a personal care attendant is not intended to replace generic transportation or to be used merely for convenience.

If providing transportation, a valid driver's license and insurance (i.e. liability) is required by State Law.

The FMSA shall ensure these requirements are documented. A relative, including a legal liable relative, and/or a legal guardian may serve as a personal care self-directed worker as long as the 1) the relative/legal guardian is otherwise qualified to provide these services and 2) the relative/legal guardian does not also serve as the same participant's representative/Employer of Record (EOR).

A legal liable relative may only provide extraordinary care, which means care exceeding the range of activities that a legal liable relative would ordinarily perform in the household on behalf of 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.

If a relative or legal liable relative and/or legal guardian is the choice of provider for personal care under the waiver, the Support Coordinator will document that relationship in the PCP to ensure the person-centered planning team is cognizant of the need to ensure no conflict of interest occurs.

Supervision:

The EOR is responsible for the supervision, training and general oversight of each Self-Directed Personal Care worker.

Documentation:

The participant and EOR must maintain documentation of the dates and hours of service provided and provide this to the FMSA at least bi-weekly. Daily or weekly logs, signed by the worker and by the individual or EOR, which identify the individual, the worker providing the service, the date(s) of service, the time service began and the time service ended, and the activities provided within each span of work, will be required. A form will be provided by the FMSA or may be collected by an electronic visit verification system as required by federal law.

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Self Directed Community Transportation Services Financial Management Services Agency (FMSA) The self-directed Community Transportation workers will be employed by the family and participant, who will be employers of record (EOR).

Frequency of Verification:

Annually;

The EOR is responsible for assuring the minimum qualifications are met prior to submission of the worker application to the FMSA. The FMSA is responsible for conducting the background checks and also verifying minimum hiring qualifications are met. The FMSA checks exclusion lists monthly.

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:

Family Empowerment and Systems Navigation Counseling

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
12 Services Supporting Self-Direction	12010 financial management services in support of self-dir
Category 2:	**Sub-Category 2:**
12 Services Supporting Self-Direction	12020 information and assistance in support of self-directio
Category 3:	**Sub-Category 3:**
09 Caregiver Support	09020 caregiver counseling and/or training

Category 4: 13 Participant Training

Sub-Category 4: 13010 participant training

Service Definition *(Scope):*

Enrollment Group(s): Essential Family Preservation Supports
Seamless Transition to Adulthood Supports
Family, Career and Community Life Supports

Definition:
Family Empowerment and Systems Navigation Counseling matches the involved family members (e.g. support/care givers; legal guardians) of an individual with intellectual disabilities with a local professional or similar reputable adult with broad knowledge of the variety of programs and local community resources that are available to an individual with intellectual disabilities and his/her family. The Family Empowerment Counseling and Systems Navigation Service is intended to be a time-limited service that involves assessment of the individual's situation (including needs, goals), assessment of the family's specific goals and needs for information, assistance, and referral to address the individual and family's situation. The service further includes, researching as needed, and sharing of the identified information, connecting the family with assistance, and making referrals as appropriate. The goal of the service is to empower the family with the information, connections and referrals they need, and to work with the family to increase their skills in problem-solving and leveraging available programs and community resources, including Support Coordination. This service is also intended, through temporary peer supervision, to facilitate an opportunity for interested family members, who have received this service, to become providers of this service themselves in order to grow the network of providers of this service over time.

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

- These services are intended to support appropriate assessment of goals/needs following by the timely sharing of information, sources of assistance, and referrals to address the individual and family's situation; therefore, this service should not be provided on an indefinite basis, nor should these services be provided for companionship or purposes only.
- The focus of these services should be customized to the specific goal(s) of the individual receiving these services.
- These services cannot be provided to paid family members or paid legal guardians.
- Transportation of the person or family members of the person receiving this service is not included in the rate or in the scope of expectations for the Navigator delivering this service.
- The Support Coordinator is responsible for monitoring the satisfaction of the person and family served and outcomes resulting from this service on a monthly basis and documenting these things in the person's record.

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	DDD Certified Provider
Individual	Family Empowerment Counselor

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Family Empowerment and Systems Navigation Counseling

Provider Category:

Agency

Provider Type:

DDD Certified Provider

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

DDD Provider Certification

Other Standard *(specify):*

The Executive Director/owner/operator must possess a Bachelor's degree from an accredited institution in Public Health, Special Education, Social Work, Business Administration, Public Administration, Psychology, or other Human Services field, or must be a Registered Nurse.

The Executive Director/owner/operator must possess, or be eligible to qualify for, licensure or certification in their particular field, if applicable.

The Executive Director/owner/operator must have considerable experience (5 or more years) working with individuals with intellectual and developmental disabilities in community settings.

The Agency must be Certified Community Provider in good standing with DDD including:

No placement on Provisional status within the past 24 months; and no substantiated findings of abuse, neglect, mistreatment or exploitation within the past 12 months.

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Empowerment and Systems Navigation Counseling

Provider Category:

Individual

Provider Type:

Family Empowerment Counselor

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

None

Other Standard *(specify):*

Age 18;
Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense;
Must pass a pre-employment drug screen;
TB skin test as required by Alabama Medicaid Agency;

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Financial Literacy and Work Incentives Benefits Counseling

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
12 Services Supporting Self-Direction	12010 financial management services in support of self-dir
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09020 caregiver counseling and/or training
Category 3:	**Sub-Category 3:**
13 Participant Training	13010 participant training
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Service Title: Financial Literacy and Work Incentives Benefits Counseling

Enrollment Group(s):

Seamless Transition to Adulthood Supports
Family, Career and Community Life Supports
Supports to Sustain Community Living

Definition:
For a waiver participant living at home with the family who is providing a home and/or natural care or support for the waiver participant, the Financial Literacy component of this service is designed to:

- Support continuity of stable housing, community tenure, and natural supports for the waiver participant by supporting the person in sustaining and improving his/her economic self-sufficiency
- Enable improvement of waiver participant's economic self-sufficiency necessary to sustain his/her living situation including availability of natural supports for that living situation
- Assist with evaluating a waiver participant's financial health and current level of financial literacy, and making a plan with specific strategies to improve financial health and increase the waiver participant's level of financial literacy
- Teach financial literacy skills
- Assist with access to community resources available to address improvement of economic self-sufficiency and financial health, including ability to sustain current living arrangement.

For a waiver participant sixteen (16) and older who is living independently or in a supported living arrangement, the Financial Literacy component of this service is designed to:

- Enable the waiver participant to improve his/her economic self-sufficiency necessary to continue to maintain independent/supported living in the community
- Assist the waiver participant with evaluating his/her financial health and current level of financial literacy, and making a plan with specific strategies to improve his/her financial health and increase his/her level of financial literacy
- Teach the person financial literacy skills
- Assist the waiver participant to access community resources available to the person that address improvement of economic self-sufficiency and the person's financial health, including ability to sustain the independent/supported living arrangement.

For a waiver participant sixteen (16) or older, regardless of living situation, this service may include both Financial Literacy and Work Incentive Benefits Counseling as appropriate to the needs of the person.

Work Incentive Benefits Counseling is designed to:

- Provide general introductory education that identifies and explains the multiple pathways to ensuring individualized integrated competitive employment results in increased economic self-sufficiency (net financial benefit) through the use of various work incentives. This general introductory education should also repudiate myths and alleviate fears and concerns related to seeking and working in individualized integrated competitive employment.
- Provide a thorough Work Incentive Benefits Analysis addressing the benefits, entitlements, subsidies and services the individual receives to assess the impact that income from employment may have on continued eligibility and benefit amounts, including health coverage. Individuals are informed of work incentives, provisions that are designed to help protect benefits while working (i.e. Impairment Related Work Expense, Earned Income Exclusion, Plan for Achieving Self Support (PASS), Continued Medicaid and Extended Medicare, as well as other benefit programs for which the individual may be eligible. The information is intended to assist the person in making informed decisions about how much they can work and earn through individualized integrated competitive employment.
- Both the general introductory education service and the Work Incentive Benefits Analysis must provide education and information on the income reporting requirements for public benefit programs, including the Social Security Administration.
- This service may also include assistance with the submission of a PASS Plan or Impairment Related Work Expenses (IRWE) to the Social Security Administration depending on the needs of the individual.

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

- For Financial Literacy services, there must be a documented and current concern about the ability of the waiver participant to sustain their current living arrangement.
- For Work Incentive Benefits Counseling, in addition to ensuring this service is not otherwise available to the individual within 90 days under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.), the Waiver may not fund this service if CWIC Benefits Counseling services funded through the Federal Work Incentives Planning and Assistance (WIPA) program are available to the individual.
- Introductory general education as part of Work Incentive Benefits Counseling shall be limited to individuals ages 16-60

who are not currently employed in individualized, integrated competitive employment and shall be limited to a total of four (4) hours of face-to-face service. This component of service can be reauthorized once per waiver year.

- Work Incentive Benefits Analysis, as part of Work Incentive Benefits Counseling, shall be limited to individuals ages 16-60 who are not currently employed in individualized, integrated competitive employment and shall be limited to a total of twenty-three (23) hours of service covering all necessary steps for production of a Work Incentive Benefits Analysis report. This component of service may be authorized no more than once every three (3) years and only if circumstances have significantly changed since the prior authorization, warranting a new analysis.
- Assistance with development of a PASS Plan or IRWE is limited to a total of fifteen (15) hours of service covering all necessary steps involved for submission to, and approval by, the Social Security Administration. This component of service may not be authorized more than once every three (3) years and only if the person's circumstances warrant this and Social Security Administration approval is likely.
- PRN Problem-Solving services for someone to maintain individualized integrated competitive employment: up to four (4) hours per situation requiring PRN assistance. This service may be authorized up to three (3) times per year if necessary for the individual to maintain individualized integrated competitive employment.
- The service must be provided in a manner that supports the person's communication style and needs, including, but not limited to, age-appropriate communications, translation and/or interpretation services for persons of limited English-proficiency or who have other communication needs requiring translation including sign language interpretation, and ability to communicate with a person who uses an assistive communication device.
- This service may not be provided if the person receives any form of work benefits counseling from any other source or waiver service (i.e., Supported Employment).

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	DDD Certified Provider
Individual	Financial Literacy Counselor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Financial Literacy and Work Incentives Benefits Counseling

Provider Category:

Agency

Provider Type:

DDD Certified Provider

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

DDD Provider Certification

Other Standard *(specify):*

The Executive Director/owner/operator must possess a Bachelor's degree from an accredited institution in Public Health, Special Education, Social Work, Business Administration, Public Administration, Psychology, or other Human Services field, or must be a Registered Nurse.

The Executive Director/owner/operator must possess, or be eligible to qualify for, licensure or certification in their particular field, if applicable.

The Executive Director/owner/operator must have considerable experience (5 or more years) working with individuals with intellectual and developmental disabilities in community settings.

The Agency must be Certified Community Provider in good standing with DDD including:

No placement on Provisional status within the past 24 months; and no substantiated findings of abuse, neglect, mistreatment or exploitation within the past 12 months.

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Financial Literacy and Work Incentives Benefits Counseling

Provider Category:

Individual

Provider Type:

Financial Literacy Counselor

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

See Other

Other Standard *(specify):*

Minimum of Associates Degree in human service or related field; and
For Work Incentives Benefits Counseling: Must be a certified Community Work Incentives Coordinator (CWIC) or Work Incentives Practitioner (WIP);

Age 18;
Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense.

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov).

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Housing Counseling Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17030 housing consultation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Enrollment Group(s): Seamless Transition to Adulthood Supports (for ages 18-22, if needed)
Family, Career and Community Life Supports
Supports to Sustain Community Living

Definition:

Services which provide assistance to a person when acquiring housing in the community, where ownership or rental of housing is separate from service provision. The purpose of Housing Counseling Services is to promote consumer choice and control of housing and access to housing that is affordable, accessible to the extent needed by the individual, and promotes community inclusion. Housing Counseling Services include counseling and assistance to the individual, based on individual needs and a plan reflecting these needs, in the following areas:

- Exploring both home ownership and rental options;
- Exploring both individual and shared housing situations;

- Identifying financial resources and determining affordability;
- Identifying how earned income, or an increase in earned income, could impact choice, access and affordability of housing options
- Identifying preferences of location and type of housing;
- Identifying accessibility and modification needs;
- Locating available housing by educating and supporting the person to search for available housing;
- Identifying and assisting with access to financing if homeownership is goal;
- Identifying and assistant with access to rental subsidies if renting is goal;
- Educating the person on the rights and responsibilities of a tenant, including how to ask for reasonable accommodations and modifications, how to request repairs and maintenance, and how to file a complaint if necessary; and,
- Planning for ongoing management and maintenance if homeownership is goal.

Housing Counseling Services are time-limited services but are not one-time services and may be accessed more than once if an individual's needs dictates this.

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

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	Housing Counselor
Agency	Certified DDD Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Housing Counseling Services

Provider Category:

Individual

Provider Type:

Housing Counselor

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

None

Other Standard *(specify):*

Must have specialized training, certification and/or relevant experience in housing issues and how these impact people with disabilities.

Age 18;
Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense.

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Housing Counseling Services

Provider Category:

Agency

Provider Type:

Certified DDD Provider

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

DDD Provider Certification

Other Standard *(specify):*

The Executive Director/owner/operator must possess a Bachelor's degree from an accredited institution in Public Health, Special Education, Social Work, Business Administration, Public Administration, Psychology, or other Human Services field, or must be a Registered Nurse.

The Executive Director/owner/operator must possess, or be eligible to qualify for, licensure or certification in their particular field, if applicable.

The Executive Director/owner/operator must have considerable experience (5 or more years) working with individuals with intellectual and developmental disabilities in community settings.

The Agency must be Certified Community Provider in good standing with DDD including:

No placement on Provisional status within the past 24 months; and no substantiated findings of abuse, neglect, mistreatment or exploitation within the past 12 months.

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Housing Start-Up Assistance

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17030 housing consultation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Service Title: Housing Start-Up Assistance

Enrollment Group(s): Seamless Transition to Adulthood Supports (for ages 18-22, if needed)
Family, Career and Community Life Supports
Supports to Sustain Community Living

Definition:
A service intended to provide essential services and items needed to establish an integrated community living arrangement for persons relocating from an institution or a provider owned or controlled residential setting to one where the individual is directly responsible for his/her own living expenses. Housing Start-Up Assistance is intended to enable the person to establish an independent or supported living arrangement. Allowable costs include:

- Deposit required for a leased or rented living arrangement
- Initial fees and/or deposits to establish utility service for water, heat, electricity, phone
- Purchase of basic and essential items needed to establish a safe and secure home:
  - External locks and keys
  - Smoke and carbon monoxide detectors
  - Fire extinguisher
  - Flashlight

o First Aid Kit
- Moving costs

Housing Start-Up Assistance may also include person-specific services and supports that may be arranged, scheduled, contracted or purchased, which support the person's successful transition to a safe, accessible independent or supported living situation:
- Moving service
- Packing supplies
- Cleaning service
- Electronics set-up

No institutional length of stay requirement exists to access this service.

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

- Housing Start-Up Assistance costs in excess of $1,000 per person, not including deposit required for executing a lease/residency agreement, require prior approval from DMH/DDD central office for expenditures or purchases. Authorization of this service more than once every three (3) years requires prior approval from DMH/DDD central office.
- Services or items covered by this service may not be purchased more than 180 days prior to the date the person relocates to the new independent/supported living arrangement.
- Housing Start-Up Assistance services exclude:

o Purchase of food;
o Payment of rent beyond advanced payment (e.g. a deposit) of one month's rent required at the time of signing a lease or residency agreement;
o Purchase of leisure or recreational devices or services (e.g., television or video equipment, cable or satellite service);
o Purchase of service agreements or extended warranties for appliances or home furnishings;
o Home modifications necessary to address safety and accessibility in the member's living arrangement, which may be provided via other sources or the Minor Home Modifications waiver service; and,
o Housekeeping services provided after occupancy which, if needed, may be provided through other sources or other waiver or Medicaid state plan services.

- When this service is provided to an individual transitioning from a residential institution to a community-based independent/supported living setting, the service is not billed until the date the individual leaves the institution and begins 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	DDD Certified Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Housing Start-Up Assistance

Provider Category:

Agency

Provider Type:

DDD Certified Provider

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

The Executive Director/owner/operator must possess a Bachelor's degree from an accredited institution in Public Health, Special Education, Social Work, Business Administration, Public Administration, Psychology, or other Human Services field, or must be a Registered Nurse.

The Executive Director/owner/operator must possess, or be eligible to qualify for, licensure or certification in their particular field, if applicable.

The Executive Director/owner/operator must have considerable experience (5 or more years) working with individuals with intellectual and developmental disabilities in community settings.

The Agency must be Certified Community Provider in good standing with DDD including:

No placement on Provisional status within the past 24 months; and no substantiated findings of abuse, neglect, mistreatment or exploitation within the past 12 months.

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Independent Living Skills Training

HCBS Taxonomy:

Category 1: 08 Home-Based Services

Sub-Category 1: 08010 home-based habilitation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

Service Title: Independent Living Skills Training

Enrollment Group(s): Essential Family Preservation Supports
Seamless Transition to Adulthood Supports
Family, Career and Community Life Supports
Supports to Sustain Community Living

Definition:
Time-limited, focused service that provides targeted education and training for specific skill development to enable the waiver participant to develop ability to independently perform routine daily activities at home as specified in the person's Person-Centered Plan. Services are not intended to provide substitute task performance by staff. Services are instructional and training-oriented, focused on development of skills identified in the Person-Centered Plan. Independent Living Skills Training may include only education and training for skill development related to:

- Personal hygiene, self-care skills and routines
- Food and meal preparation, including menu planning
- Home upkeep/maintenance including outdoor upkeep/maintenance as applicable
- Money management including skills for controlling and safeguarding personal financial resources at home
- Home-based communication device use (e.g. computer/phone/cell phone)
- Skills for personal safety at home
- Parenting skills (if minor children of waiver participant residing with waiver participant)

Independent Living Skills Training is intended as a short-term service designed to allow a person to acquire specific skills for independence in defined tasks and activities for community living.
Goals for skill development and independence at home must be age-appropriate for the waiver participant while recognizing that learning skills for maximizing individual initiative, autonomy and independence at home should start at a very young age. The provider must prepare and follow a plan utilizing systematic instruction and other evidence-based strategies for teaching the specific skills identified in the Person-Centered Plan. The provider must further ensure consistent teaching methods if multiple staff share responsibility for delivery of the service to a waiver participant.

Because home-based skills are being taught, parents and/or other natural supports in the home will be encouraged to observe the training so they can learn how to use the instructional strategies, reinforce the learned skills and contribute to ensuring the maintenance of these skills after the service ends.

The provider must document weekly progress toward achieving each independent living skill identified in the Person-Centered Plan. The provider is expected to provide this service in the person’s own home where the skills will be used, rather than maintaining a separate service location or practicing skills in places that are not the places where they will be used by the participant.

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

- The service amount, duration, and scope must be documented in the PCP.

- For children 21 years and younger, State Plan Services available through EPSDT are utilized prior to expending waiver funds.
- This service may be authorized for a maximum of 10 hours/week (no more than 2 hours/day) but shall be appropriate to the goal for authorizing the service and the person's existing level of skill (gap between existing level of skill and goal) prior to the service being authorized;
- Once a waiver participant has achieved the ability to independently perform specific routine daily activities, this service may only be authorized to address a different routine daily activity (e.g., the above service limitations are enforced per skill identified as in need of training as specified in the person's PCP), or authorized, if needed, only very intermittently and for minimal time, to focus on sustaining skills for independence already achieved so these are not lost.

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	DDD Certified Provider
Individual	Independent Living Skills Trainer

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Independent Living Skills Training

Provider Category:

Agency

Provider Type:

DDD Certified Provider

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

DDD Provider Certification

Other Standard *(specify):*

The Executive Director/owner/operator must possess a Bachelor's degree from an accredited institution in Public Health, Special Education, Social Work, Business Administration, Public Administration, Psychology, or other Human Services field, or must be a Registered Nurse.

The Executive Director/owner/operator must possess, or be eligible to qualify for, licensure or certification in their particular field, if applicable.

The Executive Director/owner/operator must have considerable experience (5 or more years) working with individuals with intellectual and developmental disabilities in community settings.

The Agency must be Certified Community Provider in good standing with DDD including:

No placement on Provisional status within the past 24 months; and no substantiated findings of abuse, neglect, mistreatment or exploitation within the past 12 months.

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Independent Living Skills Training

Provider Category:

Individual

Provider Type:

Independent Living Skills Trainer

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

None

Other Standard *(specify):*

Must have at least one (1) year of experience working directly with individuals with intellectual disabilities or other developmental disabilities.
An Associate's degree from an accredited institution in a human services field is preferable but not required.

Age 18;
Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense;
Must pass a pre-employment drug screen;
TB skin test as required by Alabama Medicaid Agency;

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Individual Directed Goods and Services

HCBS Taxonomy:

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

Service Definition *(Scope):*

Enrollment Group(s): Essential Family Preservation Supports
Seamless Transition to Adulthood Supports
Family, Career and Community Life Supports
Supports to Sustain Community Living

Definition:
Individual Directed Goods and Services are services are available to only those participants self-directing services who are able to save funds through negotiation of worker's employment wages. Individual goods and services include services, equipment or supplies, for the waiver participant’s use and benefit, that are specified in the person’s PCP and that are not otherwise provided to the individual through this waiver or through the Medicaid State Plan.
Purchases through Individual Directed Goods and Services must address an identified goal/outcome and related need in the Person-Centered Plan (including improving or maintaining the participant's opportunities for full membership in the community and/or competitive integrated employment) and meet the following requirements:

- The item or service will decrease the need for other Medicaid services and/or decrease dependency on paid support services; and/or
- The item or service will promote inclusion in the community, including enhancing family involvement; and/or
- The item or service will increase the waiver participant’s independence, including improved cognitive, social or behavioral functioning, and development or maintenance of personal, social or physical skills for independence; and/or
- The item or service will increase the waiver participant's health and safety in the home or in his/her community; and/or
- The item or service will increase the waiver participant’s ability to continue living in the community and avoid institutionalization
- Upon enrollment in self-direction and whenever the individual’s budget is reviewed and/or updated, the person may identify goods and services they wish to save for, and these will be included in the savings plan and in the person’s budget,

and submitted to the FMSA. A copy of the savings plan will be kept in the person's record and maintained by the Support Coordinator. Each month, the FMSA will be paid the proportional allotment specified in the savings plan and will follow their process of working with the individual on procurement and reimbursement, as well as adjusting the person's budget accordingly. The FMSA will notify the Regional Office, and the Support Coordinator of the actual amount spent on Individual Directed Goods and Services monthly.

- The Support Coordinator will be responsible for monitoring the balances of the savings to ensure proper utilization. The Support Coordinator has oversight of expenditures of Individual Goods and Services and must document the need of any item or service in the case record. The DDD Fiscal staff will review the savings plan annually and verify accurate and appropriate use of savings, based on documentation of balances and expenditures by Support Coordinators and the FMSA, respectively.

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

- • All purchases must be for items or services that are not illegal or otherwise prohibited by Federal and State statutes and regulations. All purchases can only be made if the participant does not have the funds to purchase the item or service and the item or service is not available at no cost to the participant through another source. All purchases must also be evaluated to ensure cost effectiveness as compared to other available uses of the savings account to meet the person's goals/outcomes and related needs and to assures health, safety, and welfare.
- Individual Directed Goods and Services are limited to those individuals self-directing services.
- The limit on amount of funds for purchases under Individual Directed Goods and Services is determined individually based on the balance of the individual's savings account at the time of the request for purchase. The savings account is maintained by the Financial Management Services Agency. The duration of this service is again based on the individual's savings account balance and the individual's participation in self-directed services. If an individual returns to traditional waiver services (stops self-directed any services) the ability to access any dollars from the savings account and utilize this service will be terminated. Additionally, dollars not utilized will be refunded to the Division of Developmental Disabilities.
- Dollars can be accumulated past the fiscal year, however, cannot exceed $10,000.00 at any given time.
- State plan services should be expended prior to the utilizing the Individual Goods and Services.
- Individual Goods and Services can be utilized prior to expenditure of waiver funds in the event there are no providers available to the participant to provide a service that can otherwise be purchased through Individual Directed Goods and Services. This must be documented in the case record.
- Items, goods or services that are not for the primary benefit of the participant are prohibited. Items, Goods and Services unrelated to the person's identified goals/outcomes and related assessed needs are prohibited.
- Experimental or prohibited treatments are excluded, as well as room and board, items solely for entertainment of recreation, cigarettes and alcohol.
- Purchase of goods or services that are illegal or otherwise prohibited by Federal and State statutes and regulations is prohibited.

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 Worker

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Self-Directed Worker

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Age 18;
Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense;
Must pass a pre-employment drug screen;
TB skin test as required by Alabama Medicaid Agency;

In addition to the above qualifications, there are post-hire requirements that can be found at this link: (https://mh.alabama.gov/community-waiver-program/).

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Minor Home Modifications

HCBS Taxonomy:

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

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

Service Definition *(Scope):*

Enrollment Group(s): Essential Family Preservation Supports
Seamless Transition to Adulthood Supports
Family, Career and Community Life Supports

Definition:

Modifications to the home, required b the individual PCP, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home. Such modifications include:

- Provision and installation of certain home mobility aids, including:
  - A wheelchair ramp and modifications directly related to and specifically required for the construction or installation of the ramp
  - Handrails for interior or exterior stairs or steps
  - Grab bars and other devices
- Minor physical adaptations to the interior of the individual's place of residence which are necessary to ensure the health, welfare and safety of the individual, or which increase the member's mobility and accessibility within the residence, including:
  - Widening of doorways
  - Modification of bathroom facilities
  - Installation of electric and plumbing systems necessary to accommodate any medical equipment/supplies needed for the welfare of the individual

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:

- Adaptations that are necessary to support the person to work at home in individualized, integrated competitive employment can be covered but only if they are not the responsibility of the person's employer, if applicable, under the Americans with Disabilities Act and/or if funding to cover these modifications is not available to the individual from another source (e.g. Alabama Division of Vocational Services; Alabama Workforce System). The ADMH/DDD Minor Home Modifications Pre-Authorization Checklist must be completed to document that adaptations which are necessary to support the person to work at home in individualized, integrated competitive employment are not the responsibility of the person's employer under the American's with Disabilities Act and to document that funding to cover these modifications is not available to the individual from any other source.
- Any minor home modification must be documented, including documentation of assessed need that justifies the modification, in the person's Person-Centered Plan, to include the specific rationale for their implementation
- An evaluation by an appropriate professional (e.g., a Physical Therapist) may be necessary to assist in the determination of structural requirements.
- Covered adaptations of rented or leased homes should be those extraordinary alterations that are uniquely needed by the individual and for which the property owner would not ordinarily be responsible.
- Excluded are installation of stairway lifts or elevators and those adaptations which are considered to be general maintenance of the residence or which are considered improvements to the residence or which are of general utility and not of direct medical or remedial benefit to the individual, such as installation, repair, replacement or roof, ceiling, walls, or carpet or other flooring; installation, repair, or replacement of heating or cooling units or systems; installation or purchase of

air or water purifiers or humidifiers; and installation or repair of driveways, sidewalks, fences, decks, and patios.

- Adaptations that add to the total square footage of the home are excluded from this benefit.
- Minor Home Modifications do not include the installation of equipment for Remote Supports monitoring which are covered under Remote Supports.

Minor Home Modifications are limited to $5,000 per waiver year. A Community Services Director, with approval from DDD Central Office, may authorize services in excess of the benefit limit as a cost-effective alternative to institutional placement or other medically necessary covered services, or transition to an enrollment group with a higher expenditure cap.

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	Authorized Contractor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Minor Home Modifications

Provider Category:

Agency

Provider Type:

Authorized Contractor

Provider Qualifications

License *(specify):*

Must meet all applicable state (Alabama Code 230-X-1) and local licensure requirements.

Certificate *(specify):*

None

Other Standard *(specify):*

Must meet all construction, wiring, and/or plumbing building codes, as applicable.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDD Fiscal Management

Frequency of Verification:

Upon selection

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:

Natural Support or Caregiver Education and Training

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09020 caregiver counseling and/or training
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Enrollment Group(s): Essential Family Preservation Supports
Seamless Transition to Adulthood Supports
Family, Career and Community Life Supports

Definition:
This service provides a natural, unpaid support or natural, unpaid caregiver of a waiver participant with education, training and technical assistance, as needed, to enable the natural support or natural caregiver to effectively provide supports to the waiver participant as documented in the person-centered plan. The service enables the natural support or natural caregiver for a waiver participant to:

- Achieve greater competence and confidence in providing supports
- Support the waiver participant's growth and development
- Sustain their role in providing natural, unpaid support and/or care for the waiver participant

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

- Natural Support or Caregiver Education and Training is offered only for an unpaid natural support or natural caregiver identified as such in person-centered plan for the waiver participant.
- Education, training and technical assistance activities are based on the unique needs of the waiver participant and his/her natural support or natural caregiver and are specifically identified in the Person-Centered Plan prior to authorization of this service.
- Service authorization valued up to $500 per year is maximum for each waiver participant, regardless of how many natural support or caregivers may receive assistance through this service. The authorization may be used to benefit more than one care or support giver involved with the waiver participant so long as each of these support/caregivers are documented in the person-centered plan.

● Reimbursement will only be made after a report summarizing the education, training and technical assistance services provided, outcomes achieved, time spent, and associated expenses is submitted to, and approved by, the Support Coordinator.

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	DDD Certified Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Natural Support or Caregiver Education and Training

Provider Category:

Agency

Provider Type:

DDD Certified Provider

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

The Executive Director/owner/operator must possess a Bachelor's degree from an accredited institution in Public Health, Special Education, Social Work, Business Administration, Public Administration, Psychology, or other Human Services field, or must be a Registered Nurse.

The Executive Director/owner/operator must possess, or be eligible to qualify for, licensure or certification in their particular field, if applicable.

The Executive Director/owner/operator must have considerable experience (5 or more years) working with individuals with intellectual and developmental disabilities in community settings.

The Agency must be Certified Community Provider in good standing with DDD including:

No placement on Provisional status within the past 24 months; and no substantiated findings of abuse, neglect, mistreatment or exploitation within the past 12 months.

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Occupational Therapy

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11080 occupational therapy
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Enrollment Group(s): Seamless Transition to Adulthood Supports (for age 21+ only, if needed)
Family, Career and Community Life Supports
Supports to Sustain Community Living

Definition:
Occupational therapy is the application of occupation-oriented or goal-oriented activity to achieve optimum functioning, to prevent dysfunction, and to promote health. The term occupation as used in occupational therapy refers to any activity engaged in for evaluation, specifying, and treating problems interfering with functional performance. Services must begin with the OT evaluation that, if necessary, results in the development of a treatment plan.

The evaluation of an individual is to determine level of functioning, need for therapy, and all information necessary for the development of the treatment plan. The treatment plan should outline the frequency of service (maximum one session per

week in combination with home or community-based program implementation by natural/paid direct support providers), goals of therapy, and outcomes or milestones to be reached by the participant.

Occupational therapy involves the application of diagnostic and prognostic tasks and treating individuals in the prescribed therapy, including treatment training programs, to secure and/or obtain necessary functioning. The OT is expected to recommend exercises to the participant and his/her natural/paid direct support providers that will be completed at home or other appropriate integrated community setting(s), and that will help to ensure maximum benefit of OT is achieved and gains are sustained over time, after OT sessions have ended. To this end, the OT may also provide consultation and training to natural/paid direct support providers. Services to natural/paid direct support providers will be allowed when the services are for the direct benefit of the recipient and are necessary to enable the recipient to experience maximum benefit of OT, and ensure gains are sustained over time, after OT sessions have ended. The OT should teach the primary natural/paid direct support providers how to continue all relevant exercises and activities that can be done at home or other appropriate integrated community setting(s) with the participant.

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

- Occupational Therapy requires a physician's prescription and documentation in the form of an initial evaluation and development of a treatment plan with established goals that must be present in the case record and must justify the need for service.
- Services must be listed on the PCP and be provided and billed in 15-minute units of service.
- Occupational therapy is limited to no more than 5O hours or 200 units annually and no more than one session a week. If it appears that more frequent occupational therapy is needed, and the benefit from which cannot be accomplished through natural/paid direct support providers, trained by the OT, implementing a home or community-based OT program in-between OT sessions, the OT must re-evaluate and submit another treatment plan as described above to the Support Coordinator who will complete a request for action to the Regional Office and Central Office to approve. No more than an additional 50 hours, or 200 units will be allowed per individual per waiver year.
- Occupational therapy under the waiver is not available to children under the age of 21 because this service is covered under the State Plan EPSDT services.
- Service delivery in less than 1:1 ratio is not permitted.

Documentation: Providers of service must maintain a service log that documents specific days on which occupational therapy services were delivered, including detailed documentation of what the service entailed. Occupational therapist must sign each treatment note and must describe progress made on goals established in the treatment plan.

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	Occupational Therapist
Agency	Certified DDD Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Occupational Therapy

Provider Category:

Individual

Provider Type:

Occupational Therapist

Provider Qualifications

License *(specify):*

Occupational Therapists employed or contracted by provider organization are licensed under the Code of Alabama, 1975 Sec. 34-39-5.

Certificate *(specify):*

None

Other Standard *(specify):*

Age 18;
Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense.

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Occupational Therapy

Provider Category:

Agency

Provider Type:

Certified DDD Provider

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

DDD Provider Certification

Other Standard *(specify):*

The Executive Director/owner/operator must possess a Bachelor's degree from an accredited institution in Public Health, Special Education, Social Work, Business Administration, Public Administration, Psychology, or other Human Services field, or must be a Registered Nurse.

The Executive Director/owner/operator must possess, or be eligible to qualify for, licensure or certification in their particular field, if applicable.

The Executive Director/owner/operator must have considerable experience (5 or more years) working with individuals with intellectual and developmental disabilities in community settings.

The Agency must be Certified Community Provider in good standing with DDD including:

No placement on Provisional status within the past 24 months; and no substantiated findings of abuse, neglect, mistreatment or exploitation within the past 12 months.

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Peer Specialist Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12010 financial management services in support of self-dir
Category 2:	**Sub-Category 2:**
12 Services Supporting Self-Direction	12020 information and assistance in support of self-directio
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Service Title: Peer Specialist Services

Enrollment Group(s): Seamless Transition to Adulthood Supports
Family, Career and Community Life Supports
Supports to Sustain Community Living

Definition:
A service that assists a person to develop and utilize skills and knowledge for self-determination in one or more of the following areas:

- Directing the person-centered planning (PCP) process;
- Understanding and considering self-direction;
- Understanding and considering individualized integrated employment/self-employment; ands
- Understanding and considering independent and supported living community living options.

The service is provided on a time-limited basis, determined by the person's individual need, by a peer with intellectual or developmental disabilities who has experience matched to the focus areas, needs and goals of the person receiving this service: has successfully directed their own Person-Centered Planning process; has self-directed their own services; has successfully obtained individualized integrated employment at a competitive wage; and/or utilizes independent/supported living options.

A qualified Peer Specialist service provider understands, empathizes with the person while working to empower the person, supporting three critical areas important for enhancing self-esteem and self-determination:

- The human need for connections, social supports and allies;
- Overcoming the disabling power of learned helplessness, low expectations, and the stigma of labels; and
- Supporting self-advocacy, informed choice and dignity of risk in decision making.

The Peer Specialist service provider offers:

- Education and training on the principles of self-determination, informed decision making and informed risk-taking;
- One-on-one training, information and targeted support to encourage and support the person to lead their own Person-Centered Planning process, pursue self-direction, seek individualized, integrated competitive employment and/or pursue independent living/supported living options in the community;
- Education on self-direction, including best practices recruiting, hiring and supervising staff;
- Planning support and support for exercising self-determination and using self-advocacy skills in regard to pursuing individualized, integrated competitive employment;
- Planning support and support for exercising self-determination and using self-advocacy skills in regard to pursuing independent/supported living opportunities, including selection of place to live and, if needed or desired, housemates; and,
- Assistance with identifying opportunities for increasing natural allies a person has to rely on, including opportunities for the development of valued social relationships, and expanding unpaid sources of support in addition to, or reduce reliance on, paid services.

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

- These services are intended to support an individual in knowledge and skill acquisition and should not be provided on an indefinite basis, nor should these services be provided for companionship purposes only.
- The focus of these services should be customized to the specific goal(s) of the person receiving these services.
- Transportation of the person receiving this service is not included in the rate or in the scope of expectations for the Peer Specialist.
- The Support Coordinator is responsible for monitoring the satisfaction of the person served and outcomes resulting from this service on a monthly basis and documenting these things in the person's record.
- Medicaid does not pay for the initial training required to become a paid provider of Peer Specialist Supports.

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	Peer Specialist
Agency	DDD Certified Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Peer Specialist Services

Provider Category:

Individual

Provider Type:

Peer Specialist

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

None

Other Standard *(specify):*

Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense;
Must pass a pre-employment drug screen;
TB skin test as required by Alabama Medicaid Agency;

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Peer Specialist Services

Provider Category:

Agency

Provider Type:

DDD Certified Provider

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

DDD Provider Certification

Other Standard *(specify):*

The Executive Director/owner/operator must possess a Bachelor's degree from an accredited institution in Public Health, Special Education, Social Work, Business Administration, Public Administration, Psychology, or other Human Services field, or must be a Registered Nurse.

The Executive Director/owner/operator must possess, or be eligible to qualify for, licensure or certification in their particular field, if applicable.

The Executive Director/owner/operator must have considerable experience (5 or more years) working with individuals with intellectual and developmental disabilities in community settings.

The Agency must be Certified Community Provider in good standing with DDD including:

No placement on Provisional status within the past 24 months; and no substantiated findings of abuse, neglect, mistreatment or exploitation within the past 12 months.

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Assistance-Community

HCBS Taxonomy:

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

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

Service Definition *(Scope):*

Enrollment Group(s): Essential Family Preservation Supports
Seamless Transition to Adulthood Supports
Family, Career and Community Life Supports
Supports to Sustain Community Living

Definition:
A range of services and supports designed to assist an individual with a disability to perform, participate fully in his/her community and supports for activities of daily living and instrumental activities of daily living that the individual would typically do for themselves if they did not have a disability and that occur outside the home. Personal Assistance-Community services may be provided outside the person's home, at an integrated workplace where the person is paid a competitive wage, or other places in the broader community to support community participation, involvement and contribution by the person. Personal Assistance-Community services must be provided consistent with the goals/outcomes defined in the Person-Centered Plan and with the over-arching goal of ensuring the individual's full community participation and inclusion.
Participant goals and support needs, as documented in the Person-Centered Plan, shall be addressed by the Personal Assistance-Community provider in a manner that supports and enables the individual to achieve the highest level of independence possible. Personal Assistance-Community may be used to address assistance needs in the workplace and community, if personal care and assistance are the only type of supports an individual needs in these locations. Otherwise, personal care and assistance is included in Supported Employment or Community Integration Connections and Skills Training services and the provider of those services shall be responsible for these needs during the hours that Supported Employment on-the-job supports (i.e. Individual Job Coaching or Small Group supports) or Community Integration Connections and Skills Training services are provided.
Eligible Personal Assistance-Community services include the following:

- As appropriate to the individual need, based on the nature of the community involvement, this service includes assistance with instrumental activities of daily living outside the home, including accompaniment and minor problem-solving necessary to achieve and sustain increased independence, competitive integrated employment and inclusion in the community.
- Assistance to ensure the individual is always supported to the extent needed to interact with other members of the broader community, including assistance with engaging co-workers and community members participating in the same places and activities.
- Assisting individuals to develop an increased range of positive, reciprocal relationships is a key goal of Personal Assistance-Community.
- With consent of the individual, if natural supports and/or workplace colleagues are willing to provide supports that would otherwise be provided by a Personal Assistance-Community worker, this service involves training on how to provide the specific Personal Assistance services they are willing to provide.

As appropriate to the individual need, based on the nature of the community involvement, this service includes assistance, support, supervision and partial participation with eating, toileting, personal hygiene and grooming, and other activities of daily living as appropriate and needed to sustain competitive integrated employment, integrated community participation, involvement and contribution.

Training:

Training:

There are no requirements for a certain number of training hours for agency or self-directed workers. There is a state-sponsored course that must be completed by agency workers. For continuing education, only state-sponsored Incident Prevention and Management Training is required for all workers.

Note: The State does not maintain a listing of qualified PCA/PCS staff that is made available to individuals and families for

this waiver.

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

- Authorization based on individual need after accounting for the availability of sustainable natural supports. This service never replaces natural supports available to the waiver participant but rather augments these natural supports, as needed, to ensure these natural supports can continue to be sustained over time. ADMH/DDD Administrative Code 580-5-30 (Chapter 580-5-30.pdf) defines natural supports as unpaid services by family, friends, community entities, groups and other community networks. If a person lives with another person (i.e. natural support or relative) and the roommate/partner/relative is unwilling or unable to provide care (i.e. they work outside the home), or the waiver participant does not want them to be a caregiver, the participant may access the full number of hours their Personal Care Assessment determines is needed by utilizing a provider other than the natural support(s) they live with.
- The services under the CWP waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.
- Not available to a waiver enrollee ages 5-20 during the hours public school is in session.
- This service cannot be delivered in a waiver participant's home or in a provider owned or controlled service setting of any kind.
- This service is not available on the same day that any of the following are authorized:

Per diem Breaks and Opportunities (Respite), per diem or weekly Supported Living Services, per diem Adult Family Home, or per diem Community-Based Residential Services.

- Transportation of the person to and from this service is not included in the rate paid for this service. Where staff delivering this service meet a person at his/her home to start the service, transportation of the person to this service is not necessary and shall not be separately authorized. Likewise, where staff delivering this service on a given day conclude this service at the person's home, transportation of the person from this service is not necessary and shall not be separately authorized.
- Transportation for attending medical appointments is covered under Non-Emergency Medical Transportation and not included in this service.
- With relevant substantiating documentation and DDD central office approval, a Community Services Director (CSD) may authorize services in excess of the benefit limit (for up to 90 days) as a cost-effective alternative to institutional placement, other medically necessary covered benefits, or transition to an enrollment group with a higher expenditure cap. Reauthorization for additional periods of time is possible with re-assessment and CSD and DDD central office approval.
- Medicaid does not pay for qualifications required of an individual to become a paid provider of this service.

If self-directing this service:

A relative, including a legal liable relative, and/or a legal guardian may serve as a personal assistance- community self-directed worker as long as the 1) the relative/legal guardian is otherwise qualified to provide these services and 2) the relative/legal guardian does not also serve as the same participant's representative/Employer of Record (EOR).The FMSA shall ensure these requirements are documented.

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	DDD Certified Provider Agency

Provider Category	Provider Type Title
Individual	Personal Assistance Worker

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Assistance-Community

Provider Category:

Agency

Provider Type:

DDD Certified Provider Agency

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

DDD Provider Certification

Other Standard *(specify):*

The Executive Director/owner/operator must possess a Bachelor's degree from an accredited institution in Public Health, Special Education, Social Work, Business Administration, Public Administration, Psychology, or other Human Services field, or must be a Registered Nurse.

The Executive Director/owner/operator must possess, or be eligible to qualify for, licensure or certification in their particular field, if applicable.

The Executive Director/owner/operator must have considerable experience (5 or more years) working with individuals with intellectual and developmental disabilities in community settings.

The Agency must be Certified Community Provider in good standing with DDD including:

No placement on Provisional status within the past 24 months; and no substantiated findings of abuse, neglect, mistreatment or exploitation within the past 12 months.

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).

Training:

Agency workers have most of all the required courses offered free-of-charge through state-sponsored learning management systems. This includes Incident Prevention and Reporting training which is required prior to serving a participant and annually thereafter.

First Aid and CPR certifications and Infection Control training are the responsibility of the provider agency (for provider staff). Training specific to the person and their person-centered plan is provided by the agency for agency-employed workers.

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Assistance-Community

Provider Category:

Individual

Provider Type:

Personal Assistance Worker

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

None

Other Standard *(specify):*

Self-directed personal care workers must:
i. Be at least 18 years of age;
ii. Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense;
iii. Must pass a pre-employment drug screen;
iv. If providing transportation, have valid driver's license and insurance as required by State Law. The FMSA shall ensure these requirements are documented.

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).

Supervision:

The EOR is responsible for the supervision, training and general oversight of each Self-Directed Personal Assistance-Community worker.

Training:

The State also requires self-directed workers to complete Incident Prevention and Reporting training prior to serving a participant and annually thereafter through use of a free, state-sponsored online course.

First Aid and CPR certifications and Infection Control training are only required for self-direction workers if the employer of record (EOR) requires these trainings. Training specific to the person and their person-centered plan is provided by the EOR and participant for self-directed workers.

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Services Agency (FMSA)

Frequency of Verification:

Annually;

The EOR is responsible for assuring the minimum qualifications are met prior to submission of the worker application to the FMSA. The FMSA is responsible for conducting the background checks and also verifying minimum hiring qualifications are met. The FMSA checks exclusion lists monthly.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Physical Therapy

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11090 physical therapy
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Enrollment Group(s): Seamless Transition to Adulthood Supports (for age 21+ only, if needed)
Family, Career and Community Life Supports
Supports to Sustain Community Living

Definition:
Physical therapy is treatment of an individual by the employment of effective properties of physical measures and the use of therapeutic exercises and rehabilitative procedures with or without assistive devices, for the purpose of preventing, correcting, or alleviating a physical or mental disability. Services must begin with the PT evaluation that, if necessary, results in the development of a treatment plan.

The evaluation of an individual to determine level of functioning, need for therapy, an all information necessary for the development of the treatment plan. The treatment plan should outline the frequency of service (maximum one session per week in combination with home-based program implementation natural/paid direct support providers), goals of therapy, and outcomes or milestones to be reached by the participant.

Physical therapy involves applying diagnostic and prognostic tasks and providing treatment training programs that are designed to: preserve and improve abilities for independent function, such as range of motion, strength, tolerance, coordination and facility performing activities of daily living; and prevent irreducible progressive disabilities through means such as the use of orthotic and prosthetic appliances, assistive and adaptive devices, positioning, behavior adaptations and sensory stimulation. The PT is expected to recommend exercises to the participant and his/her natural/paid direct support providers that will be completed at home or other appropriate integrated community setting(s), and that will help to ensure maximum benefit of PT is achieved and gains are sustained over time, after and if PT sessions have ended. To this end, the PT may also provide consultation and training to natural/paid direct support providers. Services to natural/paid direct support providers will be allowed when the services are for the direct benefit of the recipient and are necessary to enable the

recipient to experience maximum benefit of PT, and ensure gains are sustained over time, after PT sessions have ended. The PT should teach the primary natural/paid direct support providers how to continue all relevant exercises that can be done at home or other appropriate integrated community setting(s), including ROM exercises for the participant.

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

- Physical Therapy requires a physician's prescription and documentation in the form of an initial evaluation and development of a treatment plan with established goals that must be present in the case record and must justify the need for service.
- Services must be listed on the PCP and be provided and billed in 15-minute units of service.
- Physical therapy is limited to no more than 5O hours or 200 units annually and no more than one session a week. If it appears that more frequent physical therapy is needed, and the benefit from which cannot be accomplished through natural/paid direct support providers, trained by the PT, implementing a home or community-based PT program in-between PT sessions, the PT must re-evaluate and submit another treatment plan as described above to the Support Coordinator who will complete a request for action to the Regional Office and Central Office to approve. No more than an additional 50 hours, or 200 units will be allowed per individual per waiver year.
- Physical therapy under the waiver is not available to children under the age of 21 because the service is covered under State Plan EPSDT services.
- Medicaid State Plan physical therapy in a hospital outpatient setting must be utilized first or documentation maintained it was confirmed unavailable to or previously exhausted by the individual.
- Service delivery in less than 1:1 ratio is not permitted.
- Documentation: Providers of service must maintain a service log that documents specific days on which physical therapy services were delivered, including detailed documentation of what the service entailed. Physical therapist must sign each treatment note and must describe progress made on goals established in the treatment plan.

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	Physical Therapist
Agency	Certified DDD Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Physical Therapy

Provider Category:

Individual

Provider Type:

Physical Therapist

Provider Qualifications

License *(specify):*

Physical Therapists employed or contracted by provider organization are licensed under the Code of Alabama, 1975 Sec.34-

24-212.

Certificate *(specify):*

None

Other Standard *(specify):*

Age 18;
Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense.

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Physical Therapy

Provider Category:

Agency

Provider Type:

Certified DDD Provider

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

DDD Provider Certification

Other Standard *(specify):*

The Executive Director/owner/operator must possess a Bachelor's degree from an accredited institution in Public Health, Special Education, Social Work, Business Administration, Public Administration, Psychology, or other Human Services field, or must be a Registered Nurse.

The Executive Director/owner/operator must possess, or be eligible to qualify for, licensure or certification in their particular field, if applicable.

The Executive Director/owner/operator must have considerable experience (5 or more years) working with individuals with intellectual and developmental disabilities in community settings.

The Agency must be Certified Community Provider in good standing with DDD including:

No placement on Provisional status within the past 24 months; and no substantiated findings of abuse, neglect, mistreatment or exploitation within the past 12 months.

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Positive Behavior Supports

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10040 behavior support
Category 2:	**Sub-Category 2:**
13 Participant Training	13010 participant training
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Service Title: Positive Behavior Supports

Enrollment Group(s): Essential Family Preservation Supports
Seamless Transition to Adulthood Supports
Family, Career and Community Life Supports
Supports to Sustain Community Living

Definition:
Expertise, training and technical assistance in evidence-based positive behavior support strategies to assist natural, co-worker and/or paid staff in supporting individuals who have behavioral support needs. Positive Behavior Supports are designed to improve the ability of unpaid natural supports and paid direct support staff to carry out therapeutic interventions. As needed, providers of Positive Behavior Supports conduct assessments, develop a person's behavior support plan and train/consult with unpaid caregivers and/or paid support staff who are implementing the person's behavior support plan, which is necessary to facilitate the person's successful participation in the community, in employment and to ensure the

person can remain in his/her current community living situation or transition to a less restrictive living situation. Service includes:
1. Assessment to inform the development of behavior support plans for settings where needed (home; work; community), including methods for evaluating effectiveness.
A Functional Assessment will be facilitated by the provider and will include:
i. Interviews with the participant, team leaders, staff, guardian, and professionals across settings.
ii. A review of background information.
iii. Evaluation of interviews to examine function of behavior.
iv. The identification and assessment of previously used strategies for effectiveness.
v. The identification of staff/caregiver training needs.
vi. The collection of data on behaviors to establish a baseline.

● Based on the needs and goals of the individual, development of a home and/or community and/or worksite behavior support plan and/or intervention plan. These plans should incorporate strategies for preventing negative behaviors, identify replacement behaviors, describe how staff/natural support should intervene in a behavioral situation and identify desired fading procedures if necessary. These plans should be understandable to the staff/natural supports expected to implement them. Plans may include recommendations for assistive technology/equipment, workplace and community integration site modifications and clearly defined behavioral interventions.

● Training and technical assistance to carry out the behavior support plan and monitoring of the person and the natural support/staff in the implementation of the plans.
The provider will identify training needs and outline a training plan for staff/unpaid caregivers.
i. Training will include instruction about implementation of the behavior plan in the context of providing other services included in the person's Person-Centered Plan, and guidance, as necessary, to safely maintain and support the person in the relevant community settings. Training must be aimed at assisting the unpaid caregiver/staff in meeting the needs of the person.

● Following the completion of identified training and technical assistance, the provider will provide consultation/follow up 1-2 times per month to examine plan implementation and effectiveness. As needed, revisions of the plan will be done to assure progress toward achievement of desired outcomes. Tele-consulting through the use of two-way, real time-interactive audio and video between places of greater and lesser clinical expertise to provide behavioral consultation services when distance separates the behavioral expert from the person.

This service may also include time-limited consultation with the person and his/her Person-Centered Planning team to consider available service providers and potential providers and assist the person to identify and select providers that can meet the unique needs of the member and to identify additional supports necessary to implement behavior plans and perform therapeutic interventions.
As needed, this service is also used to allow the behavioral specialist to be an integral part of the person-centered planning team, as needed, to participate in team meetings.

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

● This service does not supplant or duplicate services available through the Medicaid State Plan, EPSDT, or through section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.).
● This service does not supplant or replace services provided under the Medicaid State Plan through a Mental Health Center for an individual with an intellectual disability who has a diagnosis of a mental illness or substance use disorder.
● The Positive Behavior Supports specialist and the paid direct support staff are able to bill for their service time for an individual concurrently.
● The implementation of Positive Behavior Supports (and any associated Behavior Support Plans) that involve restrictions must be regularly monitored on an ongoing basis by the qualified provider of Positive Behavior Supports.
● Positive Behavior Supports must be implemented to comply with the ADMH Division of Developmental Disabilities Behavioral Services Procedural Guidelines.
● Positive Behavior Supports is limited to no more than 480 units per year.
● A Community Services Director may authorize services in excess of the benefit limit as a cost-effective alternative to institutional placement or other medically necessary covered service, or transition to an enrollment group with a higher expenditure cap.

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	Certified DDD Provider
Individual	Positive Behavior Supports Specialist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Positive Behavior Supports

Provider Category:

Agency

Provider Type:

Certified DDD Provider

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

DDD Provider Certification

Other Standard *(specify):*

The Executive Director/owner/operator must possess a Bachelor's degree from an accredited institution in Public Health, Special Education, Social Work, Business Administration, Public Administration, Psychology, or other Human Services field, or must be a Registered Nurse.

The Executive Director/owner/operator must possess, or be eligible to qualify for, licensure or certification in their particular field, if applicable.

The Executive Director/owner/operator must have considerable experience (5 or more years) working with individuals with intellectual and developmental disabilities in community settings.

The Agency must be Certified Community Provider in good standing with DDD including:

No placement on Provisional status within the past 24 months; and no substantiated findings of abuse, neglect, mistreatment or exploitation within the past 12 months.

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Positive Behavior Supports

Provider Category:

Individual

Provider Type:

Positive Behavior Supports Specialist

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

None

Other Standard *(specify):*

Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense.
Worked in the Intellectual/Developmental Disability (IDD) field for five (5) years or more, two of which much have been at a professional level in a position that addressed challenging behavior or who worked in a related field (e.g., mental health);
Holds an appropriate BA/BS level degree, master's degree, other advanced degree above the level of Masters or equivalent experience in a field related to human services, such as psychology, social work, behavioral, disabilities, or rehabilitation psychology;
Has completed training in positive behavior supports and/or behavioral psychology and/or applied behavioral science.

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Remote Supports

HCBS Taxonomy:

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

Service Definition *(Scope):*

Enrollment Group(s): Seamless Transition to Adulthood Supports
Family, Career and Community Life Supports
Supports to Sustain Community Living

Service Definition:
The provision of supports to a waiver participant who is 18 years of age or older, at their place of residence, by Remote Support staff housed at a remote location and who are engaged with the person through equipment with the capability for live, two-way communication. Remote Supports shall be provided in real time, not via a recording, by awake staff at a remote monitoring base using the appropriate stable, reliable connection.

While Remote Supports are being provided, the remote support staff shall not have duties other than remote support. Equipment used to meet this requirement may include but is not limited to one or more of the following components:

- Sensor Based System (e.g. motion sensors, doors, windows, personal pagers, smoke detectors, bed sensors etc.)
- Radio frequency identification
- Live video feed
- Live audio feed
- Web-based monitoring system
- Another device that facilitates live two-way communication
- Contact ID

Remote Supports are provided pursuant to the Person-Centered Plan (PCP) and required protocol(s) that are developed from, and support implementation of, the PCP. Remote Supports are intended to address a person's assessed needs in his/her residence and are to be provided in a manner that promotes autonomy and minimizes dependence on paid support staff. Remote Supports should be explored prior to authorizing services that may be more intrusive, including Personal Care .

A person's team, including the person themselves, shall assess whether Remote Support is appropriate and sufficient to ensure the person's health and welfare assuming all appropriate protocols are in place to minimize risk as compared to the overall benefit of Remote Supports for the individual. A backup support person is always identified, available and responsible for responding to the site of the person’s residence whenever the person otherwise needs in-person assistance, including emergencies. Backup support may be provided on an unpaid basis by a family member, neighbor, friend, or other person selected by the individual, or on a paid basis by a local provider of waiver services. When backup support is provided on a paid basis by a local provider, that provider shall be the primary contact for the Remote Support vendor. To ensure no duplication of payment when the paid backup support vendor works at the same time as the remote support worker, a single Remote Supports vendor staff can provide support to more than one person at a time, including up to 4 people living together if all the individuals are sharing the Remote Supports service with the cost divided among the people sharing the service.

The Remote Support staff shall have detailed and current written protocols for responding to a person's needs as specified in the PCP, including contact information for the backup support person(s) to provide assistance when necessary. The PCP and written protocols shall also set forth the procedures to be followed should the person request that the equipment used for delivery of Remote Support be turned off. When a person needs assistance, but the situation is not an emergency, the Remote Support staff shall address the situation as specified in the individual's Remote Supports written protocol(s). If the protocol involves the Remote Support staff contacting backup support, the backup support person shall verbally acknowledge receipt of a request for assistance from the Remote Support staff and shall arrive at the person's location within a reasonable amount of time (as specified in the PCP, but no longer than one (1) hour) when a request for in-person assistance is made. If a known or reported emergency involving a person arises, the Remote Support staff shall immediately assess the situation and call emergency personnel first, if that is deemed necessary, and then contact the backup support person. The Remote Support staff shall stay engaged with the person during an emergency, as appropriate to the situation, until emergency personnel or the backup support person arrives.
The Remote Supports vendor shall provide initial and ongoing training to its staff to ensure they know how to use the monitoring base system and have training on the most recent versions of the written protocols for each person supported.
The Remote Supports vendor shall ensure a suitably trained person from their agency, or from another provider agency for the person, provides the person who receives Remote Supports with initial and ongoing training on how to use the remote support system as specified in the PCP.

The Remote Supports vendor shall have a backup power system (such as battery power and/or generator) in place at the monitoring base in the event of electrical outages. The Remote Supports vendor shall have other backup systems and additional safeguards in place which shall include, but are not limited to, contacting the backup support person in the event the monitoring base system stops working for any reason. The Remote Supports vendor shall comply with all federal, state, and local regulations that apply to the operation of its business or trade, including but not limited to, 18 U.S.C. section 2510 to section 2522 as in effect on the effective date of this rule. The Remote Supports vendor shall have an effective system for notifying emergency personnel such as police, fire, emergency medical services, and psychiatric crisis response entities.

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

- For children 21 years and younger, State Plan Services available through EPSDT are utilized prior to expending waiver funds.
- Remote Supports shall only be provided in waiver participants' place of residence when paid or unpaid sources of support are not present in the residence, except temporarily, if needed, when the Remote Supports are being initially introduced.
- Camera systems are located in communal areas of the home where the individual is likely to spend time and not places where an individual may wish to go to gain privacy (e.g., bathroom or bedroom). Systems are customizable and can be located wherever the individual prefers.
- When Remote Supports involve the use of audio and/or video equipment that permits remote support staff to view activities and/or listen to conversations in the residence, the person who receives the service and each person who lives with the person shall consent in writing after being fully informed of what remote support entails including, but not limited to, that the remote support staff will observe their activities and/or listen to their conversations in the residence, where in the residence the remote support will take place, and whether or not recordings will be made. If the person or a person who lives with the person has a guardian, the guardian shall consent in writing. The person's service and support administrator shall keep a copy of each signed consent form with the PCP.
- A monitoring base shall not be located at the residence of a person who receives Remote Supports.
- A secure network system requiring authentication, authorization, and encryption of data that complies with applicable state laws currently in effect shall be in place to ensure that access to computer, video, audio, sensor, and written information is limited to authorized persons.
- If a Reportable Event as defined in the DDD Critical Incident Prevention and Management System occurs while a person is being monitored, the Remote Supports provider shall retain, or ensure the retention of, any video and/ or audio recordings and any sensor and written information pertaining to the incident for at least seven years from the date of the incident.
- With relevant substantiating documentation and DDD central office approval, a Community Services Director (CSD) may authorize use of this service in the home of a waiver participant(s) living with family as a cost-effective alternative to other medically necessary covered benefits, transition to an enrollment group with a higher expenditure cap, or to avoid institutional placement. Reauthorization is possible with re-assessment and CSD and DDD central office approval.
- All residents of a home where Remote Supports are provided must give advance, informed consent to being subject to the remote monitoring apparatus, as must anyone who later joins the residence. In addition, there must be a protocol (e.g., a written sign, etc.) for informing visitors to the residence that they might be recorded.

● When a person receives Remote Supports with Paid Backup Support, the Remote Supports provider shall stop billing for the Remote Supports service for the period of time that the Paid Backup Support provider has been contacted, by the Remote Supports provider, to respond to and support the participant on an in-person basis. The Paid Back-Up Support provider is responsible for notifying the Remote Supports provider when their in-person support of the participant has concluded.

• With relevant substantiating documentation and CWP Director approval, a CWP Support Coordinator may authorize use of this service in the home of a waiver participant(s) living with family as a cost-effective alternative to: (1) other services assessed to be needed, (2) transition to an enrollment group with a higher expenditure cap, or (3) avoid institutional placement. Reauthorization is possible with re-assessment and CWP Director approval.

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	Technology Installer & Provider
Individual	Back-Up Support Worker
Agency	Paid Back-Up Support Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Remote Supports

Provider Category:

Agency

Provider Type:

Technology Installer & Provider

Provider Qualifications

License *(specify):*

As applicable to federal, state and local statutes

Certificate *(specify):*

As applicable to federal, state and local statutes

Other Standard *(specify):*

Recognized and experienced vendor or Remote Supports technology with experience in at least two (2) other states and current capability to provide Remote Supports services in geographic areas covered by this waiver in State of Alabama.

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Remote Supports

Provider Category:

Individual

Provider Type:

Back-Up Support Worker

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

None

Other Standard *(specify):*

Age 18;
Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense;
Must pass a pre-employment drug screen;
TB skin test as required by Alabama Medicaid Agency;

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Remote Supports

Provider Category:

Agency

Provider Type:

Paid Back-Up Support Provider

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

DDD Provider Certification

Other Standard *(specify):*

The Executive Director/owner/operator must possess a Bachelor's degree from an accredited institution in Public Health, Special Education, Social Work, Business Administration, Public Administration, Psychology, or other Human Services field, or must be a Registered Nurse.

The Executive Director/owner/operator must possess, or be eligible to qualify for, licensure or certification in their particular field, if applicable.

The Executive Director/owner/operator must have considerable experience (5 or more years) working with individuals with intellectual and developmental disabilities in community settings.

The Agency must be Certified Community Provider in good standing with DDD including:

No placement on Provisional status within the past 24 months; and no substantiated findings of abuse, neglect, mistreatment or exploitation within the past 12 months.

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Skilled Nursing

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05020 skilled nursing
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

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

Service Definition *(Scope):*

Enrollment Group(s): Seamless Transition to Adulthood Supports (for age 21+ only, if needed)
Family, Career and Community Life Supports

Definition:
Services listed in the PCP which are within the scope of the State's Nurse Practice Act and must be provided by a registered professional nurse (RN), or licensed practical (LPN) or vocational nurse under the supervision of a registered nurse, licensed to practice in the state of Alabama. An RN is required to perform the supervisory visit every 60 days for an LPN providing this service.
To authorize this service, a physician's order is required followed by a Regional Office RN completing an assessment to determine if the services may be safely and effectively administered in the home or community (the place or places of service where the individual desires to receive the service). There is no restriction on the place of service except the service may not be provided in facility-based non-residential service settings or other settings that do not fully comport with the setting standards contained in the federal HCBS settings rule, including the additional standards that apply to provider owned or controlled settings. This assessment by the Regional Office RN also will identify and confirm the specific type of Skilled Nursing service needed and the amount of time needed.

Services are of two types:
1. Training and supervision provided to natural caregivers and/or direct support professionals (self-direction or agency workers) related to medical care and/or assistance with ordinarily self-administered medications to be provided by the natural caregiver or direct support professional. This training is not available to direct support professionals working for agencies providing residential services (Supported Living; Adult Family Home; Community-Based Residential Services) because payment for the nurse supervision is already included in the rate paid for those services.

2. Nursing procedures that meet the person's health needs as ordered by a physician. LPN services may provide skilled care for the recipient if a licensed physician prescribes the service. The supervising RN evaluates the participant and establishes the nursing plan of care prior to assigning services to the LPN.
Of the above two ways to provide this service, the Regional Office RN will authorize the most cost-effective option for the meeting the waiver participant's needs through this service, ensuring consistency with the physician's order in all cases.
When Skill Nursing Services are provided to waiver participants living in their own homes or living with family, it is intended to focus on training of the natural caregiver and training/supervision of the person's direct support professional(s) and is not intended as a private duty nursing service.
The services of the nurse must be documented by a nursing note that includes the identity and Medicaid number of the consumer, the date of service, the beginning and ending time of the service, and the nursing service(s) provided within that time. In addition, the nursing note should include, as appropriate, the nurse's assessment, changes in the participant's condition, follow-up measures, communications with family, caregivers or physicians, training or other pertinent information. The nurse must sign and date the note. A record of the RN/LPN visit will be captured by an Electronic Visit Verification Monitoring system.

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

- Authorization of this service, and inclusion in the PCP, is subject to a physician's order, based on medical necessity, and an assessment by a Regional Office RN. The need for continued medically necessary Skilled Nursing services must be ordered by the individual's physician every year at the time of the annual redetermination and a reassessment by a Regional Office RN must occur at least annually.
- This service is not available to individuals during the time they are receiving residential services, including training and supervision of direct support professionals working for agencies providing residential services (Supported Living; Adult Family Home; Community-Based Residential Services) because payment for the nursing services, including nurse supervision, is already included in the rate paid for those services.
- For individuals living with natural caregivers, the individual must require skilled nursing training, supervision and/or care which exceeds the caregiver's ability to care for the recipient. If a caregiver has been providing care that is otherwise proposed to be provided through Skilled Nursing services, there must be a negative change in the individual's condition or the caregiver's status that has occurred to warrant supplanting the caregiver's role by authorizing Skilled Nursing services.
- For individuals living with natural caregivers, a commitment on the part of the natural caregiver to participate in and complete training with the Skilled Nursing service provider is essential. The primary natural caregiver will indicate this

commitment by participating in the creation, and signing, of the Skilled Nursing Agreement for Care form. Additional caregivers identified for training must be indicated on the Skilled Nursing Agreement for Care form. In the event that multiple caregivers exist who need training at separate times or in separate places, an adjustment in the hours approved for this service may be made.

- The service may not be provided in facility-based non-residential service settings or other settings that do not fully comport with the setting standards contained in the federal HCBS settings rule, including the additional standards that apply to provider owned or controlled settings.
- Skilled Nursing under the waiver is not available to children under the age of 21 because Private Duty Nursing is covered under the State Plan EPSDT 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	Certified DDD Provider
Individual	Nurse

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:

Agency

Provider Type:

Certified DDD Provider

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

DDD Provider Certification

Other Standard *(specify):*

The Executive Director/owner/operator must possess a Bachelor’s degree from an accredited institution in Public Health, Special Education, Social Work, Business Administration, Public Administration, Psychology, or other Human Services field, or must be a Registered Nurse.

The Executive Director/owner/operator must possess, or be eligible to qualify for, licensure or certification in their particular field, if applicable.

The Executive Director/owner/operator must have considerable experience (5 or more years) working with individuals with intellectual and developmental disabilities in community settings.

The Agency must be Certified Community Provider in good standing with DDD including:

No placement on Provisional status within the past 24 months; and no substantiated findings of abuse, neglect, mistreatment or exploitation within the past 12 months.

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:

Individual

Provider Type:

Nurse

Provider Qualifications

License *(specify):*

Nurses are licensed under the Code of Alabama; 1975 Sec. 34-21.

Certificate *(specify):*

None

Other Standard *(specify):*

Age 18;
Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense;
Must pass a pre-employment drug screen;
TB skin test as required by Alabama Medicaid Agency;

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Speech and Language Therapy

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11100 speech, hearing, and language therapy
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Enrollment Group(s): Seamless Transition to Adulthood Supports (for age 21+ only, if needed)
Family, Career and Community Life Supports
Supports to Sustain Community Living

Definition:
Speech and language therapy includes diagnostic, screening, preventive and corrective services provided on an individual basis, when referred by a physician (M.D., D.O.). Services must begin with the SLT evaluation that, if necessary, results in the development of a treatment plan.

The evaluation of an individual is to determine level of functioning, need for therapy, and all information necessary for the development of the treatment plan. The evaluation is customized to the individual and may include screening and evaluation of the individual's speech and hearing functions or a comprehensive speech and language evaluation. The treatment plan should outline the frequency of service (maximum one session per week in combination with home or community-based program implementation by natural/paid direct support providers), goals of therapy, and outcomes or milestones to be reached by the participant.

These services address improvement in speech fluency and intelligibility and development of an individual's communications skills including expressive and receptive communication skills. These services may include swallowing therapy in additional to other treatment services if the evaluation identifies this as an assessed need. The SLT is expected to recommend exercises and activities to the participant and his/her natural/paid direct support providers that will be completed at home or other appropriate integrated community setting(s), and that will help to ensure maximum benefit of SLT is achieved and gains are sustained over time, after SLT sessions have ended. To this end, the SLT may also provide consultation and training to natural/paid direct support providers. Services to natural/paid direct support providers will be allowed when the services are for the direct benefit of the recipient and are necessary to enable the recipient to experience maximum benefit of SLT, and ensure gains are sustained over time, after SLT sessions have ended. The SLT should teach the primary natural/paid direct support providers how to continue all relevant exercises and activities that can be done at home or other appropriate integrated community setting(s) with the participant.

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

- Services must be listed on the PCP and prescribed by the participant's physician and related to a participant's particular diagnosis.
- An evaluation is required by the qualified speech therapist to determine the need for service. If there is a need for service, the speech therapist must develop the treatment plan outlining the frequency of service and length of time expected to meet outlined goals and expected outcomes. The need for service must be documented in the case record and the service must be expected to result in improvement in functioning for the waiver participant.
- Speech/Language Therapy must be due to an acute episode and should terminate once therapy becomes maintenance in nature.
- Speech and Language Therapy is limited to no more than thirty (3O) hours or 120 units annually and no more than one session a week. If it appears that more frequent SLT is needed, and the benefit from which cannot be accomplished through natural/paid direct support providers, trained by the SLT, implementing a home or community-based SLT program in-between SLT sessions, the SLT must re-evaluate and submit another treatment plan as described above to the Support Coordinator who will complete a request for action to the Regional Office and Central Office to approve. No more than an additional 30 hours, or 120 units will be allowed per individual per waiver year.
- Speech and Language Therapy under the waiver is not available to children under the age of 21 because this service is covered under the State Plan EPSDT services.
- Service delivery in less than 1:1 ratio is not permitted.

Documentation: Providers of service must maintain a service log that documents specific days on which speech and language therapy services were delivered, including detailed documentation of what the service entailed. The speech therapist must sign each treatment note and describe progress made toward goals established in the treatment plan.

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	Speech & Language Therapist
Agency	Certified DDD Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Speech and Language Therapy

Provider Category:

Individual

Provider Type:

Speech & Language Therapist

Provider Qualifications

License *(specify):*

Speech Therapists employed or contracted by provider organization are licensed under the Code of Alabama, 1975 Sec. 34-

28A-1, Ch. 870-x-1-7

Certificate *(specify):*

None

Other Standard *(specify):*

Age 18;
Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense.

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Speech and Language Therapy

Provider Category:

Agency

Provider Type:

Certified DDD Provider

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

DDD Provider Certification

Other Standard *(specify):*

The Executive Director/owner/operator must possess a Bachelor's degree from an accredited institution in Public Health, Special Education, Social Work, Business Administration, Public Administration, Psychology, or other Human Services field, or must be a Registered Nurse.

The Executive Director/owner/operator must possess, or be eligible to qualify for, licensure or certification in their particular field, if applicable.

The Executive Director/owner/operator must have considerable experience (5 or more years) working with individuals with intellectual and developmental disabilities in community settings.

The Agency must be Certified Community Provider in good standing with DDD including:

No placement on Provisional status within the past 24 months; and no substantiated findings of abuse, neglect, mistreatment or exploitation within the past 12 months.

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Supported Employment Individual

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03021 ongoing supported employment, individual
Category 2:	**Sub-Category 2:**
03 Supported Employment	03030 career planning
Category 3:	**Sub-Category 3:**
03 Supported Employment	03010 job development
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Enrollment Group(s): Seamless Transition to Adulthood Supports (age 16 and up)
Family, Career and Community Life Supports
Supports to Sustain Community Living

Definition:
A progression of services provided, as needed, on an individual basis for a person who, because of their disability(s), needs support to obtain and/or maintain an individualized, competitive or customized job in an integrated community setting for which the person is compensated at or above the minimum wage. These services are designed to support the achievement of individualized integrated employment outcomes consistent with the person's employment/career goals and conditions for success, as determined through Exploration and/or Discovery if such services are needed to accurately identify these goals and conditions.
The expected outcome of this service is sustained paid employment in a competitive or customized job, with an employer who is not the person’s service provider, and for which a person is compensated at or above the minimum wage, but not less than the customary wage paid by the employer for the same or similar work performed by persons without disabilities. The

job also offers the level of benefits offered to persons without disabilities performing the same/similar work.
Supported Employment—Individual Employment Support services are individualized and may include the following components:

Exploration
A time-limited & targeted service designed to help a person make an informed choice about whether to pursue an individualized, competitive or customized job in an integrated community setting for which compensation is at or above the minimum wage. Exploration is limited to no more than 30 calendar days from the date of service initiation. This service is not appropriate for persons who know they want to pursue an individualized, competitive or customized job in an integrated community setting for which the person is compensated at or above the minimum wage. It includes introductory activities to identify a person's areas of specific interest, experience and skill related to individualized, integrated employment.
This service also includes exploration of employment opportunities that are specifically related to the person's identified interests, experiences and/or skills through at least three uniquely arranged business tours, informational interviews and/or job shadows. Each activity shall include time for set-up, preparation for participation in the activity, & debriefing with the person after each opportunity.
It also includes introductory, basic education on the numerous work incentives for SSI and/or SSDI beneficiaries and how Supported Employment services work (including Vocational Rehabilitation services). The provider documents each date of service, the activities performed that day, & the duration of each. This service culminates in a written report, on a template issued by DMH/DDD, summarizing the process & outcomes, due no later than 45 calendar days after the service commences. Exploration is paid on an outcome basis, after the written report is received & approved.

Discovery
A time-limited & targeted service, if not otherwise available to the individual from the Alabama Department of Rehabilitative Services, designed to help a person, who wishes to pursue an individualized, competitive or customized job in an integrated community setting for which the person is compensated at or above the minimum wage, to identify through person-centered assessment, planning and exploration:
● Strong interests toward one or more specific aspects of the labor market;
● Skills, strengths & other contributions likely valuable to employers;
● Conditions necessary for successful employment.

Discovery may involve a comprehensive analysis of the person's history, interviews with family, friends & support staff, observing the person performing work skills, & career research in order to determine the person's career interests, talents, skills & support needs, & the writing of a Profile, a pre-assessment specific to the needs of Waiver-eligible persons, which may be paid for through the Waiver to provide a valid assessment for Vocational Rehabilitation (VR) services to begin, which would begin with the development of an Employment Plan through ADRS.
Discovery shall be limited to no more than 60 calendar days from the date of service initiation. The provider documents each date of service, the activities performed that day, & the duration of each activity. The information developed through Discovery allows for activities of typical life to be translated into possibilities for individualized, integrated employment. Discovery results in the production of a detailed written Profile, following content requirements established by DMH/DDD, summarizing the process, learning & recommendations for next steps. The written Profile is due no later than 75 calendar days after the service commences. Discovery is paid on an outcome basis, after the written Profile is received & approved.

Job Development Plan

A time-limited & targeted service, if otherwise not available to the individual from ADRS, designed to create a clear plan for Job Development to obtain an individualized, competitive or customized job in an integrated community setting for which the person is compensated at or above the minimum wage. This service is limited to 30 calendar days from the date of service initiation. This service includes a planning meeting involving the person & other key people who will be instrumental in supporting the person to become employed in an individualized, competitive or customized job in an integrated community setting for which the person is compensated at or above the minimum wage. This service may also include assistance with the submission of a PASS Plan to the Social Security Administration, depending on the needs of the individual. This service culminates in a written plan, on a template issued by DMH/DDD, directly tied to the results of Exploration, Discovery, as applicable when previously authorized, and is due no later than 30 calendar days after the service commences.

Job Development

Job Development is a service, if otherwise not available to the individual from ADRS, that supports a person to obtain an individualized, competitive or customized job in an integrated community setting for which the person is compensated at or above the minimum wage. This service is designed to implement the Job Development Plan, if applicable, & should result in the achievement of an individualized, integrated employment outcome consistent with the person's employment and career goals, as determined through Exploration (if necessary), Discovery (if necessary) &/or the employment planning process and reflected in the PCP.
The Job Development strategy should reflect best practices & whether the person is seeking competitive or customized employment. This service will be paid on an outcome basis once an individualized, competitive or customized job in an integrated community setting for which the person is compensated at or above the minimum wage has commenced, with payment tiered based upon the person's level of disability (ICAP score; additional assessment as identified by DMH/DDD).

Job Coaching

Job Coaching for individualized, integrated employment, if not otherwise available to the individual from ADRS, includes identifying and providing services and supports that assist the person in maintaining and advancing in individualized employment in an integrated setting. Job Coaching includes supports provided to the person and their supervisor or co-workers, either remotely (via technology) or face-to-face. Job Coaching supports must be guided by a Job Coaching fading plan and must include systematic instruction utilizing task analysis to teach the person to independently complete as much of their job duties as possible.
Examples of Job Coaching strategies that may be approved include:

- Job analysis
- Job adaptations
- Instructional prompts
- Verbal instruction
- Self-management tools
- Physical assistance
- Role play
- Co-worker modeling
- Written instruction

Assistive Technology should also be introduced whenever possible to increase independence and productivity. Job Coaching also must include the engagement of natural supports (e.g., employers, supervisors, co-workers, or volunteers at the job site; or friends or family members in supportive roles) in the workplace to provide additional targeted supports that allow the job coach to maximize his/her ability to fade.

Job Coaching is not time-limited. The amount of time authorized for this service is a percentage of the person's hours worked, based on individual need. Payment per unit of service is tiered to encourage fading and is also based on the person's level of disability ((ICAP score; DMH/DDD functional assessment) and the length of time the person has been employed. This service cannot include payment for the supervisory & co-worker activities rendered as a normal part of the business setting and that would otherwise be provided to an employee without a disability. The use of this service shall be authorized on a time limited basis (i.e., no more than 180 days) and reviewed to determine amount of service needed during next authorization period.

Career Advancement
A time-limited career planning and advancement support service, if not otherwise available to the individual from the Alabama Department of Rehabilitative Services, for persons currently engaged in individualized, integrated employment who wish to obtain a promotion and/or a second individualized, integrated employment opportunity. The service focuses on developing and successfully implementing a plan for achieving increased income and economic self-sufficiency through promotion to a higher paying position or through a second individualized, integrated employment or self-employment opportunity.
The outcomes of this service are:

- The identification of the person’s specific career advancement objective;
- Development of a viable plan to achieve this objective; and
- Implementation of the plan which results in the person successfully achieving his/her specific career advancement

objective.
Career Advancement is paid on an outcome basis, after key milestones are accomplished:
- Outcome payment number one is paid after the written plan to achieve the person's specific career advancement objective is reviewed and approved. The written plan must follow the template prescribed by DMH/DDD.
- Outcome payment number two is paid after the person has achieved his/her specific career advancement objective and has been in the new position or second job for a minimum of 40 hours.

This service may not be included on a PCP if the PCP also includes any of the services that are also covered under Supported Employment-Individual, except Job Coaching. This service may not be authorized retroactive to a promotion or second job being made available to a person. Supports for Career Advancement may be authorized and paid once every 3 years (with a minimum of three 365-day intervals between services), and if evidence exists that the individual is eligible for promotion or able to present as a strong candidate for employment in a second job (e.g. has strong reference(s), performance review(s) and/or good attendance record from current employer). The only exception is in situations where the provider who was previously authorized and paid for outcome payment number one did not also earn outcome payment number two because they did not successfully obtain a promotion or second job for the person. In this situation, reauthorization for outcome payments number one and two may occur a maximum of once per year (with a minimum 365-day interval between services), so long as the reauthorization involves the use of a new/different provider.

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

- The Waiver will not cover services which are otherwise available to the person under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.). If this service is authorized, documentation is maintained that the service is not timely available to the person under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).
- This service will not duplicate other services provided to the individual and face-to-face delivery of the service may not be billed for during the same period of time (e.g., the same hour or 15-minute unit) that another face-to-face service is billed.
- The Supported Employment—Individual provider shall be responsible for any Personal Assistance needs during the hours that Supported Employment services are provided. However, the Personal Assistance services may not comprise the entirety of the Supported Employment—Individual service. All providers of Personal Assistance under Supported Employment—Individual shall meet the Personal Assistance provider qualifications.
- The combination of services the person is eligible to receive that occur outside of the home and in the broader community shall be limited to a combined maximum of 40 hours per week, except in instances where the person is 16+ and employed in competitive integrated employment 20 or more hours per week, in which case the person can receive up to 48 hours per week less any hours the person is working in competitive integrated employment without any waiver services. Expenditure caps also apply. Depending on enrollment group and age, the services the person is eligible to receive that occur outside of the home may include Supported Employment-Individual services, Supported Employment — Small Group, Community Integration Connections and Skills Training, and/or Personal Assistance-Community.
- Transportation of the person to and from this service is not included in the rate paid for this service. Where staff delivering this service meet a person at his/her home to start the service, transportation of the person to this service is not necessary and shall not be separately authorized. Likewise, where staff delivering this service on a given day conclude this service at the person's home, transportation of the person from this service is not necessary and shall not be separately authorized.
- This service does not include support for volunteering.
- This service does not include supporting paid employment in sheltered workshops or similar facility-based settings, or in a business enterprise owned by a provider of the person's services.
- This service does not include payment for the supervisory activities rendered as a normal part of the business setting.
- If a person is successfully employed in individualized, integrated employment, services may be used to explore advancement opportunities in his or her chosen career, if such services are not otherwise available to the individual through Alabama Division of Rehabilitation Services.
- Social Security's Ticket to Work Outcome and Milestone payments do not conflict with CMS regulatory requirements and do not constitute an overpayment of Federal dollars for services provided since Ticket to Work payments are made for an outcome, rather than for a Medicaid service rendered.
- Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

o Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment;

- Payments that are passed through to users of supported employment services; or
- Payments for training that is not directly related to a person's supported employment program.

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	DDD Certified Provider Agency
Individual	Job Developer
Individual	Job Coach

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Employment Individual

Provider Category:

Agency

Provider Type:

DDD Certified Provider Agency

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

DDD Provider Certification

Other Standard *(specify):*

Employs a program manager who will supervise DSP's providing these services and who is qualified to provide Supported Employment services by holding a CESP, ACRE or Customized Employment certification, or other qualification pre-approved by DMH/DDD, and who has at least two (2) years' experience providing Supported Employment or similar employment services.

The Executive Director/owner/operator must possess a Bachelor's degree from an accredited institution in Public Health, Special Education, Social Work, Business Administration, Public Administration, Psychology, or other Human Services field, or must be a Registered Nurse.

The Executive Director/owner/operator must possess, or be eligible to qualify for, licensure or certification in their particular field, if applicable.

The Executive Director/owner/operator must have considerable experience (5 or more years) working with individuals with intellectual and developmental disabilities in community settings.

The Agency must be Certified Community Provider in good standing with DDD including:

No placement on Provisional status within the past 24 months; and no substantiated findings of abuse, neglect, mistreatment or exploitation within the past 12 months.

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Employment Individual

Provider Category:

Individual

Provider Type:

Job Developer

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

See Other

Other Standard *(specify):*

Age 18;
Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense;
Must pass a pre-employment drug screen;
TB skin test as required by Alabama Medicaid Agency;

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Employment Individual

Provider Category:

Individual

Provider Type:

Job Coach

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

See Other

Other Standard *(specify):*

Age 18;
Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense;
Must pass a pre-employment drug screen;
TB skin test as required by Alabama Medicaid Agency;

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Supported Employment Small Group

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03022 ongoing supported employment, group
Category 2:	**Sub-Category 2:**

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

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

Service Definition *(Scope):*

Enrollment Group(s): Seamless Transition to Adulthood Supports (age 16 and up)
Family, Career and Community Life Supports
Supports to Sustain Community Living

Definition:
A service providing employment services and training activities to support successful transition to individualized integrated employment or self-employment, or to supplement such employment and/or self-employment when it is only part-time. The service may include:

- Small group career planning and Exploration
- Small group Discovery classes/activities
- Other educational opportunities related to successful job acquisition and working successfully in individualized integrated employment
- Employment in integrated business, industry and community settings

Examples include mobile crews, small enclaves and other small groups participating in integrated employment that is specifically related to the identified interests, experiences and/or skills of each of the persons in the small group and that results in acquisition of knowledge, skills and experiences that facilitate transition to individualized integrated employment or self-employment, or that supplement such employment or self-employment when it is only part-time.

The maximum group size for mobile crews and enclaves is four (4) people with disabilities working together while receiving this service.
In the enclave model, a small group of people with disabilities (no more than four (4) people) is trained and supervised to work as a team among employees who are not disabled at the host company's work site.

In the mobile work crew model, a small crew of workers (including no more than four (4) persons with disabilities and ideally also including workers without disabilities who are not paid providers of this service) work as a distinct unit and operate as a self-contained business that generates employment for their crew members by selling a service. The crew typically works at several locations within the community.

In each model, the Supported Employment—Small Group provider is responsible for training, supervision, and support of participants.

The expected outcome of this service is the acquisition of knowledge, skills and experiences that facilitate career development and transition to individualized integrated employment or self-employment, or that supplement such employment and/or self-employment when it is only part-time. The individualized integrated employment or self-employment shall be consistent with the individual’s personal and career goals, as documented in their PCP. Supported Employment—Small Group shall be provided in a way that presumes all participants are capable of working in individualized integrated employment and/or self-employment.

Participants in this service shall be encouraged, on an ongoing basis, to explore and develop their interests, strengths, and abilities relating to individualized integrated employment and/or self-employment. In order to reauthorize this service, the PCP must document that such opportunities are being provided through this service, to the person, on an on-going basis. The PCP shall also document and address any barriers to the person transitioning to individualized integrated employment or self-employment if the person is not already participating in individualized integrated employment or self-employment. Any person using this service to supplement part-time individualized integrated employment or self-employment shall be offered assistance to increase hours in individualized integrated employment and/or self-employment as an alternative or partial alternative to continuing this service.

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

- The provider is expected to conduct this service in integrated, non-disability-specific business, industry or community settings that meet all HCBS setting standards and do not isolate participants from others who do not have disabilities. These settings cannot be provider-owned, leased or operated settings. The settings must be integrated in and support full access of participants to the greater community, including opportunities to learn about and seek individualized integrated employment, engage in community life, and control their earned income.
- This service does not include supporting paid employment in sheltered workshops or similar facility-based settings, or in a business enterprise owned by a provider of the person's services.
- Paid work under Supported Employment—Small Group must be compensated at minimum wage or higher.
- Supported Employment—Small Group does not include vocational or Employment Path services, employment or training provided in facility-based work settings.
- Transportation of the person to and from this service is not included in the rate paid for this service; however transportation provided during the course of Supported Employment—Small Group Supports is considered a component part of the service and the cost of this transportation is included in the rate paid to providers of this service.
- This service will not duplicate other services provided through Medicaid state Waiver plan services and may not be billed for during the same period of time (e.g., the same hour) as other such services.
- The Supported Employment—Small Group provider shall be responsible for any Personal Assistance needs during the hours that Supported Employment-Small Group Supports are provided; however, the Personal Assistance services may not comprise the entirety of the Supported Employment—Small Group service. All providers of Personal Assistance under Supported Employment—Small Group shall meet the Personal Assistance service provider qualifications, as verified during initial provider certification and follow-up certification surveys.
- The combination of services the person is eligible to receive that occur outside of the home and in the broader community shall be limited to a combined maximum of 40 hours per week, except in instances where the person is 16+ and employed in competitive integrated employment 20 or more hours per week, in which case the person can receive up to 48 hours per week less any hours the person is working in competitive integrated employment without any waiver services. Expenditure caps also apply. Depending on enrollment group and age, the services the person is eligible to receive that occur outside of the home may include Supported Employment-Individual services, Supported Employment — Small Group, Community Integration Connections and Skills Training, and/or Personal Assistance-Community.
- This service does not include support for volunteering.
- The Waiver will not cover services which are otherwise available to the person under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.). If this service is authorized, documentation is maintained that the service is not available to the person under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). A person does not have to be found ineligible for services under section 110 of the Rehabilitation Act of 1973 to determine and document this service is not available.
- Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
  - Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment;
  - Payments that are passed through to users of supported employment services; or
  - Payments for training that is not directly related to a person's supported employment program.

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	Job Coach
Agency	DDD Certified Provider Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Employment Small Group

Provider Category:

Individual

Provider Type:

Job Coach

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

See Other

Other Standard *(specify):*

Age 18;
Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense;
Must pass a pre-employment drug screen;
TB skin test as required by Alabama Medicaid Agency;

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Employment Small Group

Provider Category:

Agency

Provider Type:

DDD Certified Provider Agency

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

DDD Provider Certification

Other Standard *(specify):*

Employs a program manager who will supervise DSP's providing these services and who is qualified to provide Supported Employment services by holding a CESP, ACRE or Customized Employment certification, or other qualification pre-approved by DMH/DDD, and who has at least two (2) years' experience providing Supported Employment or similar employment services.

The Executive Director/owner/operator must possess a Bachelor's degree from an accredited institution in Public Health, Special Education, Social Work, Business Administration, Public Administration, Psychology, or other Human Services field, or must be a Registered Nurse.

The Executive Director/owner/operator must possess, or be eligible to qualify for, licensure or certification in their particular field, if applicable.

The Executive Director/owner/operator must have considerable experience (5 or more years) working with individuals with intellectual and developmental disabilities in community settings.

The Agency must be Certified Community Provider in good standing with DDD including:

No placement on Provisional status within the past 24 months; and no substantiated findings of abuse, neglect, mistreatment or exploitation within the past 12 months.

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Supported Living Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08010 home-based habilitation

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

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

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

Service Definition *(Scope):*

Enrollment Group(s): Supports to Sustain Community Living
Family, Career and Community Life Supports

Definition:
Services that include training and assistance in maintaining a home of one's own: a residence not owned or controlled by a waiver service provider or a residence that is not the home of a family caregiver. The home may be shared with other freely chosen housemates who may or may not also receive waiver services and/or have a disability. Supported Living Services are provided with the goal of maximizing the person's independence and interdependence with housemates and natural supports, using a combination of teaching, training, technology and facilitation of natural supports. Supported Living Services are delivered according to the person's Supported Living Service Plan (a part of the PCP) and may include supports for any of the following:

- Maintaining home tenancy or ownership;
- Managing money, budgeting and banking;
- Planning and preparing meals;
- Shopping for food and home supplies;
- Maintaining personal appearance and hygiene;
- Health and wellness goals and activities;
- Developing and maintaining positive relationships with neighbors; and,
- Overseeing/assisting with managing self-administered medication and/or medication administration, as permitted under Alabama's Nurse Practice Act;
- Performing other non-complex health maintenance tasks, as needed and as permitted by state law.
- Travel training and support and/or assistance with arrangement of transportation by a third party, and/or provision of transportation as needed by the individual to support the person's employment and community involvement, participation and/or contribution;
- Assistance with building interpersonal and social skills through assistance with planning, arranging and/or hosting social opportunities with family, friends, neighbors and other members of the broader community with whom the person desires to socialize;
- Ensuring home and community safety is addressed including emergency preparedness planning;
- Implementation of behavioral support plans developed by qualified behavioral specialists; and
- On-call supports for as-needed or emergency assistance.

This service is intended for persons who, with technology, natural supports and good advanced planning, need intermittent and/or on-call staff support to remain in their own home and who do not need and will not benefit from around-the-clock staffing. Supported Living Services are differentiated from Personal Assistance by virtue of the 24-hour on-call access to supports on an as-needed/emergency basis that are part of Supported Living Services. It is the responsibility of the provider to ensure that the person has an emergency preparedness plan in place at all times, this plan is shared with the Support Coordinator and others on the Person-Centered Planning team, and the person is supported to learn and practice this plan at regular intervals.

A fraction of this service may be delivered remotely via remote supports/monitoring if: (1) appropriate for the participant as determined by the PCP team; (2) if all requirements for this service as outlined in this service definition are met; and (3) all requirements in Appendix C-1-d are met. In these situations, the provider of this service is expected to contract with a

remote support/remote monitoring provider that is paid for its technology and services by the service provider. On a case-by-case basis, ADMH staff will evaluate the provider's use of remote support/remote monitoring with a participant(s) to determine the impact on the provider's cost to deliver the service and determine if a rate adjustment is needed.

All individual goals/objectives for Supported Living Services, along with a description of needed Supported Living Services supports to achieve them, shall be established via the person-centered planning process and documented in the Supported Living Service Plan which is made part of the Person-Centered Plan and which determines the specific weekly rate paid for the service. The Supported Living Service Plan and the corresponding goals/objectives, must consider:

- The person's current level of independence
- Availability of natural supports
- Ability to utilize technology
- Ability to rely on housemates, neighbors, etc.
- Other services the person may be receiving, regardless of funding source

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

- A person receiving Supported Living Services shall not be eligible to receive Personal Assistance-Home, Personal Assistance-Community, Independent Living Skills Training, Breaks and Opportunities (Respite), Adult Family Home or Community-Based Residential Services as separate services.
- Transportation covered under this service may not duplicate transportation provided through the Community Transportation service. Transportation to/from medical appointments and services is covered under Non-Emergency Medical Transportation available through the Medicaid State Plan and not through this service or the waiver.
- A minimum of one (1) face-to-face service visit to the residence, lasting at least one hour, is required each week for each person who receives Supported Living Services, in addition to on-call, around-the-clock availability of the provider staff, in the event unplanned or emergency supports are needed.
- A person receiving Supported Living Services may receive Remote Supports to maximize the use of technology supports. The Supported Living Service Plan must reflect the use of Remote Supports and the monthly rate paid for this service must take account of the use of Remote Supports and the role the Supported Living Service provider may play in the implementation of Remote Supports.
- Persons receiving Supported Living Services may choose to receive this service in a shared living arrangement involving a maximum of three (3) persons per residence receiving this service. Each person may require differing levels of support and/or types of waiver services in addition to Supported Living Services as detailed in their Person-Centered Plan and Supported Living Services Plan. Other individuals sharing the residence and receiving Supported Living Services may participate in different HCBS programs, so long as the provider is qualified to safely and appropriately meet the needs of each person in the residence.
- The service shall not be provided in a home where the person lives with family members (e.g., parents, grandparent, siblings, children, or spouse, whether the relationship is by blood, marriage or adoption), unless such family members are also persons receiving waiver services.
- Certain family members of the person supported (e.g., spouse, parent, child, or legal guardian, regardless of relationship) shall not be reimbursed to provide Supported Living Services. Other family members may be reimbursed to provide the service, if they otherwise meet provider qualifications and hiring requirements or are employed by an approved provider.
- The reimbursed rate for each unit of service is determined by formal assessment. The determined reimbursed rate for each unit of service will be for a period defined by the formal assessment process, with reassessment occurring no less than every six (6) months as a part of the Person-Centered Plan and the Supported Living Services Plan semi-annual review, or more frequently, in the event of changes in needs or circumstances that require changes to the Supported Living Services Plan.
- Supported Living Services shall be provided in a manner which ensures the person's rights of privacy, dignity, respect, and freedom from coercion and restraint. Any rights restrictions must be implemented in accordance with DMH/DDD policy, Federal Law 42 CFR 441.301(a)(2)(xiii), and procedures for rights restrictions.
- Reimbursement for this service shall not include the cost of maintenance of the dwelling.
- Residential expenses (e.g., telephone, cable television, food, rent, mortgage, insurance, etc.) shall be paid by the person(s) supported and, as applicable, other residents of the home, through mutual agreement.
- The provider shall not co-sign a lease or rental agreement for the person's place of residence and will sign an agreement with the person ensuring that the person will not be required to move if the person chooses a different Supported Living Services provider at any point, and if such a decision is made, the Supported Living Services provider will work with the

person and the new provider to ensure an orderly, well-planed transition with no gap in supports for the person.

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	Supported Living Worker
Agency	Certified DDD Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Living Services

Provider Category:

Individual

Provider Type:

Supported Living Worker

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

None

Other Standard *(specify):*

Age 18;
Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense;
Must pass a pre-employment drug screen;
TB skin test as required by Alabama Medicaid Agency;

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Living Services

Provider Category:

Agency

Provider Type:

Certified DDD Provider

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

DDD Provider Certification

Other Standard *(specify):*

The Executive Director/owner/operator must possess a Bachelor's degree from an accredited institution in Public Health, Special Education, Social Work, Business Administration, Public Administration, Psychology, or other Human Services field, or must be a Registered Nurse.

The Executive Director/owner/operator must possess, or be eligible to qualify for, licensure or certification in their particular field, if applicable.

The Executive Director/owner/operator must have considerable experience (5 or more years) working with individuals with intellectual and developmental disabilities in community settings.

The Agency must be Certified Community Provider in good standing with DDD including:

No placement on Provisional status within the past 24 months; and no substantiated findings of abuse, neglect, mistreatment or exploitation within the past 12 months.

In addition to the qualifications above, there are post-hire requirements that can be found at this link: (http://mh.alabama.gov/community-waiver-program/).

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH DDD Certification

Frequency of Verification:

Annually

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.

Service
Community-Based Residential Services
Adult Family Home
Remote Supports
Supported Living Services

1. Will any in-person visits be required?

◉ **Yes.**

○ **No.**

2. *By checking each box below, the state assures that it will address the following when delivering the service remotely/via telehealth.*

☒ **The remote service will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc.** ***Explain:***

Remote service delivery will be structured to safeguard the individual's privacy, dignity, and personal autonomy at all times. Remote Supports, Residential Habilitation, and Supported Living Services are the only services that can be delivered remotely. Video recording systems are in communal areas of the home where the individual is likely to spend time and not places where an individual may wish to go to gain privacy (e.g., bathroom or bedroom). When remote supports involve the use of audio and/or video equipment that permits remote support staff to view activities and/or listen to conversations in the residence, the person who receives the service and each person who lives with the person shall consent in writing after being fully informed of what remote support entails including, but not limited to, that the remote support staff will observe their activities and/or listen to their conversations in the residence, where in the residence the remote support will take place, and whether or not recordings will be made. If the person or a person who lives with the person has a guardian, the guardian shall consent in writing. The person's service and Supports Coordinator shall keep a copy of each signed consent form with the PCP.

Specific individualized plans and protocols for the use of remote supports must address how the plan is maximizing privacy while ensuring health and safety. It is recognized that the alternative (an in-person DSP) also infringes upon a person's privacy and both options for support must address privacy. Remote supports provide for the option of technology to be installed in bathrooms and bedrooms (e.g. sensors, call buttons) that trigger a response only when something occurs (per the participant's individualized protocol) that indicates a situation compromising health/safety may be occurring. The use of video equipment in dressing, bathing and toileting areas is prohibited.

☒ **How the telehealth service delivery will facilitate community integration.** ***Explain:***

Remote service delivery allows for the use of technology to support participants safely receiving visits from members of the broader community. For example, video doorbells and two-way audio communication can ensure a participant is assisted to determine if the person(s) they are expecting are at the door or if a stranger is at the door. Additionally Remote services can provide as-needed connection with a participant who leaves his/her home to do something in the community. If the participant does not confirm they are back in the home at the agreed upon time, the Remote Supports provider can take additional steps to ensure the participant's safety. Remote Supports can be used to provide a device that allows mobile communication technology so the participant can communicate with Remote Support staff for support while in their community and/or at their job. These are some but not all examples of what is possible.

☒ **How the telehealth will ensure the successful delivery of services for individuals who need hands on assistance/physical assistance, including whether the service can be rendered without someone who is physically present or is separated from the individual.** ***Explain:***

Remote service delivery will be used in a way that supports the individual's needs while recognizing that certain tasks require in-person, hands-on support. Remote service delivery is designed to supplement needed in-person and available natural supports, not replace them. The successful delivery of these services is based on the Person-Centered Assessment and Plan and the Remote Supports assessment, plan and protocols, which identify the individual's assessed needs and determines which needs can be safely and effectively supported without the physical presence of natural supports or staff, as well as how specifically the Remote Supports will be delivered including protocols to be used by Remote Supports staff and back-up staff.

It is the responsibility of the Support Coordinator, after receiving the Remote Supports assessment, to monitor and assess the appropriateness of remote service delivery. This includes clearly identifying:
- Tasks that require hands-on or physical assistance, and therefore must be completed by in-person staff; and
- Tasks that can be safely supported remotely.

Through ongoing monitoring of service delivery, the Support Coordinator will also be able to identify if Remote Support is insufficient and whether adjustments to service delivery are needed.

☒ **How the state will support individuals who need assistance with using the technology required for telehealth delivery of the service.** ***Explain:***

The state will ensure that individuals who require help accessing or utilizing remote services receive the support they need so they can participate fully, safely, and effectively. Remote Supports requires the Remote Supports vendor to ensure a suitably trained person from their agency, or from another provider agency for the person, provides the person who receives Remote Supports with initial and ongoing training on how to use the remote support system as specified in the PCP. Ongoing monitoring of this service is done by the Support Coordinator, which includes ensuring the individual who is using the technology can do so effectively.

☒ **How the telehealth will ensure the health and safety of an individual.** ***Explain:***

Remote service delivery is implemented in a way that maintains the individual's health, safety, and well-being. To ensure the health and safety of an individual receiving Remote services, the Support Coordinator will involve the Remote Supports providers with the participant and the person-centered planning team to exchange information and determine if there is a potential for Remote Supports to be beneficial for the individual while also ensuring health and safety. If it is agreed there is potential, the Support Coordinator will authorize the Remote Supports provider selected by the participation to complete a full Remote Supports Assessment, Plan and Protocols. The Support Coordinator will then assist the participant and person-centered planning team to meet with the Remote Supports provider and review the results of the assessment, the proposed plan and the various protocols developed to guide the provision of Remote Supports for the participant. If the person-centered planning team, including the participant and Support Coordinator, agree that the Remote Supports plan and protocols can effectively and safely support the participant, the service will be authorized. All Remote Supports plans must include the following to ensure health and safety:

- Real-time monitoring and communication with the individual to enable timely intervention. Back-up systems in case of power failure, etc.
- Protocols including emergency protocols: Remote Supports will always include protocols for responding to emergencies, changes in health status, safety issues, or any signs that the individual is in distress.

These expectations will be verified as part of the person-centered planning team reviewing the Remote Supports' provider's plan and protocols developed for the participant.

The Remote Support staff shall have detailed and current written protocols for responding to a person's needs as specified in the PCP, including contact information for the backup support person(s) to provide assistance when necessary. The PCP and written protocols shall also set forth the procedures to be followed should the person request that the equipment used for delivery of Remote Support be turned off.
When a person needs assistance, but the situation is not an emergency, the Remote Support staff shall address the situation as specified in the individual's Remote Supports written protocol(s). If the protocol involves the

Remote Support staff contacting backup support, the backup support person shall verbally acknowledge receipt of a request for assistance from the Remote Support staff and shall arrive at the person's location within a reasonable amount of time (as specified in the PCP, but no longer than one (1) hour when a request for in-person assistance is made.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

○ **No. Criminal history and/or background investigations are not required.**

◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Executive Officers and owners of provider agencies must obtain both a statewide and a national criminal background clearance. This is a condition for initial certification. This is the responsibility of the Life Safety Division of the Operating Agency. Direct care staff must have a background check from local law enforcement, and a statewide or national check as indicated by the staff member's previous residences and work history. If a person's information as presented garners no results through local and/or state background checks, the national background check is warranted. Or, if information provided indicates experience in another state, a national background check may be warranted.

The Operating Agency ensures criminal background checks are completed by including them as components of the certification survey. During a certification review, the certification staff will review records for a sample of personnel (generally 10% of an organization’s staff, but no less than 6) to ensure, among other things, that all criminal background checks are completed.

ADMH will check the exclusion list at AMA and the OIG websites to ensure the applicant provider has not been previously debarred.

A completed application for certification must be sent by the provider/applicant to DMH Life Safety Division at least sixty (60) days prior to projected date of service implementation. The application process must be completed and temporary operating authority granted by the Commissioner prior to the implementation of any services by the provider. Any additional documentation must be submitted as required and specified by DMH.

DMH may accept a certification/license/ accreditation issued by other generally accepted recognized state or national organizations in lieu of an additional review through the DMH certification process. However, DMH reserves the right to apply DMH certification standards to areas it determines are not adequately addressed in other state or national standards. Further, the DMH reserves the right to conduct reviews, including onsite visits if appropriate, of programs that are certified/licensed/accredited by other entities where there is evidence of significant deficiencies.

The DMH Certification Office submits the application to the respective DMH Division(s) for approval according to the type(s) of services proposed by the provider.

The applicable DMH Division(s) review/approve the application and returns a copy of the approval to the DMH Facilities Certification Office. An initial Life Safety and Programmatic review is conducted, if applicable, by designated DMH representatives. Applications remain valid for up to six (6) months after receipt by DMH if the service has not been initiated by the provider or approved by DMH.

For new applicants/providers, the DMH will conduct criminal background checks on the primary operator and/or subcontractor of the program as defined in the Alabama Administrative Code, Section 580 3 23 .06(1)(a) and Section 580 3 23 .06(1)(b).

Once the provider completes the application process, and based upon its representations of compliance with applicable DMH standards, the provider is issued a letter of Temporary Operating Authority by the DMH Commissioner allowing it to operate for a period up to six (6) months pending the outcome of its initial certification site visit.
Author: DMH Office of Certification Authority: Code of Ala. 1975, §22 50 11.

All employees/volunteers/agents of the provider have reference and background checks prior to employment. Background checks cover the employer’s local vicinity and state. National checks are completed when the person's job history is out of state or there is sufficient reason to warrant one (no record found in local or state systems). Resources to assist in this process include the Department of Public Safety, the Department of Public Health’s Abuse Registry, as well as DMH’s Term-Trac database. Drug testing is included as part of the pre-employment screening process for employees whose job duties involve the care, safety and wellbeing of people and on reasonable suspicion (for-cause) of any employee of the organization. The organization does not hire people who have been convicted of felony crimes.

The Medicaid Re-enrollment process that is on-going assumes the responsibility of ensuring Executive Directors and owners are not listed in any federal exclusion lists.

For participants who are self-directing services, all staff employed by the participant will have a criminal background check completed by the FMSA (Financial Management Service Agency) via internet. Nurses already are licensed by the Alabama Board of Nursing, which includes background screening. Participant's representatives may also be subject to background checks if needed. The Operating Agency reviews this information on a quarterly basis.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

- (◉) **No. The state does not conduct abuse registry screening.**
- ( ) **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; (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.*

a. A Legal Liable Relative (LLR) is a parent, guardian, spouse, or legally responsible relative who is approved to provide services according to the rules and regulations specified in the Community Waiver Program (CWP) Policy and Procedure Manual and the Alabama Administrative Code. The services that a legal liable relative may provide include the following self-direction services only: Self-Directed Personal Assistance -Home and Self-Directed Personal Assistance -Community. A relative, including a legal liable relative, and/or a legal guardian may serve as a personal assistance (home or community) service self-directed worker as long as the 1) the relative/legal guardian is otherwise qualified to provide these services and 2) the relative/legal guardian does not also serve as the same participant's representative/Employer of Record (EOR). A legal liable relative may only provide extraordinary care, which means care exceeding the range of activities that a legal liable relative would ordinarily perform in the household on behalf of 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. If a relative or legal liable relative and/or legal guardian is the choice of provider for, the Support Coordinator will document that relationship in the PCP to ensure the person-centered planning team is cognizant of the need to ensure no conflict of interest occurs.

During the person-centered planning process, the Support Coordinator identifies when a service that is included in the person-centered plan, to address an assessed need, is one that a LLR can provide through self-direction. In this situation, if the LLR expresses interest in providing a service(s) through self-direction, the Support Coordinator reminds the LRR and the person-centered planning team of the conflict of interest that exists and the need for the selection of the provider to be made based on what the participant would choose if s/he was her own guardian. The Support Coordinator explains the other provider options available to the person-centered planning team, including the participant. The Support Coordinator documents the team's reasons for concluding the LLR would otherwise be the participant's chosen provider for the service(s). This includes documenting any feedback directly provided by the participant. The Support Coordinator follows the same process when the selection of provider is being revisited at subsequent person-centered planning meetings.

b. The person-centered planning team must evaluate and determine that the services for which the legal liable relative will be compensated to provide meet the criteria for "extraordinary care." Extraordinary care means exceeding the range of activities that a legal liable relative would ordinarily perform in the household on behalf of 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. This objective, written documentation must be documented in the PCP. In addition, legal liable relative may not provide more than 40 hours of compensated extraordinary care per week.

c. ADMH ensures that the provision of services rendered by the legal liable relative are in the best interest of the participant through the person-centered planning meeting. In addition, Support Coordinators provide ongoing monitoring of the receipt and quality of authorized services, as well as of the health and safety of the participant, including periodic on-site and face to face visits.

Payment may be made to legal liable relatives for furnishing the following Self-Directed services: Personal Assistance- Home and Personal Assistance- Community only. The financial management services agency (FMSA) makes payments to self-direction workers including LLR's. Payments are only made for services authorized by ADMH and actually delivered by the self-direction worker, as evidenced by timesheets submitted by the self-direction worker and approved by the employer of record (EOR) for the participant. The Support Coordinator for the participant monitors the utilization of the self-direction budget over time to ensure the type and amount of service(s) being paid for by the FMSA and delivered by the self-direction worker(s) matches the authorization. The FMSA submits claims to ADMH for payments made to self-direction workers. The state conducts automated and manual reviews of claims to ensure accuracy, prevent duplicate billing, and confirm that billed amounts do not exceed limits established in authorizations.

For self-directed services, additional controls to ensure payment is only made for services rendered include:
1) the use of an electronic visit verification (EVV) system to verify and approve services rendered by the self-direction worker (*excluding personal assistance- community services),
2) the SDL's review of a sample of authorized services in terms of amount and frequency compared to the services rendered by a self-directed worker via the EVV time records, and
3) ongoing monitoring of the receipt and quality of authorized services, as well as of the health and safety of the participant by the Support Coordinator, including periodic on-site and face to face visits.

*The additional controls indicated above also applies to LLRs that deliver services via self-direction.

As noted in Appendix I of the waiver, the method that ensures the integrity of providers billing for Medicaid payment of waiver services is through the ADIDIS system for the Alabama Department of Mental Health. The provider billings are entered into a web-based claims processing system hosted by a vendor (Harmony Information Systems) for the Department of Mental Health. The ADIDIS system checks claims prior authorizations to ensure the services billed are approved by the Operating Agency's review of the PCP.

From the ADIDIS system, approved claims flow directly to the Medicaid Management Information System through DXC, the Fiscal Intermediary. The Medicaid Management Information Systems (MMIS) performs validation edits and audits to ensure program compliance. Audits check for duplicate services, and service limitations and related services are compared to Medicaid policy and guidelines.

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 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.

A relative may be employed by a provider agency to provide waiver services as specified in C2/C3, as long as:
1) the relative is otherwise qualified to provide these services,
2) the relative is not the participant's legal guardian or a legal liable relative, and
3) the relative does not also serve as the same participant's representative/Employer of Record (EOR) for any self-directed services.

A relative and/or a legal guardian may provide self-directed waiver services as specified in C2/C3, as long as: 1) the relative/legal guardian is otherwise qualified to provide these services, and 2) the relative/legal guardian does not also serve as the same participant's representative/Employer of Record (EOR).

The participant and, as applicable, the participant's legal guardian, may designate another individual as the representative/EOR, as long as that designation meets the criteria described in E-1-f.

A relative and/or a legal guardian may provide self-directed Community Transportation services as specified in C2/C3, as long as: 1) the relative/legal guardian is otherwise qualified to provide these services, and 2) the relative/legal guardian does not also serve as the same participant's representative/Employer of Record (EOR). The participant and, as applicable, the participant's legal guardian, may designate another individual as the representative/EOR, as long as that designation meets the criteria described in E-1-f. Note that a legal liable relative (an LLR as described in Appendix C-2-d) can only provide self-directed Personal Assistance-Home, self-directed Personal-Assistance Community and self-directed Community Transportation if needed to facilitate the provision of Personal Assistance-Community which prevents isolation and ensures opportunities for the participant to access their community and interact with members of the broader community. For Community Transportation, the limit for any self-directed provider is $250 per month total mileage reimbursement. A relative may not provide more than 40 hours of paid waiver service per week.

Ongoing controls to ensure payment is only made for services rendered by the relative or legal guardian include ongoing monitoring by Support Coordinators of the receipt and quality of authorized services, as well as of the health and safety of the participant, including periodic on-site and face to face visits.

For provider agency-employed relatives, DMH also completes certification audits.

For self-directed services, additional controls to ensure payment is only made for services rendered include:
1) the use of an electronic visit verification (EVV) system to verify and approve services rendered by the self-direction worker (*excluding personal assistance- community services),
2) the SDL's review of a sample of authorized services in terms of amount and frequency compared to the services rendered by a self-directed worker via the EVV time records, and
3) ongoing monitoring of the receipt and quality of authorized services, as well as of the health and safety of the participant by the Support Coordinator, including periodic on-site and face to face visits.

*The additional controls indicated above also applies to LLRs that deliver services via self-direction.

○ **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:

Through a concurrent 1115 authority, the state will have a waiver of the requirements in 42 CFR §431.51. The state will maintain a provider network sufficient to meet beneficiary needs, including ensuring choice of provider for each waiver service except Support Coordination. For Support Coordination, through the concurrent 1115 authority, the state will limit providers to ADMH/DDD employees in Regions 1, 3, 4 and 5; and in Region 2, local 310 Board(s) or if none willing and qualified, ADMH/DDD employees. The limited provider network will improve participating providers ability to thrive by participating in this waiver and will allow the Operating Agency (ADMH/DDD) to focus its resources and staff on more effectively supporting the participating providers than would be possible if the provider network was open to all willing and qualified entities that wish to be approved waiver providers. Participant satisfaction with providers will be measured annually and Support Coordinators employed by ADMH/DDD and 310 Boards will be responsible for informing ADMH leadership of any gaps in available, qualified and willing providers for specific services under this waiver and/or in specific geographic areas where this waiver is operating.

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:
 # & % of new contracted providers that met initial licensure &/or certification standards, other standards established by Medicaid and any applicable requirements of state laws prior to service provision. Percentage=NUMERATOR[#of new contracted providers that met initial licensure &/or certification standards, other standards established by Medicaid and applicable requirements of state laws]/...

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

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** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	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 non-licensed/non-certified providers that meet waiver / 1115 Group 5 requirements and any applicable requirements of state law. Percentage = NUMERATOR [Number of non-licensed/non-certified providers that met waiver / 1115 Group 5 compliance requirements] / 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:

Performance Measure:
Number and percentage of self-directed employees/staff that meet state and waiver/ 1115 Group 5 requirements. Percentage = NUMERATOR [Number of self -directed employees that meet state and waiver/ 1115 Group 5 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 *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: FMSA	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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 providers that meet training requirements in accordance with state requirements and the approved waiver/ 1115 Group 5. Percentage = NUMERATOR [Number of providers that meet training requirements in accordance with state requirements and the approved waiver / 1115 Group 5] / DENOMINATOR [Number of providers]

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: 0% of provider training verification records are reviewed over a two year cycle

Performance Measure:
Number and percentage of enrolled self-directed employees who continue to meet

waiver / 1115 Group 5 training requirements. Percentage = NUMERATOR [Number of currently enrolled self-directed employees that continue to meet waiver / 1115 Group 5 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 new self-directed employees that meet waiver / 1115 Group 5 training requirements Percentage = NUMERATOR [Number of new self-directed employees that meet waiver / 1115 Group 5 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 *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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.

Provider agencies are certified initially for 12 months and then either annually or biennially, or placed on provisional status, depending on their survey score. A high score will result in a two-year certificate; a score between 80 and 89 will result in a one-year certificate; and a score below 80 will result in the agency being placed on provisional status.

Provisional status is a temporary condition which allows an agency to submit a plan of correction and, when approved, implement that plan. Provisional status may not exceed 60 days, and many such status conditions are set at 30 days or less. At the end of that period, a re-survey is conducted, with the expectation that the agency will at least score high enough to give them a one-year certificate. However, should the agency score less than 80 on the re-survey, the certification unit may recommend a second provisional status, which also may not exceed 60 days in length. A follow-up re-survey is conducted at the end of the second provisional period, and if the provider does not score at least an 80, a recommendation is forwarded to the Commissioner of the DMH to de-certify the provider agency.

In addition to the routine certification surveys, the Operating agency may also conduct for cause surveys, in response to concerns or complaints about treatment and care of participants. Frequently the result of a for-cause survey is that the agency gets put on provisional certification and is required to submit and implement a plan of correction.

During a process in which a provider agency is in provisional status, the Regional Offices and Advocacy Section of the operating agency provide increased monitoring and technical assistance. This is both to assure basic health and welfare of the individuals receiving services and to assist the provider agency in coming into compliance.

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.

The combination of services the person is eligible to receive that occur outside of the home and in the broader community shall be limited to a combined maximum of 40 hours per week. The state can limit services to people employed in competitive integrated employment 20 or more hours per week, in which case the person can receive up to 48 hours per week less any hours the person is working in competitive integrated employment without any waiver services.

☐ **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.

With approval of the 1115 demonstration waiver ("Community First") that will operate concurrently with this waiver, five enrollment groups with distinct funding levels will be established within this waiver:
1. (Expenditure Cap = $12,000) Children with ID, ages 3-13, that are living with family or other natural supports.
2. (Expenditure Cap = $15,000) Transition-age youth with ID, ages 14-21, who are living with family or other natural supports, or living independently (18-21).
3. (Expenditure Cap = $30,000 if living with family or other natural supports; $45,000 if living in own home/apartment) Working-age and older adults with ID, ages 22+, who are living with family or other natural supports, living independently or able to live in a non-intensive supported living arrangement.
4. (Expenditure Cap = $65,000; $100,000 if exceptional behavioral/medical needs) Individuals 3+ years old who are unable to live independently, live with family or other natural supports.
5. (Expenditure Cap = $22,000) Individuals with ID, ages 22 +, who have a minimum of one substantial functional limitation.

Enrollment groups are based on age of the waiver participant and living situation. Each enrollment group has access to a unique sub-set of services from among those detailed in Appendix C-3. Through public comment held in July, 2019 on a "concept paper" that was a first iteration of the new Community Waiver program that includes this waiver and the 1115 demonstration waiver that includes the Section 1115 Group 5 and is proposed to operate concurrently with this waiver, the proposed range of services available for each enrollment was shared publicly and stakeholder feedback was used to finalize the services available to each enrollment group. Services are specifically tailored to the age group and living situation of each enrollment group, taking account of services available through other programs depending on age (e.g. EPSDT; Public School System/Special Education; Vocational Rehabilitation). Each enrollment group will also have its own expenditure cap, based on historical utilization of similar services by individuals with ID served by ADMH/DDD in similar age range and living situation. The expenditure cap for each enrollment group has also been informed by the experience of an adjoining state operating a very similar HCBS program for IDD population and their budgeted costs after 2.5 years of program experience and with over 2,700 individuals enrolled. The expenditure cap for each enrollment group applies to all services, except Minor Home Modifications if available in that enrollment group. Expenditure caps will be monitored and adjusted, as needed, based on patterns of service utilization and expenditures for each enrollment group. Individuals are informed of the relevant expenditure caps by the Support Coordinator , based on the enrollment group(s) for which they qualify at the time information on service selection is provided. On an individual participant basis, there is a provision in policy to allow for an expenditure cap to be exceeded as a cost-effective alternative to transition to an enrollment group with a higher expenditure cap or to prevent institutionalization. If an individual cannot be safely served (addressing health and welfare needs) in the enrollment group in which they are enrolled, with the exception just described, the individual will be transitioned to an enrollment group with a higher expenditure cap. No transition to a separate waiver will need to occur. Waiver participants are notified of the enrollment group which they are being enrolled in when they enter the waiver, and they are notified in writing when they qualify for an exception to the expenditure cap or transition to an enrollment group with a higher expenditure cap. The services available by enrollment group are detailed below:

Program Enrollment Groups

	1915c Group #1	1915c Group #2	1915c Group #3	1915c Group #4	Section 1115 Group 5
Age Range	3-13	14-21	22+	3-No Limit	22+
SERVICES AND SUPPORTS					
Support Coordination	X	X	X	X	X
Supported Employment Individual	-	XXXX			
• Individual Employment Exploration*	-	X	X	X	X
• Individual Employment Discovery*	-	X	X	X	X
• Individual Employment Job Development Plan*	-	X	X	X	X
• Individual Employment Job Development*	-	X	X	X	X
• Individual Employment Job Coaching*	-	X	X	X	X
• Individual Employment Co-Worker Supports	-	X	X	X	X
• Individual Employment Career Advancement*	-	X	X	XX	
Small Group Supported Employment	-	X	X	X	X
Integrated Employment Path Services	-	X	X	X	X

Financial Literacy & Work Incentives Counseling - X X X X
Community Transportation* X X X X X
Independent Living Skills* X X X - X
Personal Assistance Home* - X X X -
Community Integration Connections & Skills Training* - - X X X
Personal Assistance Community* X X X X -
Peer Specialist Services - X X XX
Family Empowerment and Systems Navigation Counseling X X X - -
Natural Support or Caregiver Education and Training X X X - -
Breaks and Opportunities (Respite)* X X X - -
Assistive Technology and Adaptive Aids X X X X X
Remote Supports - X X X X
Housing Counseling Services - X X X X
Housing Start-Up Assistance - X X X X
Minor Home Modifications (not included in expenditure cap) X X X - -
Supported Living Services - - X X -
Adult Family Home - - - X -
Community-Based Residential Services - - - X -
Individual Directed Goods and Services* X X X X X
Positive Behavior Supports X X X X -
Physical Therapy - X X X -
Occupational Therapy - X X X -
Speech and Language Therapy - X X X -
Skilled Nursing* - X X - -

The methodology for establishing funding levels for each enrollment group is made available for public inspection at ADMH/DDD Central Office, upon request and appointment made with ADMH/DDD.

☐ **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 recieved. *(Specify and describe the types of settings in which waiver services are received.)*

ICF/IDD Level of Care: The State will undertake multiple strategies to monitor, support and ensure ongoing compliance, as summarized below:

For new settings (established after March 2014), ADMH assesses HCBS compliance through comprehensive policy and procedure and administrative reviews (e.g., lease agreements) prior to serving any waiver participant and validates compliance within 65 days of serving participants via the Individual Experience Assessment, which is a participant-focused interview. For settings established prior to March 2014, ADMH assessed HCBS compliance through comprehensive policies and procedure reviews and administrative reviews as well as site visits and interviews with participants and staff to validate HCBS Compliance.

- ADMH regularly monitors all settings for HCBS compliance through bi-annual monitoring via a monitoring tool that has a dedicated section for HCBS compliance. A Corrective Action Plan will be required as a result of non-compliance discovered during routine monitoring. Regional Certification staff are also responsible for continuing to ensure provider compliance with the Final Rule via the certification tool, which allows Certification staff to review and provide additional validation of HCBS compliance during provider certification visits. These annual or bi-annual provider certification visits provide an additional validation of Regional Office Monitoring findings of HCBS compliance, which occur semi-annually and are the primary means for monitoring settings for HCBS compliance. Regional Certification staff and Regional Office Monitors are separate entities, therefore allowing for this secondary level of validation.
- Settings must meet 100% of all Final Rule criteria with the expectation that the organizations' systems and practices are fully compliant. Settings that fail to meet this standard will be placed on provisional certification status for up to 60 days, and a Plan of Action (POA) to address the rules cited must be submitted within 30 days. Failure to submit the POA within the time specified may result in immediate decertification. Prior to the expiration of provisional certification status, the setting will undergo a follow-up site certification review to determine future certification status. If the provider does not achieve 100% compliance with all the Final Rule requirements, as designated in the certification tool, a notice will be submitted to the ADMH Commissioner requesting decertification of the provider.
- ADMH-DDD Central Office will perform validity reviews of this process by selecting a sample of Regional Office monitoring reports and reviewing the validation section two times per year to ensure continuous consistency of compliance across Alabama. The sample size will be 10% and representative of all five regions.

Monitoring: Regional Office Monitors are responsible for continuing to ensure provider compliance with the Final Rule after ADMH-DDD determines that the setting is compliant and will continue to incorporate HCBS settings compliance in their regularly scheduled biannual monitoring of settings. The monitoring tool, which is used for both residential and day habilitation programs, has a dedicated section for the monitor to review HCBS compliance. A Corrective Action Plan will be required as a result of non-compliance discovered during routine monitoring. Should the provider not remediate, the provider will be placed in a 'provisional' status. The HCBS decertification process will be instituted if ADMH-DDD determines no remediation is possible. Onsite monitoring, which is conducted biannually by Regional Community Services Staff includes observations of the setting, interviews of individuals and interviews of staff relative to the HCBS regulations. This monitoring is ongoing of all provider owned or operated settings. The Office of Certification does comprehensive reviews of the agencies annually or biennial.

Individuals who receive CWP waiver services are afforded choice of disability and non-disability specific settings. CWP waiver individuals may reside in their own homes, their family homes, Adult Family Homes, Community-Based Residential Services settings and children may also reside in non-waiver, non-relative foster care settings (which are provider owned or controlled by definition). Individuals may receive waiver services in these settings as well as in community settings.

Individual Experience Assessment: ADMH-DDD will incorporate the IEA, as described above, into all initial and annual person-centered plan reviews. The IEA will be used by Support Coordinators for ongoing monitoring of beneficiary feedback on the Final Rule.

Each individual's Support Coordinator will assist the individual and his or her family member or representative, as appropriate, in completing an initial IEA. Service provider staff may participate as requested by the individual and his or her family member or representative.

- Such assessments will be conducted during the individual's annual person-centered plan review and throughout the HCBS evaluation period, or sooner if an amendment or person-centered plan review is conducted prior to the individual's annual redetermination review.
- For provider owned or controlled residential settings, any proposed modification of requirements set forth in the Final Rule for the individual shall be reviewed to confirm that:

1. There is a specific individualized assessed need for such modifications;
2. Prior interventions and supports, including less intrusive methods, have been tried and demonstrated to be unsuccessful;
3. The proposed modification is appropriate based on the specific need identified; and
4. The proposed modification, including interventions and support, will not cause harm to the individual.
5. Each of the above items shall be documented in the person-centered plan, along with:
    i. The method of collecting data on an ongoing basis to measure the effectiveness of the modification;
    ii. A specific time limit for periodic review of the data and the effectiveness of the modification to ensure it continues to be appropriate; and
    iii. Individual's informed consent of the proposed modification.
6. If a modification to the Final Rule is determined to be inappropriate based on the person's individualized needs and in accordance with the requirements above, the area identified as noncompliant will trigger a new assessment of the provider, as applicable, and a PTCP will be developed by the provider to address any issues of noncompliance and submitted to the Regional Office for review, approval, and monitoring of implementation.

Person-centered Planning: ADMH-DDD will also utilize its recently implemented person-centered planning process to monitor specific elements of the Final Rule, as described above in Section I. The standardized process for person-centered planning places much emphasis on independence, natural supports, community supports and paid supports to ensure community integrated activities – where and with whom people live, work and recreate. ADMH-DDD has mandated the use of the process and toolkit by Support Coordinators statewide to address barriers to person-centered planning.

Stakeholder Engagement and Agency Partnership: ADMH-DDD will continue to work with stakeholders, providers, and AMA to ensure ongoing Final Rule compliance via the following activities:

- ADMH-DDD will continue its participation in the National Core Indicators for Individuals with I/DD and will use information from the surveys to target educational opportunities about HCBS
- ADMH-DDD will provide ongoing stakeholder communications via email, including HCBS education and advocacy materials. ADMH-DDD will also share and maintain HCBS documents on its website and utilize the following email address for HCBS-related inquiries: ADMH-DDD.questions@mh.alabama.gov.
- ADMH-DDD will continue to report on HCBS progress and compliance data as a regular agenda item of the DDD Subcommittee and regional provider meetings.
- ADMH-DDD will continue supporting providers who wish to transition their business model from congregate and segregated settings to full integration into the community as described further in Section I above.
- ADMH-DDD will provide ongoing targeted training to staff, providers, and other stakeholders identified through stakeholder engagement, waiver data, and quality enhancement tracking, as appropriate. Training topics will include, but not be limited to, person-centered planning, employment, housing, and community integration.
- ADMH-DDD will continue meeting regularly with AMA to review provider compliance statuses, the transition of waiver participants from noncompliant provider settings, if applicable, and other concerns relating to compliance, as appropriate.

Actions to Be Taken for Compliant and Noncompliant Providers:

ICF/IDD Level of Care: ADMH-DDD will notify AMA of all settings deemed noncompliant and mail a letter from ADMH's Commissioner to those providers informing them of the Division's final determination. For any setting where the operating provider does not complete all required remediation, or for any setting that cannot, even with remediation, overcome the presumption that the setting is institutional in nature, ADMH-DDD will work with the provider, individuals served in the setting, and others as appropriate to determine a transition strategy to a compliant setting. The transition process, including notification to providers and individuals served, is described in more detail below.

Facilitation of Choice Process: If a provider cannot or refuses to come into compliance, ADMH-DDD will implement the following processes to notify the provider and individuals served as well as transition individuals served from the non-compliant setting to a setting that meets all HCBS Final Rule requirements.

- ADMH-DDD will ensure that reasonable notice and due process are provided to anyone needing to transition. Individuals served that need to transition will receive at least a 30-day advance notice.
- ADMH-DDD will submit a request to revoke the setting's HCBS waiver setting certificate to the ADMH Commissioner based on the provider's failure to comply with Final Rule requirements.

- ADMH-DDD will notify the provider of the loss of eligibility to receive HCBS waiver funding for the setting.
  - ADMH-DDD will mail a formal notification letter from the ADMH Commissioner to the provider that outlines the specific reason(s) for transition, due process procedure, and timeline of events.
    - i. The letter will serve as formal notification indicating the intent to transition the person(s) supported.
    - ii. The provider will be directed to participate with ADMH-DDD, contracted entities, advocates, and other agencies, as applicable, in activities related to the transition of the person. This includes, but is not limited to, participating in planning meetings, ongoing provision of information, transfer of individual's personal property (to include monies and medications), and other activities as directed.
    - iii. Notifications to the person supported and the provider will be sent simultaneously to ensure both parties are aware of the need to transition at the same time.
- ADMH-DDD will notify individuals served in the noncompliant setting.
  - ADMH-DDD will mail a formal notification letter from the ADMH Commissioner to the person and, if applicable, his or her caregiver, guardian, or conservator, that outlines the specific reason(s) for the transition of individuals who desire to continue to receive HCBS waiver funded services, the due process procedure, and timeline of anticipated events. This letter will be available to the person and, if applicable, his or her caregiver, guardian, or conservator, no less than 30 days prior to transition.
    - i. The letter will serve as formal notification indicating the intent to transition the person(s) supported.
    - ii. Notifications to the person supported and the provider will be sent simultaneously to ensure both parties are aware of the need to transition at the same time.
  - Upon determining the need to transition a person as indicated by the ADMH Commissioner's letter, the individual's designated Support Coordinator will make a face-to-face visit to the person and, if applicable, his or her caregiver, guardian, or conservator, to discuss the specific reason(s) for the need to transition the person and to officially begin the transition process.
    - i. The face-to-face meeting will include those important to the person, including caregivers, family members, friends, and anyone else the person deems important. This face-to-face meeting will reflect everyone's sincere desire to ensure continuity of services while meeting the person's needs during this transition process.
- The Regional Office Placement Coordinator will assist the individual's Support Coordinator agency in ensuring that the person is given ample opportunity to learn about available HCBS compliant settings and support the individual's choice of a compliant setting.
  - The person will be afforded the opportunity to select from non-disability specific settings and select their housemates, if applicable.
  - Supports will be provided to the person to assist in transition choice, and the caregiver's schedule will be accommodated to support the person in making an informed decision about an alternate compliant setting.
  - The Regional Office Placement Coordinator will assist the individual's Support Coordinator to research all possible, appropriate settings for this person to choose from.
- Once a new provider has been selected, a person-centered planning meeting will take place to define the timelines for transition as well as specific supports and services needed in order to make a safe transition. As needed, additional time will be built into the transition plan to ensure safety, continuity of services, and that all support and services will be in place prior to the person's transition to the new provider.
- The ADMH-DDD Regional Office Placement Coordinator will assist the individual's Support Coordinator to ensure that all supports and services are in place prior to the person's transition to the new provider. This will be done through an on-site visit prior to the person transitioning and will include, at a minimum, the person, caregiver, guardian, or conservator (if applicable), the individual's Support Coordinator, an advocate, and the new provider. Any modifications or changes identified during the on-site visit as necessary for the person's health, safety, or welfare will be addressed prior to the transition as confirmed by the individual's Support Coordinator.
- After the transition has occurred, the individual's Support Coordinator will conduct the first three (3) consecutive monthly contacts face-to-face.
- ADMH-DDD will provide AMA transition updates on at least a quarterly basis.

ADMH-DDD will provide notification to both individuals and affected providers and will begin the transition process in settings determined unable or unwilling to come into compliance.

1. Individuals who receive waiver services are afforded choice of disability and non-disability specific settings. Services under this waiver are provided in the following setting types:

- Private Homes: Personal Care, Prevocational Services, Adult Companion, Respite, Assistance in Community

Integration, Supported Employment, Assistive Technology, Benefits and Career Counseling, Crisis Intervention, Environmental Accessibility Adaptations, Housing Stabilization Service, Individual Directed Goods and Services, Occupational Therapy, Personal Emergency Response System, Physical Therapy, Positive Behavior Support, Remote Supports, Skilled Nursing, Specialized Medical Supplies, Speech and Language Therapy, Supported Living Service, and Assistance in Community Integration

- Day Habilitation: Day Habilitation service, Supported Employment, Personal Care, Prevocational Services, Community Experience, Assistive Technology, Benefits and Career Counseling, Occupational Therapy, Physical Therapy, Positive Behavior Support, Skilled Nursing, Speech and Language Therapy, and Supported Living Service

For settings established prior to March 2014, ADMH assessed HCBS compliance through comprehensive policies and procedure reviews and administrative reviews as well as site visits and interviews with participants and staff to validate HCBS Compliance. For new settings (established after March 2014), ADMH assesses HCBS compliance through comprehensive policy and procedure and administrative reviews (e.g., lease agreements) prior to serving any waiver participant and validates compliance within 65 days of serving participants via the Individual Experience Assessment (IEA), which is a participant-focused interview.

2. The State undertakes multiple strategies to monitor, support and ensure ongoing compliance, as summarized below:

Ongoing Monitoring: Regional Office Monitors are responsible for continuing to ensure provider compliance with the Final Rule and will continue to incorporate HCBS settings compliance in their regularly scheduled biannual monitoring of all HCBS settings. The monitoring tool, which is used for both residential and day habilitation programs, has a dedicated section for the monitor to review HCBS compliance. A Corrective Action Plan will be required as a result of non-compliance discovered during routine monitoring. Should the provider not remediate, the provider will be placed in a 'provisional' status. The HCBS decertification process will be instituted if ADMH-DDD determines no remediation is possible. Onsite monitoring, which is conducted biannually by Regional Community Services Staff includes observations of the setting, interviews of individuals, and interviews of staff relative to the HCBS regulations. This monitoring is ongoing of all provider-owned or operated settings. The Office of Certification does comprehensive reviews of the agencies annually or biennial.

ADMH-DDD also incorporates the IEA into all initial and annual person centered plan reviews. Each individual's Support Coordinator assists the individual and his or her family member or representative, as appropriate, in completing an initial IEA. Such assessments are conducted during the individual's annual person-centered plan review and throughout the HCBS evaluation period, or sooner if significant changes occur.

For private homes, CMS has clarified that a State may presume that an individual's private home or a relative's home where an individual resides meets the home and community-based settings requirements, but it also has a responsibility to ensure that individuals living in a private home or a relative's home have opportunities for full access to the greater community. Support Coordinators use the annual IEA and person-centered planning processes to ensure this is occurring.

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.)*

ICF/IDD Level of Care: The State will undertake multiple strategies to monitor, support and ensure ongoing compliance, as summarized below:

For new settings (established after March 2014), ADMH assesses HCBS compliance through comprehensive policy and procedure and administrative reviews (e.g., lease agreements) prior to serving any waiver participant and validates compliance within 65 days of serving participants via the Individual Experience Assessment, which is a participant-focused interview. For settings established prior to March 2014, ADMH assessed HCBS compliance through comprehensive policies and procedure reviews and administrative reviews as well as site visits and interviews with participants and staff to validate HCBS Compliance.

- ADMH regularly monitors all settings for HCBS compliance through bi-annual monitoring via a monitoring tool that has a dedicated section for HCBS compliance. A Corrective Action Plan will be required as a result of non-compliance discovered during routine monitoring. Regional Certification staff are also responsible for continuing to ensure provider compliance with the Final Rule via the certification tool, which allows Certification staff to review and provide additional validation of HCBS compliance during provider certification visits. These annual or bi-annual provider certification visits provide an additional validation of Regional Office Monitoring findings of HCBS compliance, which occur semi-annually and are the primary means for monitoring settings for HCBS compliance. Regional Certification staff and Regional Office Monitors are separate entities, therefore allowing for this secondary level of validation.
- Settings must meet 100% of all Final Rule criteria with the expectation that the organizations' systems and practices are fully compliant. Settings that fail to meet this standard will be placed on provisional certification status for up to 60 days, and a Plan of Action (POA) to address the rules cited must be submitted within 30 days. Failure to submit the POA within the time specified may result in immediate decertification. Prior to the expiration of provisional certification status, the setting will undergo a follow-up site certification review to determine future certification status. If the provider does not achieve 100% compliance with all the Final Rule requirements, as designated in the certification tool, a notice will be submitted to the ADMH Commissioner requesting decertification of the provider.
- ADMH-DDD Central Office will perform validity reviews of this process by selecting a sample of Regional Office monitoring reports and reviewing the validation section two times per year to ensure continuous consistency of compliance across Alabama. The sample size will be 10% and representative of all five regions.

Monitoring: Regional Office Monitors are responsible for continuing to ensure provider compliance with the Final Rule after ADMH-DDD determines that the setting is compliant and will continue to incorporate HCBS settings compliance in their regularly scheduled biannual monitoring of settings. The monitoring tool, which is used for both residential and day habilitation programs, has a dedicated section for the monitor to review HCBS compliance. A Corrective Action Plan will be required as a result of non-compliance discovered during routine monitoring. Should the provider not remediate, the provider will be placed in a 'provisional' status. The HCBS decertification process will be instituted if ADMH-DDD determines no remediation is possible. Onsite monitoring, which is conducted biannually by Regional Community Services Staff includes observations of the setting, interviews of individuals and interviews of staff relative to the HCBS regulations. This monitoring is ongoing of all provider owned or operated settings. The Office of Certification does comprehensive reviews of the agencies annually or biennial.

Individual Experience Assessment: ADMH-DDD will incorporate the IEA, as described above, into all initial and annual person-centered plan reviews. The IEA will be used by Support Coordinators for ongoing monitoring of beneficiary feedback on the Final Rule.

Each individual's Support Coordinator will assist the individual and his or her family member or representative, as appropriate, in completing an initial IEA. Service provider staff may participate as requested by the individual and his or her family member or representative.

- Such assessments will be conducted during the individual's annual person-centered plan review and throughout the HCBS evaluation period, or sooner if an amendment or person-centered plan review is conducted prior to the individual's annual redetermination review.
- For provider owned or controlled residential settings, any proposed modification of requirements set forth in the Final Rule for the individual shall be reviewed to confirm that:
    1. There is a specific individualized assessed need for such modifications;
    2. Prior interventions and supports, including less intrusive methods, have been tried and demonstrated to be unsuccessful;
    3. The proposed modification is appropriate based on the specific need identified; and
    4. The proposed modification, including interventions and support, will not cause harm to the individual.

5. Each of the above items shall be documented in the person-centered plan, along with:
    i. The method of collecting data on an ongoing basis to measure the effectiveness of the modification;
    ii. A specific time limit for periodic review of the data and the effectiveness of the modification to ensure it continues to be appropriate; and
    iii. Individual's informed consent of the proposed modification.
6. If a modification to the Final Rule is determined to be inappropriate based on the person's individualized needs and in accordance with the requirements above, the area identified as noncompliant will trigger a new assessment of the provider, as applicable, and a PTCP will be developed by the provider to address any issues of noncompliance and submitted to the Regional Office for review, approval, and monitoring of implementation.

Person-centered Planning: ADMH-DDD will also utilize its recently implemented person-centered planning process to monitor specific elements of the Final Rule, as described above in Section I. The standardized process for person-centered planning places much emphasis on independence, natural supports, community supports and paid supports to ensure community integrated activities – where and with whom people live, work and recreate. ADMH-DDD has mandated the use of the process and toolkit by Support Coordinators statewide to address barriers to person-centered planning.
Stakeholder Engagement and Agency Partnership: ADMH-DDD will continue to work with stakeholders, providers, and AMA to ensure ongoing Final Rule compliance via the following activities:

- ADMH-DDD will continue its participation in the National Core Indicators for Individuals with I/DD and will use information from the surveys to target educational opportunities about HCBS
- ADMH-DDD will provide ongoing stakeholder communications via email, including HCBS education and advocacy materials. ADMH-DDD will also share and maintain HCBS documents on its website and utilize the following email address for HCBS-related inquiries: ADMH-DDD.questions@mh.alabama.gov.
- ADMH-DDD will continue to report on HCBS progress and compliance data as a regular agenda item of the DDD Subcommittee and regional provider meetings.
- ADMH-DDD will continue supporting providers who wish to transition their business model from congregate and segregated settings to full integration into the community as described further in Section I above.
- ADMH-DDD will provide ongoing targeted training to staff, providers, and other stakeholders identified through stakeholder engagement, waiver data, and quality enhancement tracking, as appropriate. Training topics will include, but not be limited to, person-centered planning, employment, housing, and community integration.
- ADMH-DDD will continue meeting regularly with AMA to review provider compliance statuses, the transition of waiver participants from noncompliant provider settings, if applicable, and other concerns relating to compliance, as appropriate.

Actions to Be Taken for Compliant and Noncompliant Providers:

ADMH-DDD will notify AMA of all settings deemed noncompliant and mail a letter from ADMH's Commissioner to those providers informing them of the Division's final determination. For any setting where the operating provider does not complete all required remediation, or for any setting that cannot, even with remediation, overcome the presumption that the setting is institutional in nature, ADMH-DDD will work with the provider, individuals served in the setting, and others as appropriate to determine a transition strategy to a compliant setting. The transition process, including notification to providers and individuals served, is described in more detail below.

Facilitation of Choice Process: If a provider cannot or refuses to come into compliance, ADMH-DDD will implement the following processes to notify the provider and individuals served as well as transition individuals served from the non-compliant setting to a setting that meets all HCBS Final Rule requirements.

- ADMH-DDD will ensure that reasonable notice and due process are provided to anyone needing to transition. Individuals served that need to transition will receive at least a 30-day advance notice.
- ADMH-DDD will submit a request to revoke the setting's HCBS waiver setting certificate to the ADMH Commissioner based on the provider's failure to comply with Final Rule requirements.
- ADMH-DDD will notify the provider of the loss of eligibility to receive HCBS waiver funding for the setting.
    - ADMH-DDD will mail a formal notification letter from the ADMH Commissioner to the provider that outlines the specific reason(s) for transition, due process procedure, and timeline of events.
        i. The letter will serve as formal notification indicating the intent to transition the person(s) supported.
        ii. The provider will be directed to participate with ADMH-DDD, contracted entities, advocates, and other

agencies, as applicable, in activities related to the transition of the person. This includes, but is not limited to, participating in planning meetings, ongoing provision of information, transfer of individual's personal property (to include monies and medications), and other activities as directed.

iii. Notifications to the person supported and the provider will be sent simultaneously to ensure both parties are aware of the need to transition at the same time.

- ADMH-DDD will notify individuals served in the noncompliant setting.
  - ADMH-DDD will mail a formal notification letter from the ADMH Commissioner to the person and, if applicable, his or her caregiver, guardian, or conservator, that outlines the specific reason(s) for the transition of individuals who desire to continue to receive HCBS waiver funded services, the due process procedure, and timeline of anticipated events. This letter will be available to the person and, if applicable, his or her caregiver, guardian, or conservator, no less than 30 days prior to transition.
    i. The letter will serve as formal notification indicating the intent to transition the person(s) supported.
    ii. Notifications to the person supported and the provider will be sent simultaneously to ensure both parties are aware of the need to transition at the same time.
  - Upon determining the need to transition a person as indicated by the ADMH Commissioner's letter, the individual's designated Support Coordinator will make a face-to-face visit to the person and, if applicable, his or her caregiver, guardian, or conservator, to discuss the specific reason(s) for the need to transition the person and to officially begin the transition process.
    i. The face-to-face meeting will include those important to the person, including caregivers, family members, friends, and anyone else the person deems important. This face-to-face meeting will reflect everyone's sincere desire to ensure continuity of services while meeting the person's needs during this transition process.
- The Regional Office Placement Coordinator will assist the individual's Support Coordinator agency in ensuring that the person is given ample opportunity to learn about available HCBS compliant settings and support the individual's choice of a compliant setting.
  - The person will be afforded the opportunity to select from non-disability specific settings and select their housemates, if applicable.
  - Supports will be provided to the person to assist in transition choice, and the caregiver's schedule will be accommodated to support the person in making an informed decision about an alternate compliant setting.
  - The Regional Office Placement Coordinator will assist the individual's Support Coordinator to research all possible, appropriate settings for this person to choose from.
- Once a new provider has been selected, a person-centered planning meeting will take place to define the timelines for transition as well as specific supports and services needed in order to make a safe transition. As needed, additional time will be built into the transition plan to ensure safety, continuity of services, and that all support and services will be in place prior to the person's transition to the new provider.
- The ADMH-DDD Regional Office Placement Coordinator will assist the individual's Support Coordinator to ensure that all supports and services are in place prior to the person's transition to the new provider. This will be done through an on-site visit prior to the person transitioning and will include, at a minimum, the person, caregiver, guardian, or conservator (if applicable), the individual's Support Coordinator, an advocate, and the new provider. Any modifications or changes identified during the on-site visit as necessary for the person's health, safety, or welfare will be addressed prior to the transition as confirmed by the individual's Support Coordinator.
- After the transition has occurred, the individual's Support Coordinator will conduct the first three (3) consecutive monthly contacts face-to-face.
- ADMH-DDD will provide AMA transition updates on at least a quarterly basis.

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

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Person-Centered Plan

a. Responsibility for Service Plan Development. Per 42 CFR § 441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals. 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:

The individual's team, composed of the individual, legal representative if applicable, family & friends as appropriate, support coordinator, and all other persons providing services and support to the individual, is responsible for development of the person-centered plan. It is important that people are present that know the individual very well. Note: wherever reference is made to the individual in Appendix D, the legal representative is also included, if the individual has a legal representative.

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.

Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant or be employed by an entity that providers other direct waiver services to the participant. In order to ensure conflict free support coordination, the state is employing Support Coordination staff to develop person centered plans in Regions 1, 3, 4 and 5. In Region 2, based on public comment, the state will contract with willing and qualified 310 boards that have fully deconflicted and do not provide other direct waiver service to individuals in DDD HCBS programs. Additionally, the Support Coordinator may meet with the individual without contracted providers present in order to allow an opportunity for the individual to speak freely about their providers and/or to request to change the provider for one or more services in their plan.

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):

a. The development of the PCP is driven by the individual, and with support and guidance from the Support Coordinator, as well as the support of other people of the individual's choosing. The Support Coordinator facilitates the person-centered planning process to the extent necessary to ensure a high-quality process and also facilitates the completion of the paperwork and data entry relative to the completion of the PCP.
The individual and the Support Coordinator develop the initial PCP during the first 60 days of enrollment. Any service needs related to health and safety will be identified early and will be addressed through interim PCP put in place within 14 days of enrollment, that will also include authorization of Support Coordination. At minimum, the individual and the Support Coordinator formally review and update the PCP annually. The individual and the Support Coordinator must also formally review and update the PCP when a change in the goals, needs related to goals, availability of services and supports through other systems or programs, or condition of the individual occurs. During every required face-to-face visit (a minimum of monthly for first year of enrollment and then quarterly thereafter, based on the needs of the individual) and every required monthly phone contact, the Support Coordinator and individual informally review the PCP, progress on goals, effectiveness of services, and current satisfaction of the individual. In all situations, formal or informal, when a change in the goals, needs related to goals, availability of services and supports through other systems or programs, or condition of the individual occurs, the Support Coordinator is responsible to assist the individual in updating the PCP. Information discussed in a person-centered planning meeting is communicated and explained to the person in a method he/she is most able to understand, and also communicated and explained to the legal representative (if applicable), both at and prior to the scheduled meeting; however prior discussion may not be possible in the event an emergency meeting is necessary.

b. The individual and the Support Coordinator have several person-centered planning tools and assessments available to them to be used to help identify the individual's goals, needs related to these goals, to identify generic and other system resources available to address these needs and goals, and to determine which waiver services and supports are available that best meet these goals and needs, as well as the appropriate quantities of the identified waiver services and supports.
o An assessment that results in an accurate and complete picture of the person's current situation, what is important to and for the person supported, and t identification of the individual's goals in various life domains (e.g., home, work, relationships, community membership, health and wellness), including changes the person desires in his/her life as well as things the person wishes to remain the same.
o An assessment that considered needs related to achieving or sustaining the goals identified by the individual, including identification of services and supports available from sources other than the waiver, as well as supports and services available from the waiver, that together best address these needs,
o The identification of individual risk factors, and identification of strategies to mitigate the negative aspects of these risks, including documentation of the individual's understanding of the risks (both benefits and potential negative implications) including the proposed mitigation strategies, with documentation that those strategies have been clearly explained as part of the individual making an informed decision about each identified risk;
o An assessment of the individual's current adaptive functioning through the administration, by a DDD Regional Office QIDP, of a uniform assessment instrument (the Inventory for Client and Agency Planning (ICAP);
o Additional assessments, where appropriate, by health care or other relevant professionals (e.g., occupational or physical therapists, assistive technology consultants, behavior analysts, etc.);
o The Home and Community Support (HCS) Assessment helps quantify the amount of personal assistance services needed by the individual to meet their needs
At least annually, an assessment of the individual's experience to confirm that that the settings in which the individual is receiving services and supports comport with standards applicable to HCBS Settings delivered under Section 1915(c) of the Social Security Act. This includes those requirements applicable to provider-owned or controlled settings if applicable, and except as supported by the individual's specific assessed health and/or safety need(s) and documented in the person-centered plan in accordance with federal regulatory requirements for such modifications.
c. From the person-centered planning process, informed by the assessments above, the individual and the SC identifies supports and services to address the identified individual's desired goals and outcomes. The individual and Support Coordinator first explore unpaid and natural supports, then supports and services from other systems and programs available to the individual, followed by services and support funded by the waiver program, utilizing waiver funding as the funding source of last resort. When considering waiver services, the Support Coordinator is required to assist the individual in evaluating the waiver services and supports that will most effectively meet the individual's desired goals, outcomes and needs. As a written resource, the individual has access to the document, "Waiver Service Definition Manual" which defines each service available in the waiver program, the types of goals, outcomes and needs each service is designed to address, and the requirements for provider qualifications. Support Coordinators are trained to be skilled in explaining services and supports, including those available through generic community

resources and other systems and programs.

d. Support Coordinators are required to document the individual's goals/outcomes, needs and preferences that are identified through a collaborative review of the aforementioned tools and exploratory discussion involving the individual's person-centered planning team. Prior to concluding the PCP development process, Support Coordinators must review their documentation of all of the planning conversations with the individual to ensure the PCP meets all of the person's identified needs and preferences related to their identified goals and outcomes.

When an individual chooses not to address one of their needs on the PCP, the Support Coordinator discusses this choice with the individual. If the individual elects to not address an identified need or preference through the waiver PCP, this conversation must be documented, including the Support Coordinator's effort to encourage the individual to address the need. In cases wherein the unaddressed need is related to health and safety or presents another type of risk, the Support Coordinator completes the document, "Risk Agreement – Waiver Program" with the individual to document information and resources provided to the individual. Support Coordination Supervisors (SCS) are required to ensure that the PCPs developed by their Support Coordinators meet the needs of the individual as required by this waiver and waiver program policy and work instructions. DDD Regional Office Staff conducts record reviews that evaluate a sample of individual PCPs to ensure that the PCPs adequately meet the individual's needs related to their identified goals and outcomes. SCSs and/or DDD Regional Office Staff will be required to remediate any individual negative findings as well as require a corrective action plan (CAP) to improve insufficient performance if a trend is found with a particular Support Coordinator.

e. When the individual and Support Coordinator have identified waiver services and supports to meet the individual's needs related to the individual's goals and outcomes, the individual determines whether they wish to use self-direction (if applicable for services selected) , agency providers, or a combination of self-direction for some services in the PCP and agency providers for other services.
For each need that waivers services will address, the PCP must describe the specific service or support which will meet that need, including how much, who will provide it, and when/how often it will be provided. SCs are responsible for coordinating all supports and services in the PCP and working closely with those identified in the PCP as providing specific services and supports. The SC is also responsible for monitoring the provision of those supports and services through routine monitoring visits, regular communication with the individual, and review of written documentation submitted by the providers.

f. Ongoing monitoring by the SC is accomplished through monthly face-to-face monitoring visits during the first year of enrollment and a minimum of quarterly face-to-face visits after the first year of enrollment, based on the needs of the individual. Face-to-face visits should be coordinated with the person supported (and their family or involved friend/ally, as applicable) and should generally occur in the person's residence at least once per quarter. However, if requested by the person (or their family or involved friend/ally, as applicable), visits can be scheduled at alternative locations that are convenient for the person (and their family or other involved friend/ally as applicable), unless there are specific concerns regarding the person's health and safety which would warrant that the visit is conducted atin the person's home. When an individual receives residential services, one face-to-face visit per quarter (i.e. once every 3 months) must take place in the individual's residence. Face-to-face and/or telephone contacts shall be conducted more frequently when appropriate based on the person's needs and/or request which shall be documented in the PCP or based on a significant change in needs or circumstances. Completion of a monthly status review of the PCP will be documented for each individual per service received and across service settings.

g. Person Centered Plans are subject to continuous revision, as needed. However, at a minimum, the PCP is reviewed by the Individual and SC during a formal review at least annually. During this time, the individual's progress on the goals and outcomes identified on the previous year's PCP is reviewed as a priority. The individual and Support Coordinator collaborate to ensure the new PCP is an accurate and current reflection of the individual's goals/outcomes and needs related to these goals/outcomes, and that the PCP adequately supports the individual's goals and outcomes with waiver–funded services used to wrap around generic community services and supports and services and supports available through other programs and systems.. When the cost of an individual's needs exceed the person's expenditure cap, the Support Coordinators is required to involve his/her Supervisor to review the PCP and assist the individual, as needed, in completing documentation for approval to exceed the expenditure cap (or receive approval for a one-time emergency expense) to avoid enrollment in an enrollment group with a higher expenditure cap, particularly to avoid residential placement if the person is living with natural supports or living independently.

Through the SC’s monthly and quarterly contacts(more frequently if the individual’s needs dictate), the SC will monitor the individual's health and welfare. Progress notes will document the contact and whether the outcomes stated in the person's plan are occurring for the individual and being effectively addressed by the person’s providers of waiver services and supports.

It is also the SC’s responsibility to review the provider's submitted documentation at least monthly, and note any problems, concerns, discrepancies, dramatic changes or other occurrences that would indicate a need for review of the provider’s performance or the individual’s goals/outcomes or needs. The SC's review of the provider documentation will include making further inquiries and taking appropriate action if there is reason to believe the person's health or welfare is potentially at risk and/or if services are not being delivered according to the PCP.

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.

A risk assessment is administered as part of the process for developing the person's PCP. The assessment process is intended to create an environment that establishes appropriate safeguards for the person without limiting personal experiences and growth opportunities. A person-centered approach is employed to identify risk factors, to identify the potential benefits of the individual taking certain risks (e.g. opportunities for learning, personal growth, independence, community involvement, etc. that otherwise would not be available to the individual), and to develop proactive strategies to mitigate the potential negative consequences of the identified risks. Based on the life the person desires to lead, the assessment identifies potential situational, environmental, medical, financial and other relevant risks. When risks are identified, the strategies necessary to address and mitigate them, while still enabling a person to achieve his/her desired goals/outcomes, lifestyle and routines, are incorporated into the PCP.

Each individual should have an emergency preparedness plan, should be trained on this plan, and practice implementing their plan on a regular basis. People are supported to become knowledgeable about how to access emergency medical care when needed. Medication ordered by a physician to use in a potential emergency is available in the appropriate dose, quantity and form. Whenever possible and as a first consideration, strategies will identify informal (unpaid) supports that could assist in meeting emergency needs. The individual can select from provider organizations that have emergency plans to deal with a variety of situations and accommodate the individual needs of people supported, and that ensure emergency contact numbers are readily available and accessible to their staff, volunteers and people receiving supports.

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.

Individuals in this waiver have choice from among the qualified providers (with an active provider agreement with ADMH/DDD) available for the specific services and supports for which they have an assessed need, related to a specific desired goal/outcome that cannot be met by natural supports or other generic resources or programs available to the individual. At least two providers are available for each specific service or support, from which an individual may choose, or the individual may opt to self-direct and hire their own workers with assistance from a Financial Management Service. All available providers also offer services in a choice of settings that are integrated in, and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS. The state ensures that each individual found eligible for the waiver is given choice among the qualified providers in their area for each service included in his/her PCP. The SC will provide information about qualified providers and will undertake other steps to facilitate informed choice by the waiver participant.

A Due Process Rights Form is presented to each waiver participant (and his/her family/involved friend) as part of the planning process, and each individual and/or legal representative must sign, acknowledging receipt of the information regarding his/her right to a hearing.
The individual's signature on the Free-Choice of Qualified and Contracted Providers form, and on the PCP, combined with the information presented in the Due Process Rights Form, assures the person is aware of his/her rights including choice of providers.

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 Interagency Memorandum of Understanding between the Alabama Medicaid Agency and the Alabama Department of Mental Health outlines the authority given to the Department of Mental Health to approve and sign-off on the PCP including the initial PCP as well as annual updates to the PCP. This will also include any other instances where there is a substantial change in the PCP. Below are the ways that Medicaid and DDD ensure that the requirements are met for Personal Centered Planning and Service Delivery as well as Service Plan Development:

1. The Support Coordinator monitors/reviews services, and does so on a quarterly basis at a minimum.
2. The Regional DMH Office provides a 6 month minimum visit/review to each service site and a semi-annual random review of the Support Coordinator records.
3. The DMH Programmatic Certification offices have monitoring of the person centered plan responsibility.
4. Other monitoring and technical assistance reviews are completed by DMH Advocacy office and DMH Quality Enhancement office.
5. Medicaid nurses conduct a scientifically calculated random record review each month of all plans of care for persons initially enrolled or re-determined for waiver services during the previous month. These records are made available through the Support Coordinator and/or the Regional Community Services Office.

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.

(a) Support Coordinators (SC) assist persons supported in identifying needs and preferences, and in selecting, obtaining, and coordinating services using paid and natural supports. Ongoing monitoring by SCs is essential and they have primary responsibility for determining if services are being implemented as specified in the PCP and if the services described in the plan are meeting the person's needs and assisting the person to achieve his/her desired goals and outcomes. In addition, Medicaid Quality Assurance staff also play a role in monitoring PCP implementation as described in (b).

(b) Ongoing monitoring by the SC is accomplished through monthly face-to-face monitoring visits during the first year of enrollment and a minimum of quarterly face-to-face visits after the first year of enrollment, based on the needs of the individual. Face-to-face visits should be coordinated with the person supported (and their family or involved friend/ally, as applicable) and should generally occur in the person's residence. However, if requested by the person (or their family or involved friend/ally, as applicable), visits can be scheduled at alternative locations that are convenient for the person (and their family or other involved friend/ally as applicable), unless there are specific concerns regarding the person's health and safety which would warrant that the visit is conducted at the person's home. When an individual receives residential services, one face-to-face visit per quarter (i.e. once every 3 months) must take place in the individual's residence. Face-to-face and/or telephone contacts shall be conducted more frequently when appropriate based on the person's needs and/or request which shall be documented in the PCP, or based on a significant change in needs or circumstances.

(c) Completion of a monthly status review of the PCP will be documented for each individual per service received and across service settings. Information is gathered using standardized processes and tools. The SC reports identified issues, including any issues related to risk identification and management, to management staff from the involved provider agencies or self-direction workers as applicable. DDD SC Supervisors may assist in achieving resolution when timely provider or self-direction worker response does not occur.

Monitoring of risk management is accomplished through ongoing evaluation of the effectiveness of risk identification and mitigation strategies. The success of individual strategies to mitigate specific, identified are evaluated by the person supported, their families and significant others, providers, and the SC as part of on-going planning for and monitoring of services. In addition, the SC conducts initial (if a setting where services delivered is new)) and at least annual assessment of the individual's experience, in accordance with timeframes outlined in State Protocol, to confirm that that the settings in which the person is receiving services and supports comports fully with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, including those requirements applicable to provider-owned or controlled settings, except as supported by the individual's specific assessed health and/or safety need(s) and documented in the person-centered plan in accordance with federal regulatory requirements for such modifications.

Medicaid Quality Assurance staff annually perform a separate review of a random sample of plans of care and related documents for the individuals served by each provider, to assure the individuals receiving services under the waiver, from the specific provider, have a PCP in effect for the period of time the services were provided. This review also ensures that the need for the services that were provided was documented in the plan, and that all service needs were addressed in the PCPprior to delivery.

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):
Other
If 'Other' is selected, specify:
Participant record reviews, on-site (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**

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 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):
Other
If 'Other' is selected, specify:
Participant record reviews, onsite (Certification) i.e., Participants' Assessment Forms and person centered service plan (PCCP)

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**	☐ **Other**

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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.

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 whose service plans were reviewed with the participant according to the timeframes specified in the waiver / 1115 Group 5. 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:
Participant Record Reviews, on-site (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 participants reviewed whose service plans are updated at least annually. Percentage=NUMERATOR [Number of participants reviewed whose service plans were update at least annually]/DENOMINATOR [Number of participants reviewed]

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

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

Performance Measure:
Number and percent of participants whose needs changed and whose service plans were revised accordingly. Percentage = NUMERATOR [Number of participants reviewed whose needs changed and whose service plans were revised accordingly] / DENOMINATOR [Number of participants reviewed whose needs changed]

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 PCCP's that include the signatures of the required participants in the development of the plan as indicated by the approved waiver / 1115 Group 5. 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:

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

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 / 1115 Group 5 participants that receive services and supports in the amount specified in the service plan. Percentage = NUMERATOR [Number of waiver / 1115 Group 5 participants reviewed that receive services and supports in the amount specified in the service plan] / DENOMINATOR [Number of participants reviewed]

Data Source (Select one):
Other
If 'Other' is selected, specify:
Participant record review on-site (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 / 1115 Group 5 participants that receive services and supports in the duration specified in the service plan. Percentage = NUMERATOR [Number of waiver / 1115 Group 5 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:

Participant record review on-site (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**

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

Performance Measure:
Number and percent of waiver / 1115 Group 5 participants that receive services and supports in the frequency specified in the service plan. Percentage = NUMERATOR [Number of waiver / 1115 Group 5 participants reviewed that receive services and supports in the frequency specified in the service plan] / DENOMINATOR [Number of participants reviewed]

Data Source (Select one):
Other
If 'Other' is selected, specify:
Participant record review on-site (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 / 1115 Group 5 participants that receive services and supports in the type specified in the service plan. Percentage = NUMERATOR [Number of waiver / 1115 Group 5 participants reviewed that receive services and supports in the type specified in the service plan] / DENOMINATOR [Number of participants reviewed]

Data Source (Select one):
Other
If 'Other' is selected, specify:
Participant record reviews on-site (Certification); Claims data ADIDIS

Responsible Party for	**Frequency of data**	**Sampling Approach**

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

Performance Measure:
Number and percent of waiver / 1115 Group 5 participants that receive services and supports in the scope specified in the service plan. Percentage = NUMERATOR [Number of waiver / 1115 Group 5 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:
Participant Record reviews on-site (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**	☐ **Other**

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of participants interviewed that answered "yes, all services" to being able to choose or change what kind of services they received. Percentage = NUMERATOR [Number of participants interviewed 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:
Participant interviews, on-site (Certification)

Responsible Party for data	**Frequency of data collection/generation**	**Sampling Approach** *(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 *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **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 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 participants records reviewed]

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

Performance Measure:
Number and percent of service plans that document the waiver / 1115 Group 5 participant was offered and made a choice between traditional and self-directed care. Percentage = NUMERATOR [Number of service plans that document the waiver / 1115 Group 5 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:
Participant record reviews, on-site (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 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:
Participant interviews, on-site (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:

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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.

Remediation of individual problems occurs when problems are discovered by the regional office in monitoring plans. All of the discovery measures previously listed are produced by this monitoring, and the report of monitoring also includes notation of follow-up actions needed. The measures of remediation actions needed and performed are included in the electronic aggregation and reporting system, and are listed below:

Remediation: Measure 1
The number and percent of reviews which required individual technical assistance.

Remediation: Measure 2
The number and percent of reviews which required agency wide technical assistance and training.

Remediation: Measure 3
The number and percent of reviews which required a Plan of Correction.

If there are any reviews which required a plan of correction but the plan was either not submitted, not acceptable or not implemented, follow-up action would consist of referral to a "for-cause" certification review. In addition, depending on what the specific deficits were, funding could be recouped.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- (●) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ( ) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both.

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.

a) Participants in the waiver will be offered an opportunity to self-direct services as the common law employer of record with service-specific budgetary authority. Once a participant's comprehensive assessment and PCP process has been completed, and needed waiver services are identified, the participant may select the specific services they wish to self-direct from the list of services that can be self-directed. The participant may also receive some of the services in their PCP through traditional supports and services from a provider agency, ensuring no services are duplicative. Services that can be self-directed include: Personal Assistance-Home, Personal Assistance-Community, Community Transportation, Breaks and Opportunities (Respite), Supported Employment - Individual (Exploration, Discovery, Job Development Plan, Job Development, Job Coaching, Career Advancement), Community Integration Connections and Skills Training, Independent Living Skills Training, and Skilled Nursing.
b) Each participant may choose to select self-directed services, and/or request more information about the option to self-direct services at any time. Self-Directed services is shared as an option upon enrollment and no less than during the initial and each subsequent annual person-centered planning meeting. The Support Coordinator (SC) and as needed the Support Coordination Supervisor will be able to answer questions about the self-directed services option and provide an SDS Handbook to the participant and his/her legal representative, family or involved friend.
c) The SC will complete an assessment to determine the supports needed for a participant (or his/her family/legal guardian/involved friend, on behalf of the individual) to self-direct services, and assist in the completion of the employer paperwork to send to the FMSA for initial set up. A fiscal intermediary (Financial Management Service Agency or FMSA) will be available for each participant who chooses to self-direct services. The FMSA will provide an orientation for any participant choosing to self-direct. The FMSA will train the EOR on all aspects of self-direction of services, including EOR responsibilities, required documentation, and timesheet processing. The FMSA will review EOR paperwork initially and as the EOR gains experience, will check random samples to ensure compliance. The FMSA will assure the participant's employee(s) (the self-direction workers) complete all required training in the timeframes required, including training on how to identify and report critical incidents and report incidents. All incidents should be reported to the support coordinator and Regional Office. The same follow-up procedures found in Appendix G.

The FMSA will process payments to self-direction workers. The FMSA will be paid as an administrative cost In addition to the services of the FMSA, participants who self-direct will have a SC trained in self-direction and the services available for self-direction. The SC will be able to inform and consult, intervene, and trouble shoot any problems the participant may have that cannot be addressed by the FMSA. The Support Coordinator will provide an overview to the person (and families/legal guardian/involved friend as applicable) on how to identify and report critical incidents and report incidents. All incidents should be reported to the support coordinator and Regional Office. The same follow-up procedures apply as is found in Appendix G.
Participants who select self-direction will have a budget for each service in the PCP, developed during the person-centered planning process, that they choose to self-direct. Units of service will be authorized, based on assessed need, and those units will then be converted into a dollar amount that the participant can use to hire their own staff to provide the identified service in the amount specified in the PCP.

If funds are saved through wage negotiations, these will be placed into a savings account managed by the FMSA. A savings plan will be developed through the person-centered planning process identifying items or additional needed services, otherwise coverable under the waiver (including through Individual Self-Directed Goods and Services), that are intended for purchase using the savings account. This savings plan can be revised as participant needs change. The participant/family/legal representative/involved friend (who will receive an SDS Handbook) will manage their self-direction workers and the services they deliver (with the assistance of the FMSA and support coordinator) by setting the employee pay rate, covering the cost of overtime pay (if applicable), purchasing worker's compensation insurance, and managing/utilizing the savings account.
Individual Directed Goods and Services can be accessed with accompanying self-directed waiver services and procured through the participant's savings account maintained by the FMSA. The spending plan developed will list the items the participant intends to save for and purchase and must be approved by the Support Coordination Supervisor. The reimbursement or purchase of goods and services on behalf of the waiver participant will be made through the FMSA. When reimbursing the participant directly, a valid receipt(s) will be needed. If the participant cannot pay for the good or service up front, then the FMSA will work out a process to procure a receipt and pay the vendor in advance. A copy of the valid receipt will be sent, by the FMSA, to the Support Coordinator to ensure the good or service was rendered or received.

Utilization will be reviewed routinely to ensure authorized dollars are being appropriately allocated and expended, to ensure the health, safety, and welfare of the participant, and to ensure the goals and outcomes identified in the PCP are being effectively addressed. Under-utilization of dollars will be reviewed on an individual basis. Budgets will be

reviewed annually and adjusted up or down based on prior-year utilization and a current assessment of needs. The participant will manage their services, with the assistance of the FMSA and self-directed liaison and/or support coordinator if requested, by setting the employee rate, utilizing unused dollars to purchase more self-directed services if desired, covering the cost of overtime reimbursement (if applicable, excluding family/legal guardians/legal liable relatives who render services & reside within the same home as the waiver participant), purchasing worker's compensation insurance or utilizing Individual Goods and Services as appropriate. Utilization will be reviewed routinely to ensure authorized dollars are being appropriately allocated to ensure health, safety, and welfare of the participant. Underutilization of dollars will be reviewed on an individual basis. Budgets will be reviewed annually and adjusted up or down based on utilization and needs.

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:

Participant direction opportunities are available to any wavier participants who are willing, who have the support to self-direct if needed, and who have one or more services that can be self-directed included in their PCP.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ◉ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

a) Information about opportunities for self-directed services (SDS) (e.g. describing benefits, responsibilities and liabilities, together with an overview of the FMSA role, the Support Coordinator's role, and the overall process) is available in a SDS handbook. As part of the comprehensive assessment and person–centered planning process, the SC is required to explain that SDS is an option, participation is voluntary,, the choices that are available within SDS, the supports and resources that are available to assist individuals with SDS, and an overview of the situations which may limit or terminate SDS for a member. Led by the SC, the individual and his/her team must also address which specific services the individual chooses to self-direct, what level of participation the individual chooses to exercise, whether the individual will need assistance or support to participate in SDS, resources (including natural supports) available to assist members participate in SDS, whether any potential health or safety issues exist related to SDS and how to address them, and the extent to which the member has chosen to participate in the negotiation regarding payments for services, the manner in which payroll and benefits will be administered, and the need for training legal decision makers and/or self-advocacy training for the individual. The team must also ensure mechanisms are in place to ensure the individual's expenditures are consistent with their approved budget, identify any changes needed to the individual's budget or related supports, exercise oversight over potential health and safety issues, exercise oversight regarding potential conflicts of interest, and participate with the FMSA in validating self-direction workers complete required direct service professional training. Annually, individuals must also affirm the SC explained the SDS option to them and affirmatively accept or deny the SDS option by choosing the appropriate option on their person-centered plan.
b) Information about SDS is provided by the SC.
c) The handbook will be provided to support coordinators to take with them to all planning meetings, so that they may reference and share information with individuals and team members. If an individual requests information about SDS at another time, then the SC will provide a copy of the handbook within 10 business days and schedule a discussion with the individual to be completed within 15 business days. Additional information is provided to individuals on an ongoing basis throughout the person-centered planning process.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☒ **Waiver services may be directed by a legal representative of the participant.**

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**
Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the

participant:

Representative may include a legal guardian or family member with whom the participant lives. A legal guardian or family member serving as a representative may not also be paid through self-direction to provide Personal Assistance-Home or any other waiver service. A representative must be able to assure the Regional Office that he or she has no conflict of interest and will support the individual's best interests. Second, there must be evidence that he or she is competent, willing and able to fulfill all the responsibilities, including providing sufficiently close supervision to a) assure the participant's health and welfare and b) sign the worker's timesheets with assurance each timesheet is accurate and truthful. Third, the representative must be chosen by the participant, but the representative cannot be paid for being a representative nor to provide any other waiver service to the participant. In cases where the person chosen by the participant as the representative may raise concerns of the Regional Office, a background check can be requested prior to final approval of the representative.

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
Community Integration Connections and Skills Training	☒	☒
Independent Living Skills Training	☒	☒
Natural Support or Caregiver Education and Training	☒	☒
Personal Assistance-Community	☒	☒
Personal Assistance - Home	☒	☒
Breaks and Opportunities (Respite)	☒	☒
Community Transportation	☒	☒
Supported Employment Individual	☒	☒
Individual Directed Goods and Services	☒	☒
Skilled Nursing	☒	☒

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 first Financial Management Service Agency (FMSA) was originally procured through a competitive RFP issued by the Alabama Department of Mental Health to administer Alabama's other 1915c waiver programs. The vendor organization which was originally awarded the contract demonstrated clear superiority of experience and capabilities. Based on experience, cost, and references, the Department of Mental Health has now selected two vendors to provide the FMS services. Each contract is set for two years then the RFP process has to be completed again.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

PMPM cost for FMS services is based on the number of participants enrolled.
The payments for the services provided by the FMSA will be based on an invoice submitted monthly. Payments are calculated according to a per-participant-per-month fee schedule. The fee is for a variety of activities specified in the vendor contract, and the fee is the same for every participant for whom an activity is provided during the month.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

☒ **Assist participant in verifying support worker citizenship status**

☒ **Collect and process timesheets of support workers**

☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**

☒ **Other**

Specify:

The FMSA will train the EOR on all aspects of self-direction of services, including EOR responsibilities, required documentation, and timesheet processing.
The FMSA will review EOR paperwork initially and as the EOR gains experience, will check random samples to ensure compliance.
The FMSA will procure goods and/or services on behalf of the participant.
The FMSA will maintain separate savings accounts for each participant and monitor its usage on a regular basis.
The FMS will also report budget balances to the regional office, support coordinator, and individual or his/her representative.
The FMS will conduct monthly checks to ensure no worker(s) currently employed by a waiver participant has been debarred. (Medicaid website and OIG website).
Criminal background checks may be run in situations if questions or concerns arise about the participant's chosen representative. It is the responsibility of the self-directed liaison to notify the FMSA of the request for background check. The FMSA will follow the background check processes for approved exceptional requests for representatives in the same way that is managed for the employees.
The FMSA assures prospective employees meet waiver requirements, including training requirements for the specific service(s) they are providing.
The FMSA will enroll self-directed employees that meet requirements and have valid licenses if applicable.
The FMSA will train the EOR on all aspects of self-direction of services, including EOR responsibilities, required documentation, and timesheet processing.
The FMSA will review EOR paperwork initially and as the EOR gains experience, will check random samples to ensure compliance.
The FMSA will procure goods and/or services on behalf of the participant.
The FMSA will maintain separate savings accounts for each participant and monitor its usage on a regular basis.
The FMS will also report budget balances to the regional office, support coordinator, and individual or his/her representative.
The FMS will conduct monthly checks to ensure no worker(s) currently employed by a waiver participant has been debarred. (Medicaid website and OIG website).
Criminal background checks may be run in situations if questions or concerns arise about the participant's chosen representative. It is the responsibility of the self-directed liaison to notify the FMSA of the request for background check. The FMSA will follow the background check processes for approved exceptional requests for representatives in the same way that is managed for the employees.
The FMSA assures prospective employees meet waiver requirements, including training requirements for the specific service(s) they are providing.
The FMSA will enroll self-directed employees that meet requirements and have valid licenses if applicable.

The participant and EOR must maintain documentation of the dates and hours of service provided and provide this to the FMSA at least bi-weekly. Daily or weekly logs, signed by the worker and by the individual or EOR, which identify the individual, the worker providing the service, the date(s) of service, the time service began, and the time service ended, and the activities provided within each span of work, will be required. A form will be provided by the FMSA or may be collected by an electronic visit verification system as required by federal law.

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

a) Handle all payroll taxes required by law
b) Utilize Administrative costs to cover pre-employment screenings
c) Assist with the documentation of training and other qualifications of workers as required by the waiver, including verification of citizenship
d) Maintain records to assure the worker was qualified, the service was provided in accordance with the person centered plan

e) Furnish background checks on prospective employees
f) Provide the person and family with easy access to resolve problems with payroll and provide a notification route for any other issues that may arise. This means that the FMSA, if it hears that a change may be needed or that a backup plan needs to start, will notify the operating agency, the self directed liaison and the Support Coordinator. The objective is to provide a network within which, no matter which contact the person or family makes, the information is shared and the reaction is comprehensive.
g) Also, the FMSA will help to assure the person and his or her family are and remain satisfied with the service.

Overall, 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. Additional methodologies include the following:

1. Division of Developmental Disabilities staff pulls a scientifically calculated random sample of recipients at the 95% confidence level +/- 5% and reviews the pertinent records for these individuals. Alabama Medicaid Agency Waiver Quality Assurance staff also pulls a random sample 90% confidence level +/- 5% in order to review the required records.
2. On a quarterly basis, the FMSA will provide reports and documentation to the Central office and the Support Coordinator, and the self-directing participants, that will identify the amounts paid to and on behalf of employees and include copies of the signed time sheets for those employees for each pay period. If this process shows there has been any error in timecard submissions, then the error will be corrected by the following pay period. The Support Coordinator will be responsible for all follow-up conversations with participants or the representative to 1) notify them of any change to compensation and 2) ensure that time keeping processes are clearly understood. The Support Coordinator closely monitors units paid and remaining as well as account balances to ensure there are sufficient funds in each account to cover the cost of payroll. Goods and Services will be authorized through the Support Coordinator and receipts for items paid for up front by the FMSA will be reconciled. A receipt for each item purchased is required for reimbursement.
3. Also on a quarterly basis, the FMSA is required to submit training documentation, license documentation, and a complete employee packet to the Operating Agency for review.
4. All training material used by the FMSA, employment forms, information packets, brochures and manuals will have the approval of the Alabama Medicaid Agency prior to implementation.
Additionally, there is a RFP process every two years for the FMSA to ensure all required tasks set forth by the Operating Agency can be fully implemented.

Supports furnished when the participant exercises budget authority:

☒ **Maintain a separate account for each participant's participant-directed budget**

☒ **Track and report participant funds, disbursements and the balance of participant funds**

☒ **Process and pay invoices for goods and services approved in the service plan**

☒ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other services and supports**

Specify:

Additional functions/activities:

☒ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the**

Medicaid agency

☒ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**

☒ **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The FMSA will provide reports and documentation to the Regional Office, Support Coordinator, and the self-directing participants as requested. The reimbursement to the FMSA will be based on the timecard submissions. If there has been an error in timecard submissions, then the error will be corrected by the following pay period. The Support Coordinator will be responsible for all follow-up conversations with participants or the representative to 1) notify them of any change to compensation and 2) ensure that time keeping processes are clearly understood.

The Support Coordinator closely monitors units paid and remaining as well as account balances to ensure there are sufficient funds in each account to cover the cost of payroll. Goods and Services will be authorized through the Support Coordinator and Supervisor. Receipts for items paid for up front by the FMSA will be reconciled.

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:

The individual's team led by the Support Coordinator is responsible to identify the goals/outcomes and related assessed needs of each individual who selects self-direction. The Support Coordinator is an essential link to waiver participants and families/legal representatives/involved friends who are interested in self-directing services. The Support Coordinator has the Self-Directed Services Handbook that will also be available online. Also included in this is the process for developing the budget for the participant based on the current Person-Centered Plan. All these pieces work together to establish a person in self-directing their services.

☒ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Co-Worker Supports	☐
Supported Employment Small Group	☐
Community Integration Connections and Skills Training	☐
Integrated Employment Path Services	☐
Peer Specialist Services	☐
Independent Living Skills Training	☐
Financial Literacy and Work Incentives Benefits Counseling	☐
Natural Support or Caregiver Education and Training	☐
Family Empowerment and Systems Navigation Counseling	☐
Housing Counseling Services	☐
Minor Home Modifications	☐
Positive Behavior Supports	☐
Personal Assistance-Community	☐
Adult Family Home	☐
Housing Start-Up Assistance	☐
Personal Assistance - Home	☐
Supported Living Services	☐
Support Coordination	☒
Breaks and Opportunities (Respite)	☐
Occupational Therapy	☐
Physical Therapy	☐
Community-Based Residential Services	☐
Community Transportation	☐
Supported Employment Individual	☐
Individual Directed Goods and Services	☐
Skilled Nursing	☐
Assistive Technology and Adaptive Aids	☐
Remote Supports	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Speech and Language Therapy	☐

☐ **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:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

○ **No. Arrangements have not been made for independent advocacy.**

◉ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

The Alabama Department of Mental Health operates an advocacy program independent of the Division of Developmental Disabilities (the Operating Agency). This program monitors participants to ensure their rights are not violated and operates a toll-free Advocacy Access Line during normal state business hours and a voice mail response system for after-hour callers for participants to request assistance or report issues. The number for this hotline is provided to all participants upon entry to the waiver program and will also be included with the brochure and manual provided to self-directing participants.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

Any participant who is self-directing his or her services may request to discontinue this model at any time by informing the team at his or her person-centered planning review or by contacting the Support Coordinator at any other time. The Support Coordinator will provide the participant with free choice of contracted providers in their area who will take over delivering the services, once selected by the individual. The Support Coordinator will coordinate with the individual and other providers to ensure there will be no lapse in service delivery.
An individual transitioning from self-direction to an alternate service delivery method is not terminated from the waiver program. The individual is changing how he or she obtains his or her waiver services. The circumstances under which a participant chooses to voluntarily terminate his/her use of the self- direction model will always be assessed, first by the Support Coordinator, then as needed, by the Support Coordination Supervisor, Regional Office or ADMH Advocacy Section, as a routine component of trying to improve the service delivery system.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Participants may be discharged involuntarily from self-direction because of:
1. Health or Welfare issues: the participant's and/or the representative's desire to continue self-directing will always be considered primary, but the Support Coordinator, or Regional Office staff will report adverse information to the Operating Agency. If in the considered judgment of the Operating Agency the participant's health or welfare is in jeopardy, for any reason from abuse to change of condition, then the Support Coordinator and the team will educate the participant and/or representative about the potential risk. If the participant and/or representative decides to continue, then he/she will complete and sign a risk agreement; otherwise discharge will be completed.
2. Consistent participant failure to correctly utilize the FMSA services to pay his or her staff, after efforts have been made to provide support and training and have repeatedly failed, will result in termination of self-direction and return to a traditional form of services. Likewise, a participant who consistently discharges staff and ultimately is unable to hire anyone will also be returned to traditional services.
3. Anyone who engages in false approval and reporting of timecards, or in any other way acts to deceive or defraud, will be terminated from self-direction. If the person engaging in the fraud was not the waiver participant, referral will be made to the Medicaid Fraud Unit. If that person was the waiver participant, he or she will be returned to traditional services.
4. The method of returning a person to traditional services when they are involuntarily terminated from self-direction is the same as the method used when a person is voluntarily terminated. The Support Coordinator will provide the participant with free choice of contracted providers in the area who will take over delivering the services. If a change in the services needed is required, the Support Coordinator will work with the person to update the Person-Centered Plan appropriately. If appropriate and desired by the participant, the staff which has been providing the self-directed services may be employed by the new provider agency, but that will depend on the conditions that led to the termination of self-direction. The transfer will be as fast as can be arranged depending on the circumstances: if the transition is prolonged for certain services, alternative services that can meet the individual's needs will be used as a bridge.
5. Participants who are terminated from self-direction are not provided the opportunity for a Medicaid fair hearing, because self-direction is only one method of receiving the services. As long as the participant can be and is transitioned to the same essential set of services and his or her needs are met, no adverse action has occurred.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		46
Year 2		68
Year 3		90
Year 4		132
Year 5		152

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:

Criminal background checks may be run in situations if questions or concerns arise about the participant’s chosen representative. If a background check is deemed necessary, The FMSA will provide a background check to the participant and/or representative as a component of the administrative service for which it is paid.

☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

Driver’s license and proof of appropriate insurance

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☒ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☒ **Discharge staff (common law employer)**

☐ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

☒ **Reallocate funds among services included in the budget**

☒ **Determine the amount paid for services within the state's established limits**

☐ **Substitute service providers**

☒ **Schedule the provision of services**

☐ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**

☒ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**

☒ **Identify service providers and refer for provider enrollment**

☐ **Authorize payment for waiver goods and services**

☒ **Review and approve provider invoices for services rendered**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The self-directed budget will be developed based on authorized units from the individual's PCP. The process for developing the service plan will not be different from that of traditional waiver services. The individual's support team will meet and develop the Person-Centered Plan based on the person's goals/outcomes, and related needs. Based on specified goals/outcomes and related needs for support as captured in the Person-Centered Plan, a service plan will be developed with units of service assigned to each waiver service. The service plan can include both traditional waiver services and self-directed services. The authorized units for self-directed services will be converted to a dollar amount (using the budget assessment tool) that represents the individual's budget for the year.

The individual will have the ability to hire staff (approved by the FMSA), establish the rate to be paid, use budgeted dollars to pay for additional hours of service if necessary, and utilize the Individual Directed Goods and Services service for items or services needed that meet one or more of the following requirements:

- The item or service will decrease the need for other Medicaid services
- and/or decrease dependency on paid support services; and/or
- The item or service will promote inclusion in the community, including enhancing family involvement; and/or
- The item or service will increase the waiver participant's independence, including improved cognitive, social or behavioral functioning, and development or maintenance of personal, social or physical skills for independence; and/or
- The item or service will increase the waiver participant's health and safety in the home or in his/her community; and/or
- The item or service will increase the waiver participant's ability to continue living in the community and avoid institutionalization.

All purchases must be for items or services that are not illegal or otherwise prohibited by Federal and State statutes and regulations. All purchases can only be made if the participant does not have the funds to purchase the item or service and the item or service is not available at no cost to the participant through another source. All purchases must also be evaluated to ensure cost effectiveness as compared to other available uses of the savings account to meet the person's goals/outcomes and related needs and to assures health, safety, and welfare.

Any dollars saved through wage negotiations can be applied to the Individual Directed Goods and Services service up to $10,000 per year with a required spending plan developed and maintained for each participant.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The individual will be notified of the option to self-direct services during the Person-Centered Planning process. The Person-Centered Plan requires signatures of all members of the support team, including the individual if able, indicating the option to self-direct services has been reviewed and all involved are in agreement regarding whether the individual will self-direct any services in their PCP. The self-directed services budget amount will be determined, and the participant will be informed of the budget amount during the self-direction enrollment meeting with the Support Coordinator. Requests for adjustments to the self-directed services budget will go through the Support Coordinator. Request will be made to and approved by the Regional Office with Operating Agency involvement as determined to be needed by the Regional Office. The Operating Agency will not approve changes to the budget based on financial misuse of dollars such as excessive employee pay rate, employee overtime payment, employee bonuses etc. The self-directed budget does not serve as a limit on the amount of waiver services that an individual may receive. Through assessments and the person-centered planning process, the appropriate types and amounts of services will be determined and included in the PCP. For those services the person chooses to self-direct, the budget will be built based on the participant's assessed need and units authorized in the PCP. Budget changes will not be approved for purchase of goods and services not pre-authorized.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- (●) **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ( ) **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Safeguards for preventing premature depletion of the individual's budget are multi-layered. The individual's team will review the self-directed services budget during his or her person-centered plan review. Individual Goods and Services will only be authorized if there is enough savings in the individual's budget and there is not a concern of premature depletion. The FMSA will maintain the individual's budget and savings account and will monitor it monthly to ensure it is appropriate for individual to maintain health and safety. Individual balance reports will be generated monthly and submitted to the individual, Support Coordinator and Regional Office for review. If there appears to be either overutilization or underutilization, the participant will be contacted to outline the concerns. If either over utilization or underutilization is an on-going problem, the individual and representative will be consulted and informed of the possibility of involuntary discharge of self-directed services, and a transfer to traditional waiver services will be made.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Following is a description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, subpart E.

Any waiver applicant or recipient has the right to request a fair hearing if denied home and community-based services or if a decision by the operating agency adversely affects his/her eligibility status or receipt of services. If an applicant is determined not eligible by the operating agency, he or she is provided with notification of the determination, the reason and authority for the determination, and an explanation of the appeal rights and procedures available to the applicant. The formal process of notification and appeal is in accordance with 42 C.F.R. Section 431, Subpart E and Chapter 3 (560-X-3) of the Alabama Medicaid Administrative Code. There is an appeal process conducted by the operating agency at the applicant's choice, with the right to further appeal to the Medicaid Agency being explained to the applicant. If an appeal is made to the Medicaid Agency, a hearing officer appointed by the Commissioner of the Medicaid Agency conducts fair hearings. Medicaid legal counsel will be responsible for taking a lead role in the fair hearing process. If the individual/guardian is still dissatisfied after the Fair Hearing, he/she may appeal to the Circuit Court. The OA will be responsible for defending any appeal of the administrative decision.

Waiver recipients are provided with the necessary information regarding their opportunities to request a fair hearing as part of the planning process, by receiving and signing the Due Process Rights Form. This form contains the information regarding his/her right to a hearing and acknowledges receipt of it. At the time this form is provided, the Support Coordinator also informs the person of their right to continue waiver services while under appeal.

When a change in the individual's needs suggests a change in the waiver services and PCP, the person's team discusses proposed change(s) with the person and his family/representative prior to implementation. This discussion will include an explanation of the reason for the change, further assessment of the impact of the change, and an effort to elicit agreement on the part of the person and/or his family/representative.

Whenever there is a decision by the operating agency to reduce, suspend, or terminate waiver services to coincide with the person's current need or the person's loss of eligibility for the service, the Department of Mental Health (DMH) will issue a written notice at least 10 days prior to the action to the client and or family/caregiver indicating the client's right to a fair hearing and instructions for initiating an appeal. A copy of the notice will be forwarded to the Medicaid Agency, and it will contain all the due process information required by 42 C.F.R. Section 431, Subpart E. This notification and the Due Process Rights Form referenced above can be obtained from the operating agency.

The organization has a mechanism that provides people supported and their legally authorized representatives with information regarding filing complaints and grievances. At a minimum, the complaints/grievance procedures include the name and telephone number of a designated local contact within the organization.

The designated local contact has the knowledge to inform persons, families and legally authorized representatives of the means of filing complaints and grievances and of accessing advocates, ombudsmen or rights protection within or outside the organization.

Grievance procedure information is available in frequently used areas, particularly where people receive services. Such notices include the 800 numbers of the DMH Advocacy Office, federal protection and advocacy system (ADAP) and local Department of Human Resources.

The organization provides access to persons and advocates, including a DMH internal advocate and the grievance process without reprisal.

Responses to grievances/complaints are provided within a timely manner as specified in the agency’s procedures and in a manner that the person can understand.
The organization implements a system to periodically, but at least annually, review all grievances and complaints for quality assurance purposes.

Within ninety (90) days of employment, all employees who directly provide supports to people receive training in the following areas: Rights of people served, to include the recipient complaint/grievance procedure.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates an additional dispute resolution process**

• **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.

Alabama Division of Developmental Disabilities, which is one division of the Alabama Department of Mental Health, is the Operating Agency for this waiver program. The notice of adverse action mentioned in Appendix F-1 includes an optional appeal to the Associate Commissioner of the Division of Developmental Disabilities. The consumer/family has the option to appeal in writing to the Associate Commissioner, who will arrange an appeal review, after which she or he will issue a decision within 21 calendar days. The notice also states that if the consumer/family disagrees with the Associate Commissioner's decision, they may appeal to the Medicaid Agency, and the notice indicates how and by when to do that.

The process will include a thorough review of all documents submitted with the initial application and may also include requests for additional information.

The types of disputes which can be addressed through this process include any adverse actions which have required the notice of due process to be sent to the consumer/family. Participation in this process is at the option of the consumer/family. If they choose not to participate, they may send their request for appeal directly to the Medicaid Agency.

In the rare instance that the adverse action includes terminating a service or dis-enrolling a person from the waiver who does not want to be dis-enrolled, the service will be continued until a review can be held, if the person appeals within the ten days prior of the effective date of the notice.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

• **Operational Responsibility.** Specify the state agency that is responsible for the operation of the grievance/complaint system:

The Alabama Department of Mental Health, Office of Advocacy Services.

• **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Department maintains an independent office of advocacy services, reporting directly to the Commissioner's office, which monitors programs, receives complaints through a toll-free advocacy access line during normal State of AL business hours (the number is required to be posted in every certified site and given to each consumer), and investigates or causes to be investigated any rights issue complaints received. A voicemail response is left on the phone line, encouraging after-hour callers to leave a message, which will be retrieved and responded to on the next regular business day. The recorded message also offers options for the caller to follow if more immediate assistance is required.

The types of rights issue complaints that may be reported and will be investigated fall into the following rights categories: a) Due process; b) Education; c) Complaints; d) Safe and humane environment; e) Protection from harm; f) Privacy/confidentiality; g) Personal possessions; h) Communication and social contacts; i) Religion; j) Confidentiality of records; k) Labor; l) Disclosure of services available; m) Quality treatment; n) Individualized treatment or habilitation; o) Participation in treatment or habilitation; p) Least restrictive conditions; q) Research and experimentation; r) Informed consent.

Complaints of abuse, neglect or mistreatment are immediately referred to the responsible program and an investigation is also initiated by Advocacy staff or the program within 24 hours. Any other complaint that, in the opinion of the advocate, involves threat to health or safety is treated the same way. Other complaints are opened, responsible parties notified, and investigations are initiated as soon as possible but no later than 7 working days of the report, with the expectation that the investigation will be completed within 30 working days.

Resolution is required of the provider agency, which must submit a written report. If resolution requires ongoing monitoring, the responsible division's staff will provide this. If resolution requires court intervention, the federal protection and advocacy agency known as the Alabama Disabilities Advocacy Program or the Alabama State Bar Referral Service may be contacted to arrange legal representation for the consumer. If the consumer is receiving services under the waiver and his complaint involves waiver related issues, and he cannot achieve satisfaction through the required resolution, he and his representative are referred to the Medicaid Hearing Process. This rarely occurs, because the authority of the DMH Office of Advocacy Services can resolve most problems.

Reports are generated quarterly, listing the complainant, the nature of the complaint, and the finding of the investigation, and if warranted, a notation of the resolution. These reports are provided to the staff of the Alabama Medicaid Agency.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

State Critical Event or Incident Reporting Requirements

Incident Types	Timeframes
Physical Abuse	Immediate
Sexual Abuse	Immediate
Verbal Abuse	Immediate
Neglect	Immediate
Self-Neglect	Immediate
Mistreatment	Immediate
Exploitation	Immediate
Unnatural Death	Immediate
Moderate Injury	24-hours
Major Injury	24-hours
Choking	24-hours
Fall	24-hours
Seizure	24-hours
Other	24-hours
Medication Error Level I	24-hours
Medication Error Level II	Monthly
Medication Documentation Error	Monthly
Medication Error Level III	24-hours
Missing/Eloped Consumer	Immediate
Natural Death	24 hours
Severe Behavior Problem	24-hours
Natural disaster	24-hours
Fire	24-hours
Physical Assault	24-hours
Sexual Contact	24-hours
Manual Restraint	24-hours
Mechanical Restraint	24-hours
Chemical Restraint	24-hours
Unscheduled Hospital Visit	24-hours

All DMH certified community providers shall report incidents involving individuals that occur in operated or contracted community residential and day programs, either on the provider's premises and/or while involved in an event supervised by the provider for all recipients of services. Reporting of incidents is also required when they occur in settings other than those specified above (e.g., overnight visits or outings with families).

Administrative Code Regulations:

580-5-33-.07 Protection from Abuse, Neglect, Mistreatment, and Exploitation
Each entity shall have a written plan that addresses the process of prevention and management of incidents.

The Division of Developmental Disabilities (DDD) preserves the safety, protection, and well-being of all individuals receiving services through its certified community agencies, and will take appropriate action on any mistreatment, neglect, abuse or exploitation of those individuals.

The DDD prohibits abuse, neglect, mistreatment and exploitation of individuals served, and has procedures for investigating and reporting such incidents, and for taking disciplinary and corrective actions.

The DDD has promulgated a Community Incident Prevention and Management Plan that provides guidance for community agencies/providers in the implementation of incident prevention and management systems to protect individuals from potential harm, and those agencies are required to implement this Plan as part of their DMH certification requirements.

All certified agencies are required to implement a Community Incident Prevention and Management Plan (IPMS) as required by the Division of Developmental Disabilities, to protect individuals served from harm and improve the agency's responsiveness to incidents for the purposes of prevention of harm and risk management.

Each certified agency must notify DDD of all reportable incidents and take actions in accordance with the Community IPMS requirements, which include state law and funding source requirements.

Each certified agency shall make changes/enhancements in the agency's Basic Assurances Plan as required by DDD to incorporate innovative strategies for the prevention and management of incidents, to address incident trends, and to update requirements of state law.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Each person served by a provider agency is required by regulation to be informed of his rights and responsibilities annually. Rights include being free from abuse, neglect and exploitation. Each person is also informed of the Office of Advocacy toll-free hotline, its purpose and its number. Each person is also informed by the provider of their due process rights. Support Coordinators maintain relationships with individuals to encourage them to talk about what is important to them, including what may be happening that they don't like. The Office of Advocacy Services of the Department of Mental Health conducts routine random monitoring, and Regional Offices of the Division of Developmental Disabilities conduct routine monitoring, both of which include talking with individuals.

Administrative Code Regulations:

580-5-33-.04 Promotion and Protection of Individual Rights

The organization implements a policy and procedure that clearly defines its commitment to and addresses the promotion and protection of individual rights of people.

The policy lists rights afforded all citizens as indicated by the United Nation's Declaration of Human Rights, by the Constitution, laws of the Country and State of Alabama.

The policies and procedures describe the organization's required due process that includes a Human Rights Committee review and documentation of all proposed restriction of a person' rights.

The organization has no standing policies or procedures that restrict individual rights without due process.

The organization documents, upon admission and annually thereafter, verification that it provides to persons and their legally authorized representatives an oral and written summary of rights/responsibilities and how to exercise them, in language that the person understands.

Every person shall have the right to due process with regard to complaints/grievances and rights restrictions, within the agency or program providing services. Due process is, for these purposes, defined as providing the consumer, and/or their family or guardian, with a fair process that requires, at least, an opportunity to present objections to the proposed action being contemplated.

Dignity and Respect 580-5-33-.05 of Alabama Administrative Code At a minimum, the complaint/ grievance procedures shall include:

(a) The name and telephone number of a designated local contact within the entity.
(b) The designated person shall be able to inform persons of the means of filing grievances and of accessing advocates, ombudsmen, or rights protection services within or outside the agency.
(c) Grievance procedure information shall be available in frequently used areas, particularly where people receive services. Such notices shall include the 800 numbers of the DMH Advocacy Office, federal protection and advocacy system (ADAP) and local Department of Human Resources.
(d) Agency shall provide access to advocates, including a DMH internal advocate, and the grievance/complaint process without reprisal.

Procedures for the initiation, review and resolution of complaints and grievances shall be explained to the consumer/advocate and legal guardian.

Due process is defined as providing people supported, and their legally authorized representatives, with a fair process requiring, at least, an opportunity to present objections to the proposed action being contemplated. Due process, including review by a Human Rights Committee, is implemented when it is proposed that a person's rights be restricted for any reason.

Staff are trained in due process procedures, including any procedures for placing a limitation or restriction on a person's rights. Each individual's ability to understand and exercise his or her rights is assessed and updated on an ongoing basis but at a minimum, annually.

A Human Rights Committee (HRC) reviews any restriction of a person's right(s) initially and periodically thereafter, but

at least annually, during the period in which the restriction is imposed, and will document such.

When any restrictions are being proposed for a person, the person is supported to attend and provide input at the HRC meeting in which the proposed restriction is being reviewed.

People supported are provided adequate training in due process procedures, including any procedures for placing a limitation or restriction on a person's rights and training that supports the removal of rights restrictions.

The continued need for the restriction is reviewed at least quarterly by the Qualified Intellectual Disabilities Professional (QIDP) or more often upon request of the person whose rights are restricted.

The organization utilizes a working and effective HRC that complies with the provisions of Chapter 580-5-33-.04.

The HRC reviews policies, procedures and practices that have the potential for rights restrictions without an individualized assessment.

The HRC reviews the frequencies and reasons surrounding the use of restraint for behavioral or medical purposes.

Additionally, the HRC makes recommendations to the organization for promoting people's rights, proactively promotes and protects people's rights and reviews reports of substantiated allegations of abuse, neglect, mistreatment, exploitation and other data that reveal the organization's practices with respect to human, civil and legal rights and reviews research projects involving human participation to ensure the protection of people who are involved.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The Incident Manager housed in the Regional Office will review each incident report for each reportable incident described in G-1 a. and determine if the report requires no action follow-up, action follow-up, or an investigation. All allegations of abuse, neglect, mistreatment, or exploitation are incidents that, by regulation, require an investigation. Other incidents may or may not require an investigation, based on the nature of the incident and action already taken by the provider. Nonetheless, all defined incidents must be reported by the regulations governing certification of providers. Specifically, the provider is required to first assure the participant is safe and being treated as necessary, then report the incident, assess the cause, impact and needed actions regarding the incident, and address the needs so determined. The Regional Office reviews the provider' actions, as reported, to determine their adequacy.

Each Regional Office has a lead staff person n(Incident Manager) whose primary function is Incident Prevention and Management. This Incident Manager will have other staff of the Division available to assist as needed. For instance, Certification, Advocacy and Quality Enhancement staff are available, as is a registered nurse. A physician, psychiatrist and behavior analyst are also available on call (these are in 3 of the 5 regional offices). In addition, the Incident Manager can involve other professionals in the Regional Office who routinely monitor the provider in question, as well as anyone else who knows the participant, such as the support coordinator.

If the information submitted by the provider regarding an incident is sufficient to determine: a. the person is safe, b. the issues have been resolved, c. if the person needed anything more he is receiving it, d. an analysis has been conducted to determine if the incident could have been prevented, and e. that an analysis has been made to determine if there is a pattern that needs to be addressed, the Incident Manager will document this with a recommendation to the Regional Director that the incident requires no action follow-up. If the staff person recommends, and the Regional Director determines, that an incident requires action follow-up, then the Incident Manager will coordinate the efforts. Additional staff can be involved as mentioned above, and additional information is gathered either directly by the Incident Manager or through the provider. The Regional Office can and does assign actions to the provider, with timelines. Completion dates are not to exceed 15 days based on the nature of the incident.

If more information is required of an investigation, the Regional Office can extend the timeframe of an investigation. For example, the Regional Office can initiate its own investigation if they suspect the provider is not doing an adequate job, or has a track record of insufficient investigations, or has a clear conflict of interest. Also, the Regional Office will notify local law enforcement of possible criminal activity, if the provider has not done so and the information warrants it. Other entities that are routinely notified include DMH's Advocacy Office and the Adult Protective Services Unit of the Department of Human Resources. Investigation procedures have been trained and are retrained periodically, both for providers and for Regional Offices. Investigations must be closed within 15 days, unless there are extenuating circumstances, such as the absence of a necessary witness, or when repeated efforts to get information from the provider are required. Certification of the provider includes a review of the provider's compliance with factors 4, 5 and 6 and any failure to cooperate with other factors may results in a lowered certification score, which will cause the provider to be placed on provisional certification.

Community providers are required to immediately notify legal guardians/families of all incidents involving people served, regardless of the severity level. Providers are also required to notify legal guardians/families of investigation findings and the agency's plan to prevent similar incidents from occurring in the future.

Participants are not routinely sent information by the DMH, regarding the status or outcome of an investigation. Rather, the provider will talk with the participant to explain any changes in his services that happen because of an investigation and will discuss the allegation and finding in more detail with a participant who will be able to understand what he or she is being told. Family members and other guardians will always be told the outcome by the provider and by the Support Coordinator. There are no instances in which the family members or guardians will not be notified about the outcome of an investigation. In addition, the participant, their family or their guardian may request a written summary of the investigation report, which DMH will provide.

Documentation of actions by the provider, by the Regional Office, and by others is maintained in a database at the DMH. This information is used to discern patterns and determine systemic interventions, as described in Appendix H.

Administrative Code Regulations: Each was summarized under G-1 a. above 580-5-33-.07 Protection from Abuse, Neglect, Mistreatment, and Exploitation.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for

overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

Alabama Department of Mental Health
--Division of Developmental Disabilities Central and Regional Offices
--Office of Advocacy Services

Alabama Department of Human Resources (certain incidents of abuse, neglect and exploitation must be reported to ADHR by law).

Alabama Medicaid Agency: annual review of DDD's investigations, certification files containing quality enhancement plans and technical assistance reports, and mortality reviews. Quarterly review of Advocacy's reports. Medicaid is informed of critical incidents that are systemic or otherwise rise to the level of decertification as they occur. AMA will review and approve all incidents that involve injury or harm requiring hospitalization or death and incident types that are considered high-risk (AWOL/Missing Persons, Abuse, etc.) Collected data will be reported every quarter and annually for the HCBS Quality Review Reports.

Individual providers are required to report incidents to the perspective community service office (RCS). If the provider has provided sufficient information and corrective action, then the incident is closed. If the RCS office determines that additional information is required, a request for additional information is entered into the IPMS system to the provider agency, additional info is submitted to the RCS office, and the incident is closed. If the incident requires an investigation, the RCS may require the provider agency to conduct the investigation, rely on DHR and/or local authorities or Internal Advocacy, or conduct the investigation themselves. The RCS office Director reviews all investigations for completion and thoroughness. Any additional corrective action needs are requested of the provider and followed up until complete. Additionally, all investigation initiations and completions are forwarded to the Office of Quality and Planning for additional review and approval. Medicaid is informed of critical incidents that are systemic or otherwise rise to the level of decertification. Quarterly operating agency meetings are conducted by Medicaid in which providers on "provisional certification status" for violations of Best Possible Health, Protection from Abuse, Neglect, Mistreatment, and Exploitation and Safe Environments are discussed and actions being taken. Finally, Medicaid completes an annual audit of case management agencies and their sub-contractors to review ADMHs certification process and needed follow-up.

Incident reports are submitted to the Regional Offices and entered into the IPMS system. These incidents are tracked by regional staff to completion and closure. In addition to the above, Regional QE Staff (1 in each of 5 regions) compile and analyze data on a quarterly basis for their region to identify any problematic trends or patterns. Individual provider and recipient issues identified are managed administratively by the Regional Office staff. Systemic educational development and training needs are managed by the QE staff. Also, on a quarterly basis, the Director of Quality and Planning compiles and analyzes data on a statewide basis and presents to the Developmental Disabilities Sub-Coordinating Committee, a statewide stakeholder group that makes remedial recommendations, as needed, to the Associate Commissioner for DD Services. Beginning 7/1/20, a Quality Council, to include a diverse group of stakeholders, will review this information and provide recommendations to the Associate. Commissioner for DDD Services.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Behavioral Services Procedural Guidelines describe the procedures referenced as restraint, along with the requirements for monitoring and documenting those procedures. These procedures apply only to Enrollment Groups 1-4. For the Section 1115 Enrollment Group 5, the State does not permit the use of restraints. The Behavioral Services Procedural Guidelines include a listing of the required content for a Behavioral Support Plan (BSP) and this list includes: (1) documenting other less intrusive/restrictive methods to address the behavior that have been tried but unsuccessful and (2) documenting the plan/timeline for fading/reducing the use of restraint(s) and/or restrictive measures. The Person-Centered Plan has a field that identifies when a waiver participant has a BSP and incorporates the BSP by reference in the Person-Centered Plan including specifying the documentation noted in (1) and (2) above is included in the BSP.

The PCP, which is monitored by the Regional Case Management Liaisons, requires that, for the individual served, the persons supporting them will:

- Identify any formal plans (special level staffing, fading plan, crisis protocol, restraints, restrictions, stipulations, etc.);
- Summarize the current state, including review of any incident reports; and
- Honoring preferences, note the desired future state and what is being done to increase independence & reduce any restrictions.

Unauthorized use of restraints detected through several methods:

1. Provider report. Providers must report all incidents requiring a restraint or restrictive intervention in THERAP, even if the person has an approved behavior plan that permits the use of restraints and restrictive interventions.
2. Regional and Central Office staff participate in and/or review minutes of HRC, and BPRC meeting discussion and supporting documentation to identify any instances of unauthorized restraint or any other restrictive intervention

ADMH has added a performance measure to standardize the discovery of unauthorized restrictive interventions that were not reported

3. by the provider through review of agency documentation during certification reviews.
4. ADMH regional staff also conduct additional routine monitoring visits , and are trained to observe for, and otherwise detect, the unauthorized use of restrictive interventions, including, but not limited to, staff observations and interviews, personal interviews with people receiving services and record reviews

Providers are required to train all staff who implement restraints in the appropriate application of the procedures. If a person implements the restraint incorrectly or outside the boundaries of an individual's BSP, whoever witnesses the event is obligated to report it, and the provider is required to submit an incident report and conduct an investigation regarding the inappropriate use, misuse, or unauthorized use of restraint. The Regional Community Services offices review any instances of this and follow up on the investigation, adding recommendations when necessary to those implemented by the provider to remedy the situation and prevent further occurrence. Any Emergency use of Restraint must be reported via the Incident Prevention and Management System (IPMS) procedures. If 3 of these occur within a 6 month period, the team is required to meet to determine the factors leading to the need for those restraints in order to determine what alternatives could have been tried more effectively and evaluate whether restraints should be added to the person's BSP. Additionally, at any time that Regional Office staff are conducting their usual monitoring of providers and witness or become aware that any restraint has been used without authorization, it is reported and investigated. Finally, the Certification staff routinely reviews the use of any restrictive procedure during surveys to ensure appropriateness and adequate due process.

Every staff person who works with an individual for whom restraints are a part of their BSP must receive specific training on how to implement the restraint and under what circumstances the restraint can and cannot be used before they can work with the person. All provider direct support professionals, QIDPs, and others must receive training in the Management of Aggressive and severe, challenging behavior as part of their orientation training as well as annual refreshers. Professional staff must also have that kind of training. Direct Support Professionals are required to have a high school education. The QIDP must have a minimum of a bachelor's degree as well as training on the Behavioral Guidelines. Most of the providers who contract with the division do not use restraints. Most of the agencies that serve individuals who require restraints either employ or contract with a Board Certified Behavior Analyst (BCBA). Emergency use of restraints requires authorization from a QIDP, Program Director, or Physician. Direct Support Professionals cannot just decide to implement a restraint without that authorization.

Manual Restraints are listed in the Behavioral Guidelines as a Level 3 procedure in a BSP, which requires approval by the individual and his/her team, the Behavior Program Review Committee (BPRC), and the Human Rights Committee (HRC). Mechanical Restraints are listed in the guidelines as a Level 4 (most restrictive) procedure in a BSP, which requires all of the previously listed reviews/approvals and must also be submitted for approval by the Director of Psychological and Behavioral Services (DPBS) in the Division of Developmental Disabilities. The DPBS determines the frequency of additional reviews that will be required on a case by case basis for these Level 4 BSPs. Reviews by both the BPRC and HRC committees include that they ascertain whether less restrictive procedures have been tried and documented to be ineffective prior to approving restrictive procedures, including restraints.

Level 3 Procedures are restrictive and may only be used by direct care professionals when they are included in a Behavior Support Plan (BSP). Some of the procedures may be used in emergency situations and are so designated. Emergency use of these procedures requires an order from a QIDP. The use of an Emergency Procedure three times in a six-month period requires the individual’s planning team to meet within five working days of the third use to determine if a BSP is needed. The team's determination must be documented. Staff must be trained in the use of these procedures prior to using. Each BSP containing Level 3 Procedures requires prior approval by the Behavior Program Review Committee (BPRC), review by the Human Rights Committee (HRC), and approval/consent by the individual or the parent/guardian and must be reviewed and updated at least annually.

Level 4 Procedures are considered the most restrictive and must be in a BSP (exception is Emergency Mechanical Restraint, which has an IPMS documentation requirement and a limit regarding the number of times it can be used). Each BSP containing Level 4 Procedures must be reviewed by the Director of Psychological and Behavioral Services (DPBS) in the Division of Developmental Disabilities, the BPRC, the HRC, and approval/consent by the individual or the parent/guardian. Requests for the use of these procedures should be sent to the DPBS, while consent requests are sent to the parent/guardian. The DPBS or designee will review and respond within two (2) working days of receipt of the BSP with the Level 4 Procedure. Staff must be trained in the used of approved procedures prior to using. The frequency for review and updating of the BSP with Level 4 Procedures will be indicated in the response sent by the DPBS or designee. However, a review is required at least annually.

Manual, Mechanical and Chemical Restraints are permitted in emergency situations and as procedures in properly designed and professionally monitored BSP's and implemented by trained staff, as follows.

There are three types of emergency restraints recognized in community programs:
1. Manual: the use of physical holding which is not a part of an approved BSP to involuntarily restrain the movement of the whole or portion of an individual’s body as a means of controlling his/her physical activities in order to protect him/her or others from injury.
2. Chemical (psychotropic medication): the use of medication(s) that is not a standard treatment for the individual's medical or psychiatric conditions and is used to control behavior or restrict the individual's freedom of movement
3. Mechanical: The use of commercial devices which is not part of an approved BSP to involuntarily restraint the movement of the whole or a portion of an individual’s body as a means of controlling her/her physical activities in order to protect him/her or others from injury.

Positive Behavior and Support Administrative Code 580-5-33-.11
Objectives and strategies are developed to address behaviors that interfere with the achievement of personal goals or the exercise of individual rights using the least intrusive interventions necessary and the most positively supporting interventions available.

If appropriate, people have a BSP that reduces, replaces or eliminates specific behaviors. BSP's are implemented in accordance with the DDD Behavioral Services Procedural Guidelines.

BSP's are developed based on information gathered through a functional behavioral assessment that is completed by a qualified professional and identifies physical or environmental issues that need to be addressed to reduce, replace or eliminate the behavior. The BSP outlines the specific behavioral supports that

may and may not be used.

All direct support staff receive training in behavioral techniques and plans prior to implementation of support(s) to people.

Data related to the effectiveness of an individual's BSP is reviewed periodically, but at least quarterly, or more often as required by the individual's needs.

Prior a rights restriction, the person meets with his/her Support Team to discuss the reason for the proposed restriction, except in extreme emergency to prevent the person from harming self or others. Criteria for removing the restriction are developed and shared with the person and legally authorized representative prior to imposing the restriction.

All BSP's are approved by the person's Support Team. Each BSP with Level 2 or 3 procedures is reviewed and/or approved by the Behavior Program Review Committee, the Human Rights Committee and the person or the person's legally authorized representative in accordance with DDD PBS 02 Guidelines for Levels of Intervention.

(a) The use of emergency or unplanned behavior interventions that are highly intrusive are in compliance with DDD PBS 02 Level 3 Procedures and are not used more than three(3) times in a six (6) month period without a Support Team meeting to determine needed changes in the person's BSP.
(b) If people require behavioral or medical supports to prevent harm to themselves or others, such supports are provided in accordance with DDD Behavioral Services Procedural Guidelines (DDD-PBS 01 05).
(c) The use of any restraint complies with the provisions of DDD PBS 02 Level 3 Procedures and is applied only by staff with demonstrated competency for the device or procedure used.
(d) The organization ensures that people are not subjected to highly intrusive behavior interventions or punishment for the convenience of staff, or in lieu of a BSP.
(e) The organization prohibits the use of corporal punishment, seclusion, noxious or aversive stimuli, forced exercise, or denial of food or liquids that are part of a person's nutritionally adequate diet.
(f) Behavior procedures considered the most restrictive comply with the Level 4 Provisions of DDD PBS

continued below..

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:

.. i continued from above...
The use of psychotropic medications for behavior support comply with provisions of DDD PBS 02 Level 3 and are authorized by a licensed physician, preferably a psychiatrist. The use of medication(s) to reduce or change behavior associated with psychiatric symptoms shall be considered a Level 3 intervention (DDD PBS 02). These medications are authorized by the person's physician and incorporated into a BSP and/or a Psychotropic Medication Plan.

PRN orders for psychotropic medications are administered in accordance with the Nurse Delegation Program and the Behavioral Services Procedural Guidelines.

Start ii:
Alabama Department of Mental Health
--Division of Developmental Disabilities Central and Regional Offices
--Office of Advocacy Services

Community providers are required to adhere to the Community Incident Prevention and Management System (IPMS) to eliminate, where possible the occurrence of preventable incidents and respond appropriately to reportable incidents.

Factor 4: Protection from Abuse, Neglect, Mistreatment and Exploitation (580-5-33.07)
states that the organization implements policies and procedures that define, prohibit and prevent abuse, neglect, mistreatment, exploitation and unauthorized use of restraints.

ADMH-DD Behavioral Services Procedural Guidelines (updated 2014) indicates that
use of emergency restraints 3 or more times in a 6-month period requires the Interdisciplinary Team (IDT) to meet and consider whether incorporating its use into a formal Behavioral Support Plan (BSP) is appropriate. As a result, ADMH-DD tracks data for the use of 3 or more unauthorized/inappropriate restraints in a 6-month period for individuals that did not have a BSP to address such interventions.

Incident Managers conduct daily reviews of General Event Reports (GERS) in the DD Incident Management System, Therap. The Regional Community Services Incident Review Committee conducts weekly meetings to review reportable incidents and make recommendations to community providers regarding quality of services provided.

Moreover, restraint data and other reportable incident data are collected and analyzed on a quarterly basis by Regional QES. Multi-Event Summary Reports are generated which outline all reportable incidents that occurred within each quarter. Therap enables QES to aggregate and export restraint data into an excel spreadsheet. QES filter restraint data by name to identify individuals that were subjected to an unauthorized/inappropriate use of a restraint.

Individuals meeting the threshold of 3 restraints are identified, and the GERs are reviewed to determine if the community provider and/or case management agency convened a special team meeting. The purpose of the meeting is to discuss changes in behavior that warrant excessive restraints and discuss a plan to develop a BSP to develop procedures for addressing such behaviors. Agencies that have not held special meetings to discuss are prompted to do so by the Regional Incident Manager.

The Director of Quality Enhancement collects aggregate incident data, including excessive use of restraints from the Regional Incident Manager and QES and compiles data for waiver reporting.

All incidents requiring a restraint or restrictive intervention must be reported in THERAP, even if the person has an approved behavior plan that permits the use of restraints and restrictive interventions. Collected data will be reported every quarter and annually for the HCBS Quality Review Reports, with the final report will be shared with the operating agency prior to the joint (AMA and ADMH) quality assurance quarterly meeting.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

The behavioral guidelines describe all of the behavioral training and intervention strategies that are approved for use in Alabama. For the Section 1115 Enrollment Group 5, the State does not permit the use of any restrictive interventions. The Behavioral Services Procedural Guidelines include a listing of the required content for a Behavioral Support Plan (BSP) and this list includes: (1) documenting other less intrusive/restrictive methods to address the behavior that have been tried but unsuccessful and (2) documenting the plan/timeline for fading/reducing the use of restraint(s) and/or restrictive measures. The Person-Centered Plan has a field that identifies when a waiver participant has a BSP and incorporates the BSP by reference in the Person-Centered Plan including specifying the documentation noted in (1) and (2) above is included in the BSP.

The PCP, which is monitored by the Regional Case Management Liaisons, requires that, for the individual served, the persons supporting them will:

- Identify any formal plans (special level staffing, fading plan, crisis protocol, restraints, restrictions, stipulations, etc.);
- Summarize the current state, including review of any incident reports; and
- Honoring preferences, note the desired future state and what is being done to increase independence & reduce any restrictions.

Unauthorized use of restraints detected through several methods:

1. Provider report. Providers must report all incidents requiring a restraint or restrictive intervention in THERAP, even if the person has an approved behavior plan that permits the use of restraints and restrictive interventions.
2. Regional and Central Office staff participate in and/or review minutes of HRC, and BPRC meeting discussion and supporting documentation to identify any instances of unauthorized restraint or any other restrictive intervention
3. ADMH has added a performance measure to standardize the discovery of unauthorized restrictive interventions that were not reported by the provider through review of agency documentation during certification reviews.

ADMH regional staff also conduct additional routine monitoring visits, and are trained to observe for, and otherwise detect, the unauthorized use of restrictive interventions, including, but not limited to, staff observations and interviews, personal interviews with people receiving services and record review

There are four (4) levels of procedures with each successive level indicative of greater restrictiveness, such that Level 1 procedures are not restrictive at all and Level 4 is highly restrictive. Level 2 procedures, considered to be somewhat restrictive and require reviews by the BPRC chairperson and the HRC, include: Escape Extinction, Negative Reinforcement, Positive Practice, Reparation of Property or Restitution, Response Cost Restriction of Environmental Access, Restriction of Movement inside or outside facility, Search, and Exclusionary Timeout procedures. Level 3 procedures require review by the entire BPRC and HRC prior to implementation and include: Modification of Clothing to Limit Access to Self, One to One Staffing due to behaviors, Overcorrection, Manual Restraint, Restriction of Personal Property/Visitors/Phone Calls, Use of Psychotropic Medications, and Closed-Door Timeout.

Level 4 procedures must be approved by the BPRC, HRC, and submitted to the DPBS for additional approval and more frequent review to ensure effectiveness of the procedure. There are only four procedures listed at this level of intervention: Mechanical Restraint – Programmatic Use, Mechanical Restraint – Emergency Use, Sensory Screening, and Manual Restraints not otherwise specified in Level 3 (these would be modifications of the usual manual holds that may need to occur with a person). ALL the restrictive procedures must be directly related to a behavioral challenge and the function being served by that behavior. There must also be training and reinforcement to assist the person in developing more appropriate behaviors to replace the one(s) that led to the restriction. Furthermore, there must be a plan for lifting the restriction that is reasonable in terms of the individual being able to achieve the criteria set. Procedures that are prohibited include: Use of aversive stimuli, such as spray mists or bitter tasting liquids contingent upon behaviors occurring and Corporal Punishment of any kind. While there is not a section in the behavior guidelines that lists the procedures as specifically prohibited, they are not allowed by virtue of not being in the procedures listed. Some of the definitions of procedure do refer to the fact that these are not allowed when the acceptable procedures are defined.

Prior to being assigned to a person who has a BSP, each staff person who works with an individual for whom restrictive procedures are a part of their BSP must receive specific training regarding how to implement the procedure and under what circumstances they can and cannot be used. All provider direct support professionals, QIDPs, and others must receive training in the Management of Aggressive and severe Challenging Behavior as part of their orientation training as well as via annual refreshers. Professional staff must also have that kind of training. All individuals must have Person Centered Plan in which the procedures of a BSP must be included and approved by the team and the person and then approved by the BPRC and HRC and, for the most restrictive procedures, by the DPBS. The Division of Developmental Disabilities offers training opportunities to assist service providers develop the skills related to determining the functions of behaviors being exhibited by individuals served and to connect the prevention and intervention strategies to the behavioral functions in order to increase the likelihood of successful outcomes. BSPs require renewal on an annual basis and all the review/approval groups mentioned above must assess the new plan and determine whether to approve the revised or new plan based upon the data presented from the previous program. Finally, certification staff routinely review personnel files for all necessary and required training.

Due process is defined as providing people supported, and their legally authorized representatives, with a fair process requiring, at least, an opportunity to present objections to the proposed action being contemplated.

Due process, including review by a Human Rights Committee, is implemented when it is proposed that a person's rights be restricted for any reason.

Staff are trained in due process procedures including any procedures for placing a limitation or restriction on a person's rights.

A Human Rights Committee (HRC) reviews any restriction of a person's right(s) initially and periodically thereafter, but at least annually, during the period which the restriction is imposed and will document such.

When any restrictions are being proposed for a person, the person is supported to attend and provide input at the HRC meeting in which the proposed restriction is being reviewed.

People supported are provided adequate training in due process procedures including any procedures for placing a limitation or restriction on a person's rights and training that supports the removal of rights restrictions.

The continued need for the restriction is reviewed at least quarterly by the Qualified Intellectual Disabilities Professional (QIDP) or more often upon request of the person whose rights are restricted.

The organization utilizes a working and effective HRC that complies with the provisions of Chapter 580-3-26.

The HRC reviews policies, procedures and practices that have the potential for rights restrictions without an individualized assessment.

The HRC reviews the frequencies and reasons surrounding the use of restraint for behavioral or medical purposes.

In addition to the requirements in Chapter 580-3-26 (2)(a)-(3), the HRC makes recommendations to the organization for promoting people's rights, proactively promotes and protects people's rights and reviews reports of substantiated allegations of abuse, neglect, mistreatment, exploitation and other data that reveal the organization's practices with respect to human, civil and legal rights and reviews research projects involving human participation to ensure the protection of people who are involved.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Alabama Department of Mental Health
--Division of Developmental Disabilities Central and Regional Offices
--Office of Advocacy Services

Level 2 procedures, considered to be somewhat restrictive and require reviews by the BPRC chairperson and the HRC. Level 3 procedures require review by the entire BPRC and HRC prior to implementation. Level 4 procedures must be approved by the BPRC, HRC, and submitted to the DPBS for additional approval and more frequent review to ensure effectiveness of the procedure.

DDD Certification staff routinely review personnel files for all necessary and required training.

A Human Rights Committee (HRC) reviews any restriction of a person's right(s) initially and periodically thereafter, but at least annually, during the period which the restriction is imposed and will document such.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The Operating Agency, in its function of certifying providers, and in its monitoring of direct service provision and service plan implementation, will detect any unauthorized use of restrictive interventions either through records (for instance, notes in a participant's file communicating the restriction), staff comments and discussion, or participant or family feedback during direct interviews or through communication with the advocacy hotline.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed

living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

- **Medication Management and Follow-Up**

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

The Behavioral Services Procedural Guidelines require that, for any person prescribed psychotropic or other medications for purposes of addressing/treating behavioral challenges and/or Psychiatric Symptoms, a Psychotropic Medication Plan be developed for the purpose of ensuring that reductions are considered and implemented whenever possible, based upon presentation of data to the treating Psychiatrist/Doctor. The person's habilitation team provides documentation of behavioral data and reports of psychiatric symptoms (if applicable) at every session with the treating doctor for review. If the criteria set by the team have been met, this information is presented to the doctor, and consideration is given to a reduction in medication, unless contra-indicated for medical or other extenuating circumstances that should be documented. The medication plan can be a section within the person's BSP. If a person is having "spikes" in their behaviors or in psychiatric symptoms, the provider is required to attempt to determine what factors might account for those peaks and make their findings known to the doctor. They are also required to modify the person's plan, if necessary, to address the factors leading to the ineffectiveness of the medications. Finally, the Certification staff routinely reviews records of individuals receiving Psychotropic Medication for all necessary monitoring and documentation, including necessary lab work.

Sometimes individuals have behavioral episodes that result in visits to an ER or an admission to a hospital. This requires that notification be provided to the Regional Community Services office, and the IPMS procedures are followed in those cases. If it becomes evident that there are problems with medication administration, follow-up monitoring and, sometimes, investigations are conducted as outlined in the IPMS. Finally, the Certification staff routinely reviews information related to Best Possible Health, Protection for Abuse, Neglect, Mistreatment, and Exploitation, and Safe Environments.

Medications are reviewed through the IPMS system, quarterly regional and statewide QE reports, agency participation in the Nurse Delegation Program, and routine and "for-cause" certification reviews.

Provider-employed or contracted nurses directly administer certain medications and delegate others to trained direct care staff. The nurse is responsible to provide periodic and regular evaluation and monitoring of the staff performing the delegated task and to conduct quality monitoring of the tasks performed by the staff. This evaluation and monitoring must occur at least quarterly. Direct care staff must be medication assistant certified (MAC) workers in order to assist with medication administration. The delegating RN or LPN may withdraw delegation authority (of direct care staff) at any time.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Alabama Department of Mental Health:
--Division of Developmental Disabilities

Three teams of professionals, including a medical doctor, a psychiatrist and a behavior analyst, are available through the Regional Offices to advise and assist with programs for reducing medications. These teams also provide education to local doctors who sometimes do not know the risk factors and alternatives to combinations of certain medications.

Regional nurses are required to monitor the administration of medication at each site annually. During the monitoring visit, a sample size of 5% of medication administration records are reviewed by the regional nurses to assess provider performance and identify areas for improvement. Data are collected, and recommendations are made on the Regional Nursing Monitoring form. Regional nurses schedule follow-up visits to validate implementation of recommended changes. A final copy is forwarded to the Community Services Director and the provider.

Incident reports that include medication errors in three categories are required by IPMS and entered into an electronic database where they are tracked at the consumer and provider level and trended at the systems level. Intervention will occur from the Regional Offices and/or from Certification as needed.

Certification surveys include reviews of nursing notes and incident reports every year or every other year, depending on the overall score achieved by the provider on the previous survey.

Certification surveys also include for cause surveys and provisional status re-surveys as needed.

--Office of Advocacy Services

Advocates review individual’s living situations, including issues regarding health and welfare, as well as rights, and check on medication administration on a sample basis.

Alabama Medicaid Agency:

Annual review of DDD's investigations, certification files containing quality enhancement plans and technical assistance reports, and mortality reviews.

Annual survey of providers, including a complete record review on a sample basis.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

• **State Policy.** Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

State policy follows the nursing practice act of the State. Certain types of medication administration must be performed by a nurse, but other types, such as assisting with the delivery of prescribed oral, topical, inhalant, eye or ear medications may be delegated to a trained direct care staff under a protocol approved by the Board of Nursing.

- **Medication Error Reporting.** *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

Alabama Department of Mental Health:
--Division of Developmental Disabilities

The Division of Developmental Disabilities provides ongoing reports to the Alabama Board of Nursing. Agency reports to the DDD are included in the DDD reports to the Board of Nursing annually.

(b) Specify the types of medication errors that providers are required to *record:*

A medication error occurs when a recipient receives an incorrect drug, drug dose, dose form, quantity, route, concentration, or rate of administration. A medication error is also defined as some form of variance of the administration of a drug on a schedule other than intended. Therefore, a missed dose or a dose administered one hour before or after the scheduled time constitutes a medication error.

Severities of medication errors are defined as follows:

Level 1 includes incidents in which the individual experienced no or minimal adverse consequences and no treatment or intervention other than monitoring or observation was required.

Level 2 includes incidents in which the individual experienced short term, reversible adverse consequences and treatment(s), and/or intervention(s) was/were needed in addition to monitoring and observation.

Level 3 includes incidents in which the individual experienced life-threatening and/or permanent adverse consequences.

The agency must record level 1, 2 and 3 medication errors.

(c) Specify the types of medication errors that providers must *report* to the state:

The agency must report level 1, 2 and 3 medication errors to RCS. Levels 2 and 3 must be reported verbally within 24 hours. Levels 1 and 2 must be reported on an incident form monthly. Level 3 must be reported on an incident report form within 72 hours. No action follow-up is required by RCS or the provider for Level 1 medication errors, but such errors are tracked and trended to determine patterns and need for possible intervention.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

- **State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Alabama Department of Mental Health:
--Division of Developmental Disabilities

Regional nurses are required to monitor the administration of medication at each site annually. During the monitoring visit, a sample size of 5% of medication administration records are reviewed by the regional nurses to assess provider performance and identify areas for improvement. Data are collected, and recommendations are made on the Regional Nursing Monitoring form. Regional nurses schedule follow-up visits to validate implementation of recommended changes. A final copy is forwarded to the Community Services Director and the provider.

ADMH reports these findings as critical incidents through its Therap software. The Medicaid Agency has access to view all critical incidents, including those for medication errors, in Therap and reviews these on an ongoing basis, In addition, ADMH provides a quarterly incident management report that includes a specific summary of critical incidents related to medication management and administration

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:

a. ***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 abuse, neglect, exploitation, or unexpected death incidents reviewed/investigated within the required timeframe. Percentage = NUMERATOR [Total Number of abuse, neglect and exploitation or unexpected death incidents reviewed/investigated within the required timeframe]/ DENOMINATOR [Number of abuse, neglect and exploitation or unexpected death incidents]

Data Source (Select one):
Other
If 'Other' is selected, specify:
ADMH Incident Prevention Management System (IPMS)

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of closed cases of abuse/neglect/exploitation for which the OA 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]/...

Data Source (Select one):
Other
If 'Other' is selected, specify:
...cntnd from above.....DENOMINATOR [Number of closed cases of abuse/neglect/exploitation] ADMH Incident Prevention Management System (IPMS)

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**	☐ **Other**

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of suspected abuse, neglect and exploitation incidents and unexpected deaths referred to appropriate investigative entities, e.g., Adult Protective Services, Child Protective Services and/or law enforcement. Percentage = NUMERATOR [Number of suspected abuse, neglect and exploitation incidents and unexpected deaths referred to appropriate investigative entities...

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
cntnd...e.g., APS, CPS and/or law enforcement]/DENOMINATOR[Number of instances of suspected abuse, neglect and exploitation and unexpected deaths]
ADMH Incident Prevention Management System (IPMS)

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: Daily	

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 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] / continued below...

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
continued from above..DENOMINATOR [Number of participant records reviewed]
Participant record reviews, on-site (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 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 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:
Record reviews, on-site (Certification: Training verification 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 =
☐ **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: 100% of provider training verification records are reviewed over a two year cycle

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:
Record reviews, on-site (Certification: Training verification 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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and**	☐ **Other**

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: 100% of provider training verification records are reviewed over a two year cycle

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
Number and percent of critical incidents that have been resolved by the ADMH within 60 days of the date of the critical incident report date. Percentage = NUMERATOR [Number of critical incidents resolved by the ADMH within 60 days of the date of the critical incident report date] / DENOMINATOR [Number of reported critical incidents]

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
ADMH Incident Prevention Management System (IPMS)

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of critical incident trends where systemic intervention was implemented. Percentage=NUMERATOR [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:
ADMH Incident Prevention Management System (IPMS)

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:
 # and % of critical incident trends for which systemic intervention was implemented that showed sustained improvement after 3 months, or the state implemented a corresponding revision to the intervention. Percentage=NUMERATOR[# of critical incident trends where systemic intervention was implemented that showed sustained improvement after 3 months,or the state implemented a corresponding revision..

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
cntnd from above.. to the intervention]/DENOMINATOR[# of critical incident trends for which systemic intervention was implemented. ADMH Incident Prevention Management System (IPMS)

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**

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:

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 participants with restrictive interventions where proper procedures were followed. Percentage = NUMERATOR [Number of participants with restrictive interventions where proper procedures were followed] / DENOMINATOR [Number of participants who had a restrictive intervention applied]

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
ADMH Incident Prevention Management System (IPMS)

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 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:
Participant record reviews, on-site (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:
 # and % of restraints approved in a behavior support plan that were applied 3 times in a 6 month period and resulted in a team meeting to consider revision to the behavior plan as required by state policy. Percentage=NUMERATOR [# of times restraints approved in a behavior support plan that were applied 3x in a 6 month period and resulted in a team meeting to consider revision to the behavior..

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
..cntnd..plan req.by state policy]/DENOMINATOR[# of times a restraint approved in a behavior support plan was applied 3x within 6 month period] Participant record reviews, on-site/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:

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 unapproved restrictive interventions that had a prevention plan developed as a result of the incident. Percentage = NUMERATOR [Number of unapproved restrictive interventions that had a prevention plan developed as a result of the incident] / DENOMINATOR [Number of unapproved restrictive interventions]

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
ADMH Incident Prevention Management System (IPMS)

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:

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 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):
Record reviews, on-site

If 'Other' is selected, specify:
NCI Survey

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

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 participant records reviewed that document training and education were provided to provider 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. % = NUMERATOR [Number of participant record reviews that document training & education were provided..

Data Source (Select one):
Other
If 'Other' is selected, specify:
..cntnd from above.. to provider staff]/DENOMINATOR[Number of participant records reviewed] Participant record reviews, including corresponding provider training records,on site(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 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**

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:

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

Data from the OA will be collected on a monthly basis and reported to AMA. Trends in data will be addressed as appropriate depending on the results. Remediation by the QE staff in the regional office will identify needs based on trends and act accordingly to minimize variances from the expected goal.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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.

Reports will be sent monthly to the AMA and data will be reviewed. Data reports will be discussed at quarterly meetings to discuss data and trends noticed by AMA. AMA will work with the OA to ensure correction in an efficient manner. Regional nurses are required to monitor 5% the administration of medication at each site annually. During the monitoring visit, a sample size of 5% of medication administration records are reviewed by the regional nurses to assess provider performance and identify areas of improvement. Data is collected and reviewed recommendations are made on the Regional Nursing Monitoring on ways to prevent medication errors on the appropriate form. Regional nurses follow-up to validate implementation of recommended changes. A final copy is forwarded to the Community Services Director and the provider.

ii. Remediation Data Aggregation

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

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	5% of Medication Administration records are reviewed annually.

c. Timelines

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

- (●) **No**
- ( ) **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under 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.

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.

The system improvement strategy encompasses the the 1915(c) waiver (AL1746), and it will include the two 1915(c) waivers currently operated for individuals with intellectual disabilities (AL.0001, AL.0391) on or before July 1. Alabama designed the consolidated quality improvement strategy to assess and improve the quality of services and supports provided through the 1915(c) waiver. This is evident in the following components:

1. Participant services: The 1915(c) waivers offer similar services to participants to remain in the community with the focus on the provision of services and supports to maintain or increase a level of functioning in order to achieve an individual's goals of community inclusion and participation, independence, integrated employment, or productivity.
2. Participant safeguards: The 1915(c) waivers follow the same participant safeguards outlined throughout the individual waiver and state plan applications.
3. Quality management: The information below outlines the quality management approach, which is the same or similar across the 1915(c) waivers:

a) Methodology for discovering information: The state draws from several tools to gather data and measure individual and system performance. Tools utilized include participant record and application reviews, reviews of provider certification data, reviews of case management records, analysis of FMSA data, analysis of incident reporting data and investigation records, NCI data analysis, and random sample audits of person-centered plans and claims data.
b) Manner in which individual issues are remedied: The Operating Agency is responsible for establishing the components of the quality improvement strategy, which includes the remediation of issues with the 1915(c) waivers at an individual level, and all actions and timelines are recorded and tracked through annual monitoring activities.
c) Process for identifying and analyzing trends/patterns: Data gathered from the record reviews
will be initially used to foster improvements and provide technical assistance at the agency whose records are being reviewed. Quarterly, this data will be compiled to look for systemic trends and areas in need of improvement and published on the ADMH website at: http://mh.alabama.gov, as applicable.
d) Performance indicators: The majority of the performance measures associated with CMS assurances are the same.
e) Provider network: The provider network is very similar across the 1915(c) waivers. All provider types (i.e. licensed/non-licensed, certified/non-certified) within the 1915(c) waivers are required to meet similar training and background check requirements, according to policy, in order to furnish HCBS.
f) Oversight: Provider oversight is similar across the 1915(c) waivers, and all services are included in the consolidated reporting.

Appendix A Medicaid Oversight: Medicaid Agency will trend and analyze and share findings with the Administration of the Operating Agency. The quality assurance and improvement methodology employed by Medicaid staff gathers information from on-site and off-site record reviews and direct observation, as well as, from data forwarded from the operating agency.

Appendix B Level of Care Evaluations: The Administration of the Operating Agency will jointly consider the findings from the performance measures and determine the necessary actions. Specifically, the Director of System Transition and Waiver Development will trend and analyze quarterly and annually; the Associate Commissioner will prioritize; and the Director of Case Management Services and/or the Director of Quality and Planning will implement the prioritized recommendations with the support of the Directors of the Regional Community Service Offices. All system changes are shared with the Alabama Medicaid Agency prior to implementation.

Appendix C Qualified Providers and Certification: The Administration of the Operating Agency will jointly consider the findings from certification surveys and the related performance measures and determine the necessary actions. Specifically, the Director of Quality and Planning will analyze and trend the information quarterly and annually and share this information with the Quality Council/Developmental Disabilities Sub-Coordinating Committee. This council is comprised of various provider stakeholder groups, Protection and Advocacy, DD Council representative, families, and individuals with disabilities receiving supports and services. Prioritized recommendations from the Council will be reviewed by the Associate Commissioner and Divisional

Executive Staff. Implementation which require changes to the ADMH Administrative Code rules and regulations must be approved by the Administration of the Department of Mental Health. All system changes related to the waiver are shared with the Alabama Medicaid Agency prior to implementation.

Appendix D Service Planning: The Director of Case Management review the information from the provision of Support Coordination by DDD staff persons and provide quarterly summaries of findings and recommendations. This information from the performance measures can be reviewed agency by agency, aggregated by region, and aggregated statewide. It can also be trended from quarter to quarter and year to year, within the same aggregation parameters. The Director of Case Management will analyze and trend statewide data and also consider and prioritize the recommendations of the Regional Offices. The Associate Commissioner will approve recommendations for implementation. All system changes related to the waiver are shared with the Alabama Medicaid Agency prior to implementation.

Appendix G Health and Welfare: The Regional Offices review all incident and investigation reports quarterly and provide summaries and analysis to the Director of Quality and Planning, who shares this information, as well as statewide trends, with the Quality Council. Prioritized recommendations from this council will be reviewed by the Associate Commissioner and Divisional Executive Staff. Implementation which require changes in the rule must be approved by the Administration of the Department of Mental Health. All system changes related to the waiver are shared with the Alabama Medicaid Agency prior to implementation.

Appendix I Fiscal Accountability: The Alabama Medicaid Agency will, through its monitoring process, discover problems and resolve them. The Medicaid Agency will also see, through trending of these monitoring reports, any areas of concern which may need to be addressed through efforts ranging from training to policy and regulation to changes in the MMIS edits and audits.

In conjunction with the Director of Quality and Planning, the Director of Waiver Management and System Transition will provide quarterly summaries and analysis of waiver discovery and remediation indicators. This Quality Improvement Strategy occurs across this 1915(c) waiver. Data for Health and Welfare, as well as Level of Care, Qualified Providers, Service Planning, and Self-Directed Services will be presented during the same Quality Council/Developmental Disabilities Sub-Coordinating Committee meeting. This Quality Council is comprised of various provider stakeholder groups, Protection and Advocacy, DD Council representative, families, and individuals with disabilities receiving supports and services. If recommendations are made, they will be prioritized and reviewed by the Associate Commissioner and Divisional Executive Staff. Implementation which requires changes to the ADMH Administrative Code rules and regulations must be approved by the Administration of the Department of Mental Health. Evaluation of the QIS plan is ongoing, as data is presented quarterly. The QIS will be updated to track discovery and remediation data as program requirements change. At a minimum, the QIS plan will be reviewed upon CMS three-year assurances review and updated upon renewal. All system changes related to the waiver are shared with the Alabama Medicaid Agency prior to implementation.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

All system design changes have a component of evaluation built into the plan before the design change is implemented. For example, the Division implemented a new set of regulatory standards October 1, 2012. The Division contracted with the Council on Quality and Leadership (CQL) to align our requirements with their Basic Assurances(c). The change required extensive and ongoing training of community services providers. It included ongoing reports and evaluations by the Department of Mental Health, Division of Developmental Disabilities Certification Staff with community providers. Finally, training was provided by CQL to certification staff and has been validated annually.

The current direction of system design change is multifaceted. First, beginning October 1, 2014, the provider organizations will be required to develop and implement an ongoing quality enhancement plan or Basic Assurances System. Providers will complete an organizational assessment of their compliance with the Basic Assurances. Based on the assessment, they will have to identify priority areas to target for improvement for each factor and/or develop monitoring systems to ensure maintenance of compliance. Second, Divisional Quality Enhancement Staff entered into a training with CQL to become certified quality analysts. In this role, they have analyzed the first year of certification data and are developing focused trainings on specific areas both regionally and statewide to provide assistance to community organizations. Third, Divisional QE staff and other certified trainers are required to provide three (3) 4-day workshops in Personal Outcome Measures Training(c) as developed by CQL. The vision is for all waiver participants to participate in an outcome interview to determine preference, the presence or absence of outcomes and supports, and the priorities for attainment, which will become the foundation of the individuals' person-centered plans. This is how the Division envisions more effective person-centered planning in order to meet the CMS Regulations regarding Home and Community Based Services.

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

ADMH-DD’s Quality Council Committee meets during the DD Coordinating Subcommittee (also referred to as DD Sub) on a quarterly basis to receive reports from DD staff regarding waiver services, provider certification, individual health and welfare (incident management), case management and budgeting. Recurrent trends and other issues are often identified by the committee and the responsible office is tasked with researching the area of concern, consulting with appropriate staff, and providing a resolution to the larger group in a timely manner. The committee is then afforded the opportunity to make inquiries, request follow-up information and make recommendations to further implement system improvements.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ◉ **NCI Survey :**
- ○ **NCI AD Survey :**
- ○ **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

The State of Alabama assures the financial accountability and integrity of waiver payments through the following activities:
The Alabama Medicaid Agency will serve as the administering agency for this Waiver Program. The operating agency will be the Alabama Department of Mental Health.
The Medicaid Agency and the Department of Mental Health are both audited externally by the Alabama Department of Examiners of Public Accounts on an annual basis.

The Operating Agency is responsible for initial certification as well as annual or bi-annual audits of service providers, including case management agencies, depending on their certification status. The Community Waiver Program (CWP) Certification process will consist 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 participant record reviews, reviews of support coordination records, analysis of FMSA data, analysis of incident reporting data and investigation records, NCI data analysis, and random sample audits of person-centered plans and claims data. For each certification visit, the OA uses a roster of participants served by the provider to select a stratified (i.e., to ensure representation of all services provided by each provider) random sample. The size of the sample is also dependent upon the number of participants served. Typically, the maximum sample size for any visit is 15; however, the Certification Staff reserves the right to increase the interview sample to better represent the population being supported by the organization. Overall, the audit processes for all service providers, including case management agencies, completed by the Operating Agency result in at least a confidence level of 95% with a +/-5% margin of error.

All providers are required to secure an independent audit of their financial statements. As 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. Medicaid will choose one provider from each type each quarter to audit (desk review). The date range of the reviews is for the previous quarter. Data is collected from providers by any of the following sources: reviewing a sample of the waiver case management records, direct service providers records, consumer satisfaction surveys, and tracking complaints and grievances. Additionally, the data sheets are reviewed and compared against the PCP to ensure that services were provided according to the PCP. Overall, audits do not differ by service or provider; however, for case management record audits, Medicaid uses a representative sampling approach with a confidence level of 90% and a +/- 10% margin of error. Annually, Medicaid pulls all case management recipients from the past year and uses the Raosoft software to determine and validate the sample size for its case management record audits in accordance with its representative sampling approach of using a confidence level of 90% and a +/- 10% margin of error. Medicaid then uses Excel to randomize the sample by Medicaid ID and divides up the total sample by four in order to conduct quarterly audits. Medicaid subsequently requests case management records from the sampling list each quarter and completes the full sample audit within the audit year.

The results of the audit are provided to the Operating Agency. Medicaid does not have a direct contract with the provider; therefore, it is the responsibility of the OA to credential and provide audit feedback to the provider. If AMA finds 15 or more discrepancies (total from the administrative, personnel, training, and client tool components) between its audit findings and the OA's audit findings for a given provider, AMA will issue a Corrective Action Plan (CAP) indicating the steps the OA must implement within a designated timeframe to remedy the issues.
Reimbursement made for services not provided in accordance with the PCP, or not sufficiently documented, is recouped.
Medicaid implemented the following system to ensure services are billed according to the PCP to produce more accuracy in billing:
On October 1, 2017, the Alabama Medicaid Agency implemented an Electronic Visit Verification and Monitoring (EVVM) system to monitor visits to Home and Community Based Waiver Services clients. The EVVM system will enable more accuracy in service tracking, reporting, and billing for in-home care providers. The Electronic Visit and Verification system performs automated scheduling, time/attendance tracking and claim submission that:

* *Maintains a repository of authorized services*
* *Allows web-based scheduling of service visits*
* *Verifies a workers' location and length of service visit*
* *Automatically creates a claim record for review*
* *Identifies late or undelivered services*
* *Issues alerts for late and missed visits*
* *Automatically submits claim records for payment*
* *Provides flexible reporting in real-time*
* *Check in/out immediately reflected on the web*

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 provide has a systemic issue with editing claims which can raise a flag of fraud.

Another method that ensures the integrity of providers billing for Medicaid payment of waiver services is through the ADIDIS system for the Alabama Department of Mental Health. The provider billings are entered into a web-based claims processing system hosted by a vendor (Harmony Information Systems) for the Department of Mental Health. The ADIDIS system checks claims prior authorizations to ensure the services billed are approved by the Operating Agency's review of the PCP. From the ADIDIS system, approved claims flow directly to the Medicaid Management Information System through DXC, the Fiscal Intermediary. The Medicaid Management Information Systems (MMIS) performs validation edits and audits to ensure program compliance. Audits check for duplicate services, and service limitations and related services are compared to Medicaid policy and guidelines.
Medicaid's Networks and Quality Assurance Unit conducts quarterly case management audits, reviewing case management records for the quarter prior to the one during which the audit is conducted, at a 90% confidence level. Additionally the PCP and data sheets are reviewed and compared to ensure that services were provided according to the PCP. Reimbursement made for services not provided in accordance with the PCP, or not sufficiently documented, is recouped. While ADMH does not currently conduct any other post-payment audits, there are plans underway to initiate post-payment audit procedures with a confidence level of at least 95%, +/-5%.

The Fiscal Agent Liaison Division/Contract Monitoring Unit (DXC) of the Alabama Medicaid Agency monitors the processing and payment of Medicaid claims through the Claims Processing Assessment System (CPAS). Errors are identified real-time and corrections initiated. For electronically submitted claims, the edit process is performed several times per day; for paper claims, it is performed five times per week. If a claim fails any of these edits, it is returned to the provider. The claim is processed using both clerical and automated procedures. Once the claim pass through edits, the system reviews each claim to make sure it complies with Alabama Medicaid policy and performs cost avoidance. Cost avoidance is a method that ensures Medicaid is responsible for paying for all services listed on the claim. The system then performs audits by validating claims history information against information on the current claim. Audits check for duplicate services, limited services, and related services and compares them to Alabama Medicaid policy. The claim is then assigned a status (approved to pay, denied, or suspended). Suspended claims must be worked by DXC personnel or reviewed by Alabama Medicaid Agency personnel, as required. Claims paid in error will be submitted for recoupment. Once the reviewer initiates the recoupment, the claims goes back through the system and the FFP is removed.
Monthly reports of expenditures are received by the designated Long Term Care staff in order to monitor irregular expenses. The CMS 372 report is generated annually which records cost effectiveness and cost comparisons. Provider records are audited annually or more frequently at the discretion of the Medicaid Agency.
The entity responsible for conducting the periodic independent audit of the waiver program as required by the Single State Audit Act is the Alabama Department of Examiners of Public Accounts.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the 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 claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver / 1115 Group 5 document. Percentage = NUMERATOR [Number of claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver / 1115 Group 5] / DENOMINATOR [Number of claims paid]

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Claims data ADIDS

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 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):*
Other
If 'Other' is selected, specify:
Claims data (ADIDIS) Participant Record Reviews, On-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***	☐ ***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***
	☐ ***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:

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 / 1115 Group 5 cycle. Percentage = NUMERATOR [Number of rates that remain consistent with the approved rate methodology]/DENOMINATOR [Number of rates reviewed]

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
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 =*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the 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.*

Reports are shared with the Operating Agency and the Performing Provider. Reimbursement made for services not provided in accordance with the PCP, or not sufficiently documented, is recouped. The phrase "not provided in accordance..." is

defined as exceeding an average expected rate of utilization by more than 10% and having no documentation for the exception. All waiver services are prior authorized, so that the annual limits on units of service cannot be exceeded, but average utilization, month to month, can vary.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ ***No***

○ ***Yes***

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

Proposed service rates are determined by ADMH / DDD (Operating Agency - OA) & are reviewed & approved by the Alabama Medicaid Agency (AMA), which oversees the rate determination process. Payment made by AMA to providers will be on a fee-for-service basis, with some outcome payments using methodologies known to be used in other states' 1915(c) waivers (e.g. TN & OR) for certain pre-employment services. Services for which the rates are based on a fee-for-service basis include:

Supported Employment – Individual
Co-Worker Supports
Supported Employment – Small Group
Integrated Employment Path Services
Financial Literacy & Work Incentive Benefits Counseling
Independent Living Skills Training
Personal Assistance – Home
Personal Assistance – Community
Community Integration Connections & Skills Training
Peer Specialist Services
Family Empowerment & Systems Navigation Counseling
Breaks & Opportunities (Respite)
Assistive Technology & Adaptive Aids
Remote Supports
Housing Counseling
Housing Start-Up Assistance
Supported Living Services
Adult Family Home
Community-Based Residential Services
Positive Behavioral Supports
Physical Therapy
Occupational Therapy
Speech & Language Therapy
Skilled Nursing
Support Coordination

Rates are based upon a number of factors, & all rates were formulated using the following: current pricing for similar services & stakeholder feedback on this pricing; state-to-state comparisons for similar services (including TN; MI; WI; OJ; AR); comparison of different payers for similar services; & attention to the expansion of capacity providers must undertake necessary to serve more individuals given this waiver is adding nearly 500 individuals with ID in targeted demonstration areas in each region of the state. Rates established for this waiver (https://mh.alabama.gov/community-waiver-program/)are closely aligned with rates in the ID/LAH &/or aligned with rates established in the newest HCBS program serving people with ID that is most well aligned with the goals & design of this waiver (TN ECF CHOICES). The OA's consultant was involved in establishment of the TN reimbursement rates & brought this knowledge to setting the rates for this waiver. Rates established for services in this waiver are generally higher than rates for similar services in other states reviewed as noted above. These rates are intended to support AL providers to expand capacity for 500 new referrals in a 6-9 month period when this waiver launches, providing services different from those typically utilized in ID/LAH. Since Supported Living & Remote Supports are new services for AL, the rates from WI (for Supported Living) & OH (for Remote Supports) were adopted to ensure availability, quality & use. Relative to ID/LAH, rates for this waiver are higher for the following services: Agency Personal Assistance (providers voiced concerns providing this service to more people at the ID/LAH rates); Self-Directed Personal Assistance (adjusted to align with increased Agency Personal Assistance rate); Self-Directed Breaks & Opportunities-Respite (expectation of supporting community integration, employment as part of service increased calculated cost); & Job Coach-Individual (ranges from $7.00-$9.00 to incentivize best practices while ID/LAH has flat rate of $7.50). Higher rates will ensure adequate provider network & timely access to needed services & minimize DSP turnover & vacancies to ensure continuity for waiver enrollees. Rates do not vary geographically.

The rates will be posted on ADMH website (https://mh.alabama.gov/community-waiver-program/). Stakeholders provide input into development & sufficiency of rates through posting of waiver applications, renewals & amendments for public comment, ADMH DD Sub-Committee, & other stakeholder meetings & forums. AMA solicits public comments on rate determination methods through the public input process for this waiver described in Main Section 6-I of the application.

Where stakeholder input & state-to-state comparison of payment rates for similar services supported the need for rates for particular services to be set above the rates in LAH/ID, higher rates were adopted to ensure rate sufficiency while still adhering to requirements under §1902(a)(30)(A). All rates are supported by rate models containing reasonable assumptions about provider costs to deliver each service. Rates for 1:1 service delivery are appropriately adjusted when/if more than one individual can be supported by one staff person in the delivery of a specific service. The OA will continue to measure rate sufficiency & compliance with §1902(a)(30)(A) of the Act, specifically ensuring that rates are "consistent with efficiency, economy, & quality of care & are sufficient to enlist enough providers" through implementation of provider cost reporting at least once every 5 years (timed with waiver renewal cycle). The OA will compare reported data to rate models used to establish reimbursement rates for each service, making adjustments as needed & as appropriations permit, to ensure alignment between provider reported costs & reimbursement rates.

The 3 models of residential support (Supported Living; Adult Family Home; & Community-Based Residential Services) use a daily rate, and rate ranges are proposed with individual participant rates set based on an assessment tool that takes account of the specific type, frequency, & intensity of the supports needed, & whether Remote Supports is utilized, whether more than 1 individual is sharing support at times, whether nurse oversight/delegation is needed, & the extent of transportation the provider must provide. ADMH contracted an agency from WI with 20 years of experience administering services for people with ID, including all 3 residential models, that developed & implemented the Supported Living assessment tool & is assisting ADMH to adopt this tool & is developing similar tools for Adult Family Home & Community-Based Residential Services, & training of Support Coordinators & providers on the tools.

For Supported Employment–Individual Job Coaching services, fee for service job coaching rates are based on a prospective rate model that reflects a sufficient wage for the level of qualified staff required to deliver the service & all other reasonable/anticipated costs involved. For job coaching, this prospective rate is tiered into 3 distinct rates based on the level of fading achieved, accounting for the participant's level of disability/length of time the job has been held. Using this model, providers are incentivized to fade job coaching supports over time (a key quality metric for supported employment services) while the OA can ensure no participant is excluded from supported employment-individual services based on level of disability or newness to their job. To determine a waiver participant's acuity tier for job coaching, the ICAP score will be used. Where an individual has a need for job coaching that is equal to/less than 1 hour per week, a monthly "Stabilization & Monitoring" payment encourages ongoing monitoring of the participant's employment, with minimum monthly contact requirements that prevent avoidable job losses/reductions in work hours.

For Supported Employment-Individual pre-employment services, the OA proposes to pay on an outcome basis with the unit defined for each pre-employment service based on the expected outcome of the service: Discovery outcome is the Discovery report. For each of aspect of the service, the underlying fee-for-service prospective rate for qualified job developer was used, which was also informed by existing rates for qualified job developers being paid by ADRS and in LAH/ID. The following other rate determination methods were used:
Exploration: All components of Exploration service process were defined, & the average time necessary for each step was determined: an average of 30 hours total for all required steps. The underlying fee-for-service prospective rate was multiplied by 30 hours to arrive at the payment for the outcome (the Exploration report). The unit is therefore the report. The required Exploration report, necessary for authorization of payment, contains a section that tracks actual hours/miles driven, to allow the OA to monitor the appropriateness of the outcome payment over time. The providers will also be given the Exploration Steps & Timeframes that the outcome payment is based on, prior to authorization for this service.

Discovery: All components of Discovery service process were defined, & the average time necessary for each step was determined: an average of 34 hours total for all required steps. The underlying fee-for-service prospective rate was multiplied by 34 hours to arrive at the payment for the outcome (the Discovery report). The unit is therefore the report. The required Discovery report, necessary for authorization of payment, contains a section that tracks actual hours/miles driven, to allow the OA to monitor the appropriateness of the outcome payment over time. The providers will also be given the Discovery Steps & Timeframes that the outcome payment is based on, prior to authorization for this service.

Job Development Plan: All steps necessary to create a Job Development plan with the participant were defined and the average time necessary for each step was determined, resulting in an average of 6 hours total for all required steps. The underlying fee-for-service prospective rate was multiplied by 6 hours to arrive at the payment for the outcome (the Job Development plan). The unit is therefore the plan. The required Job Development Plan, necessary for authorization of payment, contains a section that tracks actual hours and miles driven, to allow the OA to monitor the appropriateness of

the outcome payment over time. The providers will also be given the Job Development Plan Steps/Timeframes, that the outcome payment is based on, prior to receiving an authorization for this service.

Job Development: Using information from other states Medicaid HCBS programs, ADRS, & vocational rehabilitation agencies in other states, the average amount of hours necessary for completion of job development (securing outcome of paid competitive, integrated employment, consistent with a participants goals, preferences, skills and conditions for success) was determined. The average hours expected to be necessary to complete the service were multiplied by the underlying fee-for-service prospective rate for the qualified job developer to arrive at the payment for the outcome (the Report). The unit is therefore the Report. The required Job Development report, necessary for authorization of payment, contains a section that tracks actual hours and miles driven, to allow the OA to monitor the appropriateness of the outcome payment over time.

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:*

Continued from above:

Career Advancement: The service is divided into two parts: Career Advancement Plan and Career Advancement Outcome. The same assumptions used for Job Development Plan creation were used for the Career Advancement Plan. Thus, the average time necessary was determined to be 6 hours total for all required steps. The underlying fee-for-service prospective rate was multiplied by 6 hours to arrive at the outcome payment for the Plan. The unit is therefore the plan. The required Career Advancement Plan, necessary for authorization of payment, contains a section that tracks actual hours and miles driven, to allow the OA to monitor the appropriateness of the outcome payment over time. For securing the advancement opportunity, a lower outcome payment than for initial Job Development was established, based on fact person is employed and successful in their current employment. The average hours expected to be necessary to complete the service (18.75) were multiplied by the underlying fee-for-service prospective rate for the qualified job developer to arrive at the outcome payment. The unit is therefore the Report. The required Career Advancement report, necessary for authorization of payment, contains a section that tracks actual hours/miles driven, to allow the OA to monitor the appropriateness of the outcome payment over time.

Service rates in this application were set & last reviewed in 2020. Review of rates & assumptions in the rate methodologies occurs on an ongoing basis to ensure adjustments are made as needed. Re-evaluation of pricing & rate increases are considered as warranted based upon problems with service access, service quality, & budgetary opportunities. When allocations from the state Legislature are received, rates increases are determined by the OA based on problems with service access, service quality, stakeholder input, & where service rates have not been adequately adjusted over time due to budget constraints.

Begin Flow of Billings:

Each waiver participant, once approved, is added to the Alabama Medicaid's Recipient Level of Care Panel. This file holds approved dates of eligibility for waiver services.

Provider billings are entered into a web-based claims processing system hosted by a vendor (Harmony Information Systems) for the Department of Mental Health. This system, known as ADIDIS, checks claims against prior authorizations to ensure the services billed are approved by the operating agency's review of the PCP. From the ADIDIS system, approved claims flow directly to the Medicaid Management Information System through DXC, the Fiscal Intermediary as follows:
Payments made by Medicaid to providers are on a fee-for-service basis. Each covered service is identified on a claim by a procedure code.
For each recipient, the claim allows span billing for a period up to one month. There may be multiple claims in a month; however no single claim can cover services performed in different months.
If the submitted claim covers dates of service where part, or all of which were covered in a previously paid claim is rejected. The provider is required to make the corrections on the claim and resubmit for processing.
Payment is based on the number of units of service reported on the claim for each procedure code.
Accounting for actual costs and units of services provided during the waiver year, are captured on the CMS 372 Report.
All claims must be filed within twelve months from the date of service.
Payment is based on the number of units of service reported on the claim for each procedure code. There is a clear differentiation between waiver services and non-waiver services and a clear audit trail exists from the point of service through billing and reimbursement. Discrepancies are initially handled at the local level.
The ID Waiver administrator monitors expenditures on a bi-annual basis or as often as needed and monitors problems with particular service providers. If costs appear to be out of line or unusual, the provider is contacted and follow-up action is implemented as needed.
For each waiver service, a HCPC code is determined with a rate assigned to each code. The Medicaid Management Information system (MMIS) pays the claim based upon the State's determined pricing methodology applied to each service by provider type, claim type, recipient benefits and policy limitations. All claims submitted for adjudication must pass certain edits in MMIS. Once a claim passes through edits, the system reviews each claim to make sure it complies with AMA policies. The MMIS then performs audits by validating claims history information against information on the current claim. Audits check for duplicate services, limited services, and related services and compare them to Alabama Medicaid policy to ensure that recipient benefits are paid according to current policies.
Claims submitted through Electronic Visit Verification and Monitoring (EVVM) follow the same flow of billing. ADMH receives the claims from the EVVM system and processes them according to the steps as previously outlined in this section.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- (●) ***No. state or local government agencies do not certify expenditures for waiver services.***
- ( ) ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

The system performs validation edits to ensure the claim is filled out correctly and contains appropriate information for processing. Edits ensure the recipient's name matches the recipient identification number (RID); the procedure code is valid for the diagnosis; the recipient is eligible and the provider is active for the dates of service; and other similar criteria are met. For electronically submitted claims, the edit process is performed several times per day. For paper claims, it is performed five (5) times per week. If a claim fails any of these edits, it is returned to the provider.

Once claims pass through edits, the systems reviews the claim history information against information on the current claim. Audits check for duplicate services, service limitation, and related services and compare them to Alabama Medicaid policy. The system then prices the claim using the State determined pricing methodology applied to each service by provider type, claim type, recipient benefits, or policy limitations.

Once the system completes claim processing, it assigns each claim a status: approved to pay, denied, or suspended. Approved to pay and denied claims are processed through the financial cycle twice a month, at which time an Explanation of Payment (EOP) report is produced and checks are written, if applicable. Suspended claims must be worked by DXC Technology or reviewed by Alabama Medicaid Agency personnel, as required.

Claims approved for payment are paid with a single check or electronic funds transfer (EFT) transaction according to the check write schedule published by the Alabama Medicaid Agency. The check is sent to the provider's payee address with an EOP, which also identifies all denied claims, pending claims, and adjustments. If the provider is enrolled in the electronic funds (EFT) transfer process, the payment is deposited directly into the provider's bank account and the EOP is mailed separately to the provider.
Another method that ensures the integrity of providers billing for Medicaid payment of waiver services is through the ADIDIS system for the Alabama Department of Mental Health. The provider billings are entered into a web-based claims processing system hosted by a vendor (Harmony Information Systems) for the Department of Mental Health. The ADIDIS system checks claims prior authorizations to ensure the services billed are approved by the Operating Agency's review of the PCP. From the ADIDIS system, approved claims flow directly to the Medicaid Management Information System through DXC, the Fiscal Intermediary. The Medicaid Management Information Systems (MMIS) performs validation edits and audits to ensure program compliance. Audits check for duplicate services, and service limitations and related services are compared to Medicaid policy and guidelines.

Claims paid in error will be submitted for recoupment. Once the reviewer initiates the recoupment, the claims goes back through the system and the FFP is removed.

The Operating Agency is responsible for initial certification and annual audits of providers. The audits completed by the OA have a confidence level of 95% with a +/- 5% margin of error. All providers are required to secure an independent audit of their financial statements. Medicaid's Networks and Quality Assurance Division takes a sample of each type of provider over a rolling three-year period to audit from all Waivers. Data is collected from providers by any of the following sources: reviewing a sample of the waiver case management records, direct service providers records, consumer satisfaction surveys, and tracking complaints and grievances. Additionally, the PCP and data sheets are reviewed and compared against the PCP to ensure that services were provided according to the PCP. Reimbursement made for services not provided in accordance with the PCP, or not sufficiently documented, is recouped.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

- ◉ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ○ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal

funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☒ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

- (●) ***No. The state does not make supplemental or enhanced payments for waiver services.***
- ( ) ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- ( ) ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- (●) ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

State DMH (Alabama Department of Mental Health) is the operating agency for this waiver. The State DMH provides Support Coordination to all waiver participants.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- (●) ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ( ) ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ( ) ***The amount paid to state or local government providers differs from the amount paid to private providers of***

the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- (●) ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ( ) ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ( ) ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- (●) ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR § 447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

Providers may reassign payments only to ADMH, the operating agency for this waiver.

ii. Organized Health Care Delivery System. *Select one:*

- ( ) ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR § 447.10.***
- (●) ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR § 447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of

providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

The ADMH and other providers of waiver services all provide one or more Medicaid service and are eligible to be OHCDS. Providers may enroll directly with the Medicaid Agency if they wish; but in this case, they must also contract with the ADMH in order for the ADMH to pay the state match portion of the reimbursement. Free choice of provider as detailed elsewhere in this waiver application is assured by the policies and procedures in effect and practices carried out by Support Coordinators. All providers are certified and monitored between certification surveys.
Payments are made through an approved MMIS system which ensures financial accountability.

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:

The non-federal share of waiver payments is transferred to the Alabama Medicaid Agency by the Alabama Department of Mental Health (ADMH). This is managed through an IGT process in which the Medicaid Agency determines, during each billing cycle, how much non-federal match is needed to reimburse adjudicated claims, and invoices ADMH, whereupon ADMH transfers these funds to the Medicaid Agency.

For Medicaid payments under this waiver, the source of non-federal match transferred to the Medicaid Agency by the AL Department of Mental Health is 100% appropriated by the legislature to the ADMH from three tax-based funds: The General Fund; the Education Trust Fund; and the Mental Health Trust Fund.

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the

mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

- ◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ○ ***The following source(s) are used***

  Check each that applies:

  - ☐ ***Health care-related taxes or fees***
  - ☐ ***Provider-related donations***
  - ☐ ***Federal funds***

  For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- ◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

All costs related to room and board are clearly excluded from the formulas used to build the rate determination assessments for Supported Living, Adult Family Home and Community-Based Residential Services, as follows:

The rate setting methodology for these residential service options is driven by the staff hours needed by each individual, divided by the number of other individuals sharing those staff hours (staff hours). Transportation, the need for nurse oversight/delegation, if applicable, and the use of Remote Supports, assistive technology/adaptive aids, PERS, and natural supports is also factored into the rate setting methodology.

Indirect administrative and non-personnel operating costs are also factored in and clearly defined not to include room and board costs.

Participant's earned and unearned income pay for room and board.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ( ) ***Yes. Per 42 CFR § 441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing *(1 of 5)*

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- (●) ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ( ) ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] ***Nominal deductible***
- [ ] ***Coinsurance***
- [ ] ***Co-Payment***
- [ ] ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing *(2 of 5)*

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- ◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	24292.57	5931.00	30223.57	90239.00	4186.00	94425.00	64201.43
2	19085.32	6053.00	25138.32	92107.00	4273.00	96380.00	71241.68
3	23164.53	6179.00	29343.53	94014.00	4361.00	98375.00	69031.47
4	31558.14	6306.00	37864.14	95960.00	4452.00	100412.00	62547.86
5	23796.55	6437.00	30233.55	97946.00	4544.00	102490.00	72256.45

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID
Year 1	500	500
Year 2	1097	1097
Year 3	1447	1447
Year 4	1797	1797
Year 5	2147	2147

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 (ALOS) varies for each demonstration year based on the average number of beneficiaries in the 1915(c) and Section 1115 Group 5 enrolling into the Community Waiver Program each month for the Waiver Period. The total number of waiver slots, their member months, average duration and ALOS are outlined in the following table:

Waiver Period	Slots	Slot Gain from Prior Year	Total Member Months	Average Duration (in months)	ALOS (days)
Year 1 (Oct 1, 2021 to Sep 30, 2022)	500	-	3272	6.5	199.09
Year 2 (Oct 1, 2022 to Sep 30, 2023)	1,097	597	9,831	8.96	272.60
Year 3 (Oct 1, 2023 to Sep 30, 2024)	1,447	350	15,439	10.7	325.42
Year 4 (Oct 1, 2024 to Sep 30, 2025)	1,797	350	19,639	10.93	332.42
Year 5 (Oct 1, 2025 to Sep 30, 2026)	2,147	350	23,839	11.1	337.74

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:*

The average annual Factor D projection was developed using historical enrollment, utilization and expenditures for HCBS services provided under the ID and LAH 1915(c) waiver for FFY 2017 and FFY 2018. The data was aggregated for each population covered in the Community Waiver Program 1915(c) waiver. ID and LAH experience were selected because participants in the Community Waiver Program 1915(c) waiver will enroll from the current ID and LAH waivers or may be new enrollees who whose eligibility criteria meets the existing ID and LAH waivers. The historical service utilization and expenditures from ID and LAH were aggregated based on four populations outlined below: 1. 3-13 years old who are living with family or with other natural supports 2. 14-21 years old who are living with family or with other natural supports, or who are 18-22 and live independently. 3. 22+ years old who are living independently or living with family or with other natural supports. 4. 3+ years old who are unable to live independently, live with family or other natural supports. FFY 2017 and FFY 2018 data was blended together and trended from the midpoint of FFY 2017 and FFY 2018 (September 30, 2017) to the midpoint of Year 1 (May 17, 2021) using CPI-M of 2.07%. Year 1 is a 9-month period (January 1, 2021 to September 30, 2021). Projections for Year 2 (October 1, 2021 to September 30, 2022) were trended using CPI-M of 2.07 for 10.5 months (the midpoint between Year 1 and Year 2). Year 2 was trended using CPI-M of 2.07% to develop Years 3-5 (October 1, 2022 to September 30, 2025). The Factor D figures reflect the annual expenditure limits for HCBS services by population outlined in Appendix C-4 . These annual limits plus the amount for 1915(c) waiver services not subject to the annual limit are the basis for the Factor D projections. Factor D for each population was developed based on the slots available for Year 1 (January 1, 2021 to September 30, 2021). To derive Factor D for Years 2 through 5 (October 1, 2021 through September 30, 2025), the Year 1 amounts by population

were trended at 2.07% and aggregated for the total available waiver slots during each year. The trend factor of 2.07% is based on the Bureau of Labor Statistics Consumer Price Index for medical services (CPI-U) from 2017-2019.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor D' for Year 1 was developed using historical enrollment and expenditures for state plan services from FFY 2017 and FFY 2018 data. The data for FFY 2017 and FFY 2018 was blended together and trended from the midpoint of FFY 2017 and FFY 2018 to the midpoint of Year 1 using CPI-M of 2.07%. Year 1 projections were trended 2.07% to develop Years 2-5.

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 was developed using historical enrollment and expenditures for ICFMR services from FFY 2017 and FFY 2018 data. The data for FFY 2017 and FFY 2018 was blended together and trended from the midpoint of FFY 2017 and FFY 2018 to the midpoint of Year 1 using CPI-M of 2.07%. Year 1 projections were trended 2.07% to develop Years 2-5.

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' was developed using historical enrollment and expenditures for state plan services used by enrollees in ICFMR from FFY 2017 and FFY 2018 data. The data for FFY 2017 and FFY 2018 was blended together and trended from the midpoint of FFY 2017 and FFY 2018 to the midpoint of Year 1 using CPI-M of 2.07%. Year 1 projections were trended 2.07% to develop Years 2-5.

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	
Breaks and Opportunities (Respite)	
Community-Based Residential Services	
Integrated Employment Path Services	
Personal Assistance - Home	
Support Coordination	
Adult Family Home	
Assistive Technology and Adaptive Aids	
Co-Worker Supports	
Community Integration Connections and Skills Training	
Community Transportation	
Family Empowerment and Systems Navigation Counseling	
Financial Literacy and Work Incentives Benefits Counseling	
Housing Counseling Services	
Housing Start-Up Assistance	
Independent Living Skills Training	
Individual Directed Goods and Services	
Minor Home Modifications	
Natural Support or Caregiver Education and Training	
Occupational Therapy	
Peer Specialist Services	
Personal Assistance-Community	
Physical Therapy	
Positive Behavior Supports	
Remote Supports	
Skilled Nursing	
Speech and Language Therapy	
Supported Employment Individual	
Supported Employment Small Group	
Supported Living 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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Breaks and Opportunities (Respite) Total:							**245322.00**
Breaks and Opportunities (Planned Respite) - Hour	☐	Hour	69	35.00	22.00	**53130.00**	
Breaks and Opportunities (Planned Respite) - Day	☐	Day	69	6.00	158.00	**65412.00**	
Breaks and Opportunities (Planned Respite) - Self-Directed per Hour	☐	Hour	24	35.00	19.80	**16632.00**	
Breaks and Opportunities (Planned Respite) - Self-Directed per Day	☐	Day	24	6.00	142.00	**20448.00**	
Emergency Respite (Out-of-Home)	☐	Day	59	6.00	190.00	**67260.00**	
Emergency Respite (Out-of-Home) - Self-Directed	☐	Day	22	6.00	170.00	**22440.00**	
Community-Based Residential Services Total:							**836000.00**
Community-Based Residential Services	☐	Day	20	200.00	209.00	**836000.00**	
Integrated Employment Path Services Total:							**80392.20**
Integrated Employment Path Services (1:1 ratio)	☐	15 Minutes	115	42.00	9.40	**45402.00**	
Integrated Employment Path Services (1:2 ratio)	☐	15 Minutes	115	42.00	5.50	**26565.00**	
Integrated Employment Path Services (1:8 classroom)	☐	15 Minutes	118	42.00	1.70	**8425.20**	
Personal Assistance - Home Total:							**898749.00**

GRAND TOTAL: 12146283.46

Total: Services included in capitation:

Total: Services not included in capitation: 12146283.46

Total Estimated Unduplicated Participants: 500

Factor D (Divide total by number of participants): 24292.57

Services included in capitation:

Services not included in capitation: 24292.57

Average Length of Stay on the Waiver: 302

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Assistance-Home	☐	15 Minutes	243	501.00	5.00	608715.00	
Personal Assistance-Home Self-Directed	☐	15 Minutes	123	524.00	4.50	290034.00	
Support Coordination Total:							1157056.80
Support Coordination	☐	Month	500	6.54	353.84	1157056.80	
Adult Family Home Total:							910000.00
Adult Family Home	☐	Day	26	200.00	175.00	910000.00	
Assistive Technology and Adaptive Aids Total:							41200.00
Assistive Technology and Adaptive Aids (per cost)	☐	Item	96	1.00	200.00	19200.00	
Assistive Technology and Adaptive Aids (per item)	☐	Hour	55	2.00	200.00	22000.00	
Co-Worker Supports Total:							316251.00
Co-Worker Supports	☐	15 Minutes	159	221.00	9.00	316251.00	
Community Integration Connections and Skills Training Total:							1295733.60
Community Integration Connections and Skills Training (1:1 ratio)	☐	15 Minutes	78	44.00	14.30	49077.60	
Community Integration Connections and Skills Training (1:2 ratio)	☐	15 Minutes	104	54.00	20.00	112320.00	
Community Integration Connections and Skills Training (1:3 ratio)	☐	15 Minutes	377	2.00	200.00	150800.00	

GRAND TOTAL: 12146283.46

Total: Services included in capitation:

Total: Services not included in capitation: 12146283.46

Total Estimated Unduplicated Participants: 500

Factor D (Divide total by number of participants): 24292.57

Services included in capitation:

Services not included in capitation: 24292.57

Average Length of Stay on the Waiver: 302

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Integration Connections and Skills Training (1:1 ratio)	☐	15 Minutes	80	44.00	14.30	50336.00	
Community Integration Connections and Skills Training (1:2 ratio)	☐	15 Minutes	120	54.00	15.00	97200.00	
Community Integration Connections and Skills Training (1:3 ratio)	☐	15 Minutes	20	200.00	209.00	836000.00	
Community Transportation Total:							574414.00
Community Transportation (volunteer)	☐	Mile	150	911.00	0.68	92922.00	
Community Transportation (Paid Driver)	☐	Mile	253	914.00	1.00	231242.00	
Community Transportation - Self Directed (Not Inc CIE)	☐	Month	51	7.00	250.00	89250.00	
Community Transportation - Self Directed (Inc CIE)	☐	Month	46	7.00	500.00	161000.00	
Family Empowerment and Systems Navigation Counseling Total:							208940.00
Family Empowerment and Systems Navigation Counseling	☐	15 Minutes	337	62.00	10.00	208940.00	
Financial Literacy and Work Incentives Benefits Counseling Total:							593040.00
Financial Literacy and Work Incentives Benefits Counseling	☐	15 Minutes	353	168.00	10.00	593040.00	
Housing							47250.00

GRAND TOTAL: 12146283.46

Total: Services included in capitation:

Total: Services not included in capitation: 12146283.46

Total Estimated Unduplicated Participants: 500

Factor D (Divide total by number of participants): 24292.57

Services included in capitation:

Services not included in capitation: 24292.57

Average Length of Stay on the Waiver: 302

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Counseling Services Total:							
Housing Counseling Services	☐	15 Minutes	210	18.00	12.50	**47250.00**	
Housing Start-Up Assistance Total:							**364240.00**
Housing Start-Up Assistance (Cost)	☐	Cost	129	4.00	640.00	**330240.00**	
Housing Start-Up Assistance (Per Hour)	☐	Unit	170	25.00	8.00	**34000.00**	
Independent Living Skills Training Total:							**115324.30**
Independent Living Skills Training	☐	15 Minutes	203	46.00	6.50	**60697.00**	
Independent Living Skills Training - Self-Directed	☐	15 Minutes	203	46.00	5.85	**54627.30**	
Individual Directed Goods and Services Total:							**150800.00**
Individual Directed Goods and Services	☐	Item	377	2.00	200.00	**150800.00**	
Minor Home Modifications Total:							**46750.00**
Minor Home Modifications	☐	Job	11	1.00	4250.00	**46750.00**	
Natural Support or Caregiver Education and Training Total:							**53000.00**
Natural Support or Caregiver Education and Training	☐	Cost	106	1.00	500.00	**53000.00**	
Occupational Therapy Total:							**49077.60**
Occupational Therapy	☐	15 Minutes	78	44.00	14.30	**49077.60**	
Peer Specialist Services Total:							**467360.00**
Peer Specialist Services	☐	15 Minutes	368	127.00	10.00	**467360.00**	

GRAND TOTAL: **12146283.46**

Total: Services included in capitation:

Total: Services not included in capitation: 12146283.46

Total Estimated Unduplicated Participants: **500**

Factor D (Divide total by number of participants): **24292.57**

Services included in capitation:

Services not included in capitation: 24292.57

Average Length of Stay on the Waiver: 302

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Assistance-Community Total:							**442240.04**
Personal Assistance-Community	☐	15 Minutes	164	278.00	5.25	**239358.00**	
Personal Assistance-Community Self-Directed	☐	15 Minutes	104	273.00	4.72	**134010.24**	
Personal Assistance-Community Self-Directed - Family	☐	15 Minutes	37	908.00	2.05	**68871.80**	
Physical Therapy Total:							**50336.00**
Physical Therapy	☐	15 Minutes	80	44.00	14.30	**50336.00**	
Positive Behavior Supports Total:							**209520.00**
Positive Behavioral Supports: Non-Crisis Consultation Services	☐	15 Minutes	120	54.00	15.00	**97200.00**	
Positive Behavioral Supports: Crisis Intervention and Stabilization	☐	15 Minutes	104	54.00	20.00	**112320.00**	
Remote Supports Total:							**111800.00**
Remote Supports (Vendor - Assessment / Plan / Protocols)	☐	Per Vendor	97	1.00	250.00	**24250.00**	
Remote Supports (Provider - Assessment / Plan / Protocols)	☐	Per Provider	97	3.00	150.00	**43650.00**	
Remote Supports (Per Residence - Install Technology)	☐	Per Residence	12	2.00	1000.00	**24000.00**	
Remote Supports (Vendor	☐	15 Minutes	110	20.00	6.50	**14300.00**	

***GRAND TOTAL:* 12146283.46**

Total: Services included in capitation:

Total: Services not included in capitation: 12146283.46

***Total Estimated Unduplicated Participants:* 500**

***Factor D (Divide total by number of participants):* 24292.57**

Services included in capitation:

Services not included in capitation: 24292.57

Average Length of Stay on the Waiver: 302

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Technology Support)							
Remote Supports (Paid Back up Support)	☐	15 Minutes	80	20.00	3.50	5600.00	
Skilled Nursing Total:							224733.60
Skilled Nursing - RN	☐	Hour	14	289.00	36.40	147274.40	
Skilled Nursing - LPN	☐	Hour	14	266.00	20.80	77459.20	
Speech and Language Therapy Total:							13384.80
Speech and Language Therapy	☐	15 Minutes	78	12.00	14.30	13384.80	
Supported Employment Individual Total:							2254118.00
Supported Employment-Individual Exploration	☐	Report	372	1.00	1200.00	446400.00	
Supported Employment-Individual-Discovery	☐	Report	368	1.00	1360.00	500480.00	
Supported Employment-Individual-Job Development Plan	☐	Plan	361	1.00	240.00	86640.00	
Supported Employment-Individual-Job Development Report	☐	Report	361	1.00	1600.00	577600.00	
Supported Employment-Individual-Job Coaching	☐	15 Minutes	371	44.00	32.00	522368.00	
Supported Employment-Individual-Career Advancement Plan	☐	Plan	262	1.00	240.00	62880.00	
Supported Employment-Individual-Career Advance Report	☐	Report	77	1.00	750.00	57750.00	

GRAND TOTAL: 12146283.46

Total: Services included in capitation:

Total: Services not included in capitation: 12146283.46

Total Estimated Unduplicated Participants: 500

Factor D (Divide total by number of participants): 24292.57

Services included in capitation:

Services not included in capitation: 24292.57

Average Length of Stay on the Waiver: 302

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Employment Small Group Total:							**66360.52**
Supported Employment-Small Group (2-3 per group)	☐	15 Minutes	167	46.00	5.06	**38870.92**	
Supported Employment-Small Group (4 per group)	☐	15 Minutes	166	46.00	3.60	**27489.60**	
Supported Living Services Total:							**322890.00**
Supported Living Services - Non-Intensive	☐	Day	15	99.00	50.00	**74250.00**	
Supported Living Services - Intensive	☐	Day	37	80.00	84.00	**248640.00**	

GRAND TOTAL: **12146283.46**
Total: Services included in capitation:
Total: Services not included in capitation: 12146283.46
Total Estimated Unduplicated Participants: **500**
Factor D (Divide total by number of participants): **24292.57**
Services included in capitation:
Services not included in capitation: 24292.57
Average Length of Stay on the Waiver: 302

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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Breaks and Opportunities (Respite) Total:							**422158.00**

GRAND TOTAL: **20936596.48**
Total: Services included in capitation:
Total: Services not included in capitation: 20936596.48
Total Estimated Unduplicated Participants: **1097**
Factor D (Divide total by number of participants): **19085.32**
Services included in capitation:
Services not included in capitation: 19085.32
Average Length of Stay on the Waiver: 273

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Breaks and Opportunities (Planned Respite) - Hour	☐	Hour	69	65.00	22.00	98670.00	
Breaks and Opportunities (Planned Respite) - Day	☐	Day	69	10.00	158.00	109020.00	
Breaks and Opportunities (Planned Respite) - Self-Directed per Hour	☐	Hour	24	65.00	19.80	30888.00	
Breaks and Opportunities (Planned Respite) - Self-Directed per Day	☐	Day	24	10.00	142.00	34080.00	
Emergency Respite (Out-of-Home)	☐	Day	59	10.00	190.00	112100.00	
Emergency Respite (Out-of-Home) - Self-Directed	☐	Day	22	10.00	170.00	37400.00	
Community-Based Residential Services Total:							34080.00
Community-Based Residential Services	☐	Day	24	10.00	142.00	34080.00	
Integrated Employment Path Services Total:							1650687.50
Integrated Employment Path Services (1:1 ratio)	☐	Day	22	10.00	170.00	37400.00	
Integrated Employment Path Services (1:2 ratio)	☐	15 Minutes	115	79.00	5.50	49967.50	
Integrated Employment Path Services (1:8 classroom)	☐	Day	20	374.00	209.00	1563320.00	
Personal Assistance - Home Total:							135366.50
Personal Assistance-Home	☐	15 Minutes	115	79.00	9.40	85399.00	

GRAND TOTAL: 20936596.48

Total: Services included in capitation:

Total: Services not included in capitation: 20936596.48

Total Estimated Unduplicated Participants: 1097

Factor D (Divide total by number of participants): 19085.32

Services included in capitation:

Services not included in capitation: 19085.32

Average Length of Stay on the Waiver: 273

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Assistance-Home Self-Directed	☐	15 Minutes	115	79.00	5.50	49967.50	
Support Coordination Total:							2122560.00
Support Coordination	☐	Month	500	12.00	353.76	2122560.00	
Adult Family Home Total:							582282.00
Adult Family Home	☐	15 Minutes	123	1052.00	4.50	582282.00	
Assistive Technology and Adaptive Aids Total:							1101760.00
Assistive Technology and Adaptive Aids (per cost)	☐	5 Minutes	500	409.00	5.28	1079760.00	
Assistive Technology and Adaptive Aids (per item)	☐	Hour	55	2.00	200.00	22000.00	
Co-Worker Supports Total:							593865.00
Co-Worker Supports	☐	15 Minutes	159	415.00	9.00	593865.00	
Community Integration Connections and Skills Training Total:							1385943.00
Community Integration Connections and Skills Training (1:1 ratio)	☐	Hour	55	2.00	200.00	22000.00	
Community Integration Connections and Skills Training (1:2 ratio)	☐	15 Minutes	104	101.00	20.00	210080.00	
Community Integration Connections and Skills Training (1:3 ratio)	☐	15 Minutes	159	415.00	9.00	593865.00	
Community Integration Connections	☐	15 Minutes	60	586.00	5.85	205686.00	

GRAND TOTAL: 20936596.48

Total: Services included in capitation:

Total: Services not included in capitation: 20936596.48

Total Estimated Unduplicated Participants: 1097

Factor D (Divide total by number of participants): 19085.32

Services included in capitation:

Services not included in capitation: 19085.32

Average Length of Stay on the Waiver: 273

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
and Skills Training (1:1 ratio)							
Community Integration Connections and Skills Training (1:2 ratio)	☐	15 Minutes	93	336.00	6.50	**203112.00**	
Community Integration Connections and Skills Training (1:3 ratio)	☐	15 Minutes	80	504.00	3.75	**151200.00**	
Community Transportation Total:							**239993.80**
Community Transportation (volunteer)	☐	Per Residence	12	3.00	1000.00	**36000.00**	
Community Transportation (Paid Driver)	☐	15 Minutes	110	37.00	6.50	**26455.00**	
Community Transportation - Self Directed (Not Inc CIE)	☐	Month	51	12.00	250.00	**153000.00**	
Community Transportation - Self Directed (Inc CIE)	☐	15 Minutes	78	22.00	14.30	**24538.80**	
Family Empowerment and Systems Navigation Counseling Total:							**434401.00**
Family Empowerment and Systems Navigation Counseling	☐	Mile	253	1717.00	1.00	**434401.00**	
Financial Literacy and Work Incentives Benefits Counseling Total:							**276000.00**
Financial Literacy and Work Incentives Benefits Counseling	☐	Month	46	12.00	500.00	**276000.00**	
Housing Counseling Services Total:							**387550.00**

GRAND TOTAL: **20936596.48**

Total: Services included in capitation:

Total: Services not included in capitation: 20936596.48

Total Estimated Unduplicated Participants: **1097**

Factor D (Divide total by number of participants): **19085.32**

Services included in capitation:

Services not included in capitation: 19085.32

Average Length of Stay on the Waiver: 273

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Housing Counseling Services	☐	15 Minutes	337	115.00	10.00	387550.00	
Housing Start-Up Assistance Total:							1175940.00
Housing Start-Up Assistance (Cost)	☐	15 Minutes	358	311.00	10.00	1113380.00	
Housing Start-Up Assistance (Per Hour)	☐	Unit	170	46.00	8.00	62560.00	
Independent Living Skills Training Total:							690077.50
Independent Living Skills Training	☐	15 Minutes	203	85.00	6.50	112157.50	
Independent Living Skills Training - Self-Directed	☐	Cost	129	7.00	640.00	577920.00	
Individual Directed Goods and Services Total:							226200.00
Individual Directed Goods and Services	☐	Item	377	3.00	200.00	226200.00	
Minor Home Modifications Total:							100941.75
Minor Home Modifications	☐	15 Minutes	203	85.00	5.85	100941.75	
Natural Support or Caregiver Education and Training Total:							226200.00
Natural Support or Caregiver Education and Training	☐	Item	377	3.00	200.00	226200.00	
Occupational Therapy Total:							46750.00
Occupational Therapy	☐	Job	11	1.00	4250.00	46750.00	
Peer Specialist Services Total:							53000.00
Peer Specialist Services	☐	Cost	106	1.00	500.00	53000.00	
Personal Assistance-Community							1266988.28

GRAND TOTAL: 20936596.48

Total: Services included in capitation:

Total: Services not included in capitation: 20936596.48

Total Estimated Unduplicated Participants: 1097

Factor D (Divide total by number of participants): 19085.32

Services included in capitation:

Services not included in capitation: 19085.32

Average Length of Stay on the Waiver: 273

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Personal Assistance-Community	☐	15 Minutes	116	82.07	14.30	**136137.72**	
Personal Assistance-Community Self-Directed	☐	15 Minutes	104	512.00	4.72	**251330.56**	
Personal Assistance-Community Self-Directed - Family	☐	15 Minutes	368	239.00	10.00	**879520.00**	
Physical Therapy Total:							**448581.00**
Physical Therapy	☐	15 Minutes	164	521.00	5.25	**448581.00**	
Positive Behavior Supports Total:							**339555.95**
Positive Behavioral Supports: Non-Crisis Consultation Services	☐	15 Minutes	37	1707.00	2.05	**129475.95**	
Positive Behavioral Supports: Crisis Intervention and Stabilization	☐	15 Minutes	104	101.00	20.00	**210080.00**	
Remote Supports Total:							**466835.00**
Remote Supports (Vendor - Assessment / Plan / Protocols)	☐	Per Vendor	97	1.00	250.00	**24250.00**	
Remote Supports (Provider - Assessment / Plan / Protocols)	☐	15 Minutes	120	101.00	15.00	**181800.00**	
Remote Supports (Per Residence - Install Technology)	☐	15 Minutes	104	101.00	20.00	**210080.00**	
Remote Supports (Vendor Technology Support)	☐	15 Minutes	110	37.00	6.50	**26455.00**	

GRAND TOTAL: ***20936596.48***

Total: Services included in capitation:

Total: Services not included in capitation: *20936596.48*

Total Estimated Unduplicated Participants: ***1097***

Factor D (Divide total by number of participants): ***19085.32***

Services included in capitation:

Services not included in capitation: *19085.32*

Average Length of Stay on the Waiver: 273

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Remote Supports (Paid Back up Support)	☐	Per Vendor	97	1.00	250.00	24250.00	
Skilled Nursing Total:							62455.00
Skilled Nursing - RN	☐	Per Residence	12	3.00	1000.00	36000.00	
Skilled Nursing - LPN	☐	15 Minutes	110	37.00	6.50	26455.00	
Speech and Language Therapy Total:							24538.80
Speech and Language Therapy	☐	15 Minutes	78	22.00	14.30	24538.80	
Supported Employment Individual Total:							2427411.90
Supported Employment-Individual Exploration	☐	Report	372	1.00	20.80	7737.60	
Supported Employment-Individual-Discovery	☐	Report	368	1.00	1360.00	500480.00	
Supported Employment-Individual-Job Development Plan	☐	Plan	361	1.00	14.30	5162.30	
Supported Employment-Individual-Job Development Report	☐	Report	361	1.00	1600.00	577600.00	
Supported Employment-Individual-Job Coaching	☐	15 Minutes	371	81.00	32.00	961632.00	
Supported Employment-Individual-Career Advancement Plan	☐	Plan	262	1.00	1360.00	356320.00	
Supported Employment-Individual-Career Advance Report	☐	Report	77	1.00	240.00	18480.00	
Supported Employment Small Group							3840640.00

GRAND TOTAL: 20936596.48

Total: Services included in capitation:

Total: Services not included in capitation: 20936596.48

Total Estimated Unduplicated Participants: 1097

Factor D (Divide total by number of participants): 19085.32

Services included in capitation:

Services not included in capitation: 19085.32

Average Length of Stay on the Waiver: 273

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Supported Employment-Small Group (2-3 per group)	☐	15 Minutes	167	85.00	32.00	**454240.00**	
Supported Employment-Small Group (4 per group)	☐	Plan	166	85.00	240.00	**3386400.00**	
Supported Living Services Total:							**173834.50**
Supported Living Services - Non-Intensive	☐	Day	15	184.00	50.00	**138000.00**	
Supported Living Services - Intensive	☐	15 Minutes	37	149.00	6.50	**35834.50**	

GRAND TOTAL: **20936596.48**
Total: Services included in capitation:
Total: Services not included in capitation: 20936596.48
Total Estimated Unduplicated Participants: **1097**
Factor D (Divide total by number of participants): **19085.32**
Services included in capitation:
Services not included in capitation: 19085.32
Average Length of Stay on the Waiver: 273

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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Breaks and Opportunities (Respite) Total:							**717768.00**
Breaks and Opportunities (Planned	☐	Hour	115	54.00	22.00	**136620.00**	

GRAND TOTAL: **33519073.53**
Total: Services included in capitation:
Total: Services not included in capitation: 33519073.53
Total Estimated Unduplicated Participants: **1447**
Factor D (Divide total by number of participants): **23164.53**
Services included in capitation:
Services not included in capitation: 23164.53
Average Length of Stay on the Waiver: 325

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite) - Hour							
Breaks and Opportunities (Planned Respite) - Day	☐	Day	115	9.00	158.00	163530.00	
Breaks and Opportunities (Planned Respite) - Self-Directed per Hour	☐	Hour	40	54.00	19.80	42768.00	
Breaks and Opportunities (Planned Respite) - Self-Directed per Day	☐	Day	40	9.00	142.00	51120.00	
Emergency Respite (Out-of-Home)	☐	Day	141	9.00	190.00	241110.00	
Emergency Respite (Out-of-Home) - Self-Directed	☐	Day	54	9.00	170.00	82620.00	
Community-Based Residential Services Total:							2748768.00
Community-Based Residential Services	☐	Day	48	274.00	209.00	2748768.00	
Integrated Employment Path Services Total:							255832.20
Integrated Employment Path Services (1:1 ratio)	☐	15 Minutes	265	58.00	9.40	144478.00	
Integrated Employment Path Services (1:2 ratio)	☐	15 Minutes	265	58.00	5.50	84535.00	
Integrated Employment Path Services (1:8 classroom)	☐	15 Minutes	272	58.00	1.70	26819.20	
Personal Assistance - Home Total:							2941934.00
Personal Assistance-Home	☐	15 Minutes	551	707.00	5.00	1947785.00	
Personal Assistance-Home Self-	☐	15 Minutes	293	754.00	4.50	994149.00	

GRAND TOTAL: 33519073.53

Total: Services included in capitation:

Total: Services not included in capitation: 33519073.53

Total Estimated Unduplicated Participants: 1447

Factor D (Divide total by number of participants): 23164.53

Services included in capitation:

Services not included in capitation: 23164.53

Average Length of Stay on the Waiver: 325

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Directed							
Support Coordination Total:							**2928779.04**
Support Coordination	☐	Month	850	9.74	353.76	**2928779.04**	
Adult Family Home Total:							**2972900.00**
Adult Family Home	☐	Day	62	274.00	175.00	**2972900.00**	
Assistive Technology and Adaptive Aids Total:							**99600.00**
Assistive Technology and Adaptive Aids (per cost)	☐	Item	236	1.00	200.00	**47200.00**	
Assistive Technology and Adaptive Aids (per item)	☐	Hour	131	2.00	200.00	**52400.00**	
Co-Worker Supports Total:							**992601.00**
Co-Worker Supports	☐	15 Minutes	379	291.00	9.00	**992601.00**	
Community Integration Connections and Skills Training Total:							**3394084.80**
Community Integration Connections and Skills Training (1:1 ratio)	☐	15 Minutes	132	68.00	14.30	**128356.80**	
Community Integration Connections and Skills Training (1:2 ratio)	☐	15 Minutes	180	84.00	20.00	**302400.00**	
Community Integration Connections and Skills Training (1:3 ratio)	☐	15 Minutes	630	3.00	200.00	**378000.00**	
Community Integration Connections and Skills Training (1:1 ratio)	☐	15 Minutes	135	68.00	14.30	**131274.00**	

GRAND TOTAL: 33519073.53

Total: Services included in capitation:

Total: Services not included in capitation: 33519073.53

Total Estimated Unduplicated Participants: 1447

Factor D (Divide total by number of participants): 23164.53

Services included in capitation:

Services not included in capitation: 23164.53

Average Length of Stay on the Waiver: 325

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Integration Connections and Skills Training (1:2 ratio)	☐	15 Minutes	205	84.00	15.00	258300.00	
Community Integration Connections and Skills Training (1:3 ratio)	☐	15 Minutes	34	309.00	209.00	2195754.00	
Community Transportation Total:							1450809.68
Community Transportation (volunteer)	☐	Mile	254	1394.00	0.68	240771.68	
Community Transportation (Paid Driver)	☐	Mile	431	1398.00	1.00	602538.00	
Community Transportation - Self Directed (Not Inc CIE)	☐	Month	87	10.00	250.00	217500.00	
Community Transportation - Self Directed (Inc CIE)	☐	Month	78	10.00	500.00	390000.00	
Family Empowerment and Systems Navigation Counseling Total:							625660.00
Family Empowerment and Systems Navigation Counseling	☐	15 Minutes	763	82.00	10.00	625660.00	
Financial Literacy and Work Incentives Benefits Counseling Total:							1955000.00
Financial Literacy and Work Incentives Benefits Counseling	☐	15 Minutes	850	230.00	10.00	1955000.00	
Housing Counseling Services Total:							162500.00
Housing Counseling Services	☐	15 Minutes	520	25.00	12.50	162500.00	
Housing Start-Up							1256032.00

GRAND TOTAL: 33519073.53

Total: Services included in capitation:

Total: Services not included in capitation: 33519073.53

Total Estimated Unduplicated Participants: 1447

Factor D (Divide total by number of participants): 23164.53

Services included in capitation:

Services not included in capitation: 23164.53

Average Length of Stay on the Waiver: 325

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assistance Total:							
Housing Start-Up Assistance (Cost)	☐	Cost	301	6.00	640.00	**1155840.00**	
Housing Start-Up Assistance (Per Hour)	☐	Unit	404	31.00	8.00	**100192.00**	
Independent Living Skills Training Total:							**374242.05**
Independent Living Skills Training	☐	15 Minutes	481	63.00	6.50	**196969.50**	
Independent Living Skills Training - Self-Directed	☐	15 Minutes	481	63.00	5.85	**177272.55**	
Individual Directed Goods and Services Total:							**510000.00**
Individual Directed Goods and Services	☐	Item	850	3.00	200.00	**510000.00**	
Minor Home Modifications Total:							**131750.00**
Minor Home Modifications	☐	Cost	31	1.00	4250.00	**131750.00**	
Natural Support or Caregiver Education and Training Total:							**121000.00**
Natural Support or Caregiver Education and Training	☐	At Cost	242	1.00	500.00	**121000.00**	
Occupational Therapy Total:							**162247.80**
Occupational Therapy	☐	15 Minutes	186	61.00	14.30	**162247.80**	
Peer Specialist Services Total:							**1413840.00**
Peer Specialist Services	☐	15 Minutes	822	172.00	10.00	**1413840.00**	
Personal Assistance-Community Total:							**1248771.44**
Personal Assistance-Community	☐	15 Minutes	364	379.00	5.25	**724269.00**	

GRAND TOTAL: **33519073.53**

Total: Services included in capitation:

Total: Services not included in capitation: 33519073.53

Total Estimated Unduplicated Participants: **1447**

Factor D (Divide total by number of participants): **23164.53**

Services included in capitation:

Services not included in capitation: 23164.53

Average Length of Stay on the Waiver: 325

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Assistance-Community Self-Directed	☐	15 Minutes	169	373.00	4.72	297534.64	
Personal Assistance-Community Self-Directed - Family	☐	15 Minutes	89	1244.00	2.05	226967.80	
Physical Therapy Total:							165737.00
Physical Therapy	☐	15 Minutes	190	61.00	14.30	165737.00	
Positive Behavior Supports Total:							710250.00
Positive Behavioral Supports: Non-Crisis Consultation Services	☐	15 Minutes	290	75.00	15.00	326250.00	
Positive Behavioral Supports: Crisis Intervention and Stabilization	☐	15 Minutes	256	75.00	20.00	384000.00	
Remote Supports Total:							292490.00
Remote Supports (Vendor - Assessment / Plan / Protocols)	☐	Per Vendor	229	1.00	250.00	57250.00	
Remote Supports (Provider - Assessment / Plan / Protocols)	☐	Per Provider	229	4.00	150.00	137400.00	
Remote Supports (Per Residence - Install Technology)	☐	Per Residence	30	3.00	1000.00	90000.00	
Remote Supports (Vendor Technology Support)	☐	15 Minutes	28	28.00	6.50	5096.00	
Remote Supports (Paid Back up Support)	☐	15 Minutes	28	28.00	3.50	2744.00	

GRAND TOTAL: 33519073.53

Total: Services included in capitation:

Total: Services not included in capitation: 33519073.53

Total Estimated Unduplicated Participants: 1447

Factor D (Divide total by number of participants): 23164.53

Services included in capitation:

Services not included in capitation: 23164.53

Average Length of Stay on the Waiver: 325

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Skilled Nursing Total:							**701043.20**
Skilled Nursing - RN	☐	Hour	32	395.00	36.40	**460096.00**	
Skilled Nursing - LPN	☐	Hour	32	362.00	20.80	**240947.20**	
Speech and Language Therapy Total:							**45216.60**
Speech and Language Therapy	☐	15 Minutes	186	17.00	14.30	**45216.60**	
Supported Employment Individual Total:							**4114324.00**
Supported Employment-Individual Exploration	☐	Report	608	1.00	1200.00	**729600.00**	
Supported Employment-Individual-Discovery	☐	Report	599	1.00	1360.00	**814640.00**	
Supported Employment-Individual-Job Development Plan	☐	Plan	584	1.00	240.00	**140160.00**	
Supported Employment-Individual-Job Development Report	☐	Report	584	1.00	1600.00	**934400.00**	
Supported Employment-Individual-Job Coaching	☐	15 Minutes	606	67.00	32.00	**1299264.00**	
Supported Employment-Individual-Career Advancement Plan	☐	Plan	424	1.00	240.00	**101760.00**	
Supported Employment-Individual-Career Advance Report	☐	Report	126	1.00	750.00	**94500.00**	
Supported Employment Small Group Total:							**186084.72**
Supported Employment-Small Group	☐	15 Minutes	301	72.00	5.06	**109660.32**	

GRAND TOTAL: ***33519073.53***

Total: Services included in capitation:

Total: Services not included in capitation: *33519073.53*

Total Estimated Unduplicated Participants: ***1447***

Factor D (Divide total by number of participants): ***23164.53***

Services included in capitation:

Services not included in capitation: *23164.53*

Average Length of Stay on the Waiver: 325

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
(2-3 per group)							
Supported Employment-Small Group (4 per group)	☐	15 Minutes	299	71.00	3.60	76424.40	
Supported Living Services Total:							839808.00
Supported Living Services - Non-Intensive	☐	Week	24	153.00	50.00	183600.00	
Supported Living Services - Intensive	☐	Day	63	124.00	84.00	656208.00	

GRAND TOTAL: 33519073.53
Total: Services included in capitation:
Total: Services not included in capitation: 33519073.53
Total Estimated Unduplicated Participants: 1447
Factor D (Divide total by number of participants): 23164.53
Services included in capitation:
Services not included in capitation: 23164.53
Average Length of Stay on the Waiver: 325

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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Breaks and Opportunities (Respite) Total:							887769.20
Breaks and Opportunities (Planned Respite) - Hour	☐	Hour	161	49.00	22.00	173558.00	
Breaks and Opportunities	☐	Day	161	9.00	158.00	228942.00	

GRAND TOTAL: 56709981.50
Total: Services included in capitation:
Total: Services not included in capitation: 56709981.50
Total Estimated Unduplicated Participants: 1797
Factor D (Divide total by number of participants): 31558.14
Services included in capitation:
Services not included in capitation: 31558.10
Average Length of Stay on the Waiver: 332

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
(Planned Respite) - Day							
Breaks and Opportunities (Planned Respite) - Self-Directed per Hour	☐	Hour	56	49.00	19.80	54331.20	
Breaks and Opportunities (Planned Respite) - Self-Directed per Day	☐	Day	56	9.00	142.00	71568.00	
Emergency Respite (Out-of-Home)	☐	Day	129	11.00	190.00	269610.00	
Emergency Respite (Out-of-Home) - Self-Directed	☐	Day	48	11.00	170.00	89760.00	
Community-Based Residential Services Total:							3586440.00
Community-Based Residential Services	☐	Day	44	390.00	209.00	3586440.00	
Integrated Employment Path Services Total:							331747.40
Integrated Employment Path Services (1:1 ratio)	☐	15 Minutes	243	82.00	9.40	187304.40	
Integrated Employment Path Services (1:2 ratio)	☐	15 Minutes	243	82.00	5.50	109593.00	
Integrated Employment Path Services (1:8 classroom)	☐	15 Minutes	250	82.00	1.70	34850.00	
Personal Assistance - Home Total:							4012334.50
Personal Assistance-Home	☐	15 Minutes	505	1043.00	5.00	2633575.00	
Personal Assistance-Home Self-Directed	☐	15 Minutes	269	1139.00	4.50	1378759.50	
Support Coordination Total:							4415049.60

GRAND TOTAL: 56709981.50

Total: Services included in capitation:

Total: Services not included in capitation: 56709981.50

Total Estimated Unduplicated Participants: 1797

Factor D (Divide total by number of participants): 31558.14

Services included in capitation:

Services not included in capitation: 31558.10

Average Length of Stay on the Waiver: 332

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Support Coordination	☐	Month	1200	10.40	353.77	4415049.60	
Adult Family Home Total:							3958500.00
Adult Family Home	☐	Day	58	390.00	175.00	3958500.00	
Assistive Technology and Adaptive Aids Total:							92000.00
Assistive Technology and Adaptive Aids (per cost)	☐	Item	218	1.00	200.00	43600.00	
Assistive Technology and Adaptive Aids (per item)	☐	Hour	121	2.00	200.00	48400.00	
Co-Worker Supports Total:							1306656.00
Co-Worker Supports	☐	15 Minutes	349	416.00	9.00	1306656.00	
Community Integration Connections and Skills Training Total:							17032002.80
Community Integration Connections and Skills Training (1:1 ratio)	☐	15 Minutes	186	61.00	14.30	162247.80	
Community Integration Connections and Skills Training (1:2 ratio)	☐	15 Minutes	256	75.00	20.00	384000.00	
Community Integration Connections and Skills Training (1:3 ratio)	☐	15 Minutes	883	75.00	200.00	13245000.00	
Community Integration Connections and Skills Training (1:1 ratio)	☐	15 Minutes	190	61.00	14.30	165737.00	
Community Integration Connections and Skills Training (1:2	☐	15 Minutes	290	75.00	15.00	326250.00	

GRAND TOTAL: 56709981.50

Total: Services included in capitation:

Total: Services not included in capitation: 56709981.50

Total Estimated Unduplicated Participants: 1797

Factor D (Divide total by number of participants): 31558.14

Services included in capitation:

Services not included in capitation: 31558.10

Average Length of Stay on the Waiver: 332

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
ratio)							
Community Integration Connections and Skills Training (1:3 ratio)	☐	15 Minutes	48	274.00	209.00	2748768.00	
Community Transportation Total:							1819277.44
Community Transportation (volunteer)	☐	Mile	358	1226.00	0.68	298457.44	
Community Transportation (Paid Driver)	☐	Mile	609	1230.00	1.00	749070.00	
Community Transportation - Self Directed (Not Inc CIE)	☐	Month	123	9.00	250.00	276750.00	
Community Transportation - Self Directed (Inc CIE)	☐	Month	110	9.00	500.00	495000.00	
Family Empowerment and Systems Navigation Counseling Total:							822510.00
Family Empowerment and Systems Navigation Counseling	☐	15 Minutes	703	117.00	10.00	822510.00	
Financial Literacy and Work Incentives Benefits Counseling Total:							2564620.00
Financial Literacy and Work Incentives Benefits Counseling	☐	15 Minutes	794	323.00	10.00	2564620.00	
Housing Counseling Services Total:							209125.00
Housing Counseling Services	☐	15 Minutes	478	35.00	12.50	209125.00	
Housing Start-Up Assistance Total:							1390528.00
Housing Start-Up Assistance (Cost)	☐	Cost	281	7.00	640.00	1258880.00	

GRAND TOTAL: 56709981.50

Total: Services included in capitation:

Total: Services not included in capitation: 56709981.50

Total Estimated Unduplicated Participants: 1797

Factor D (Divide total by number of participants): 31558.14

Services included in capitation:

Services not included in capitation: 31558.10

Average Length of Stay on the Waiver: 332

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Housing Start-Up Assistance (Per Hour)	☐	Unit	374	44.00	8.00	131648.00	
Independent Living Skills Training Total:							484725.15
Independent Living Skills Training	☐	15 Minutes	441	89.00	6.50	255118.50	
Independent Living Skills Training - Self-Directed	☐	15 Minutes	441	89.00	5.85	229606.65	
Individual Directed Goods and Services Total:							487800.00
Individual Directed Goods and Services	☐	Item	813	3.00	200.00	487800.00	
Minor Home Modifications Total:							123250.00
Minor Home Modifications	☐	Job	29	1.00	4250.00	123250.00	
Natural Support or Caregiver Education and Training Total:							112000.00
Natural Support or Caregiver Education and Training	☐	Cost	224	1.00	500.00	112000.00	
Occupational Therapy Total:							211525.60
Occupational Therapy	☐	15 Minutes	172	86.00	14.30	211525.60	
Peer Specialist Services Total:							1864680.00
Peer Specialist Services	☐	15 Minutes	758	246.00	10.00	1864680.00	
Personal Assistance-Community Total:							1796498.01
Personal Assistance-Community	☐	15 Minutes	334	542.00	5.25	950397.00	
Personal Assistance-Community Self-Directed	☐	15 Minutes	216	533.00	4.72	543404.16	

GRAND TOTAL: 56709981.50

Total: Services included in capitation:

Total: Services not included in capitation: 56709981.50

Total Estimated Unduplicated Participants: 1797

Factor D (Divide total by number of participants): 31558.14

Services included in capitation:

Services not included in capitation: 31558.10

Average Length of Stay on the Waiver: 332

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Assistance-Community Self-Directed - Family	☐	15 Minutes	83	1779.00	2.05	302696.85	
Physical Therapy Total:							216444.80
Physical Therapy	☐	15 Minutes	176	86.00	14.30	216444.80	
Positive Behavior Supports Total:							922200.00
Positive Behavioral Supports: Non-Crisis Consultation Services	☐	15 Minutes	268	106.00	15.00	426120.00	
Positive Behavioral Supports: Crisis Intervention and Stabilization	☐	15 Minutes	234	106.00	20.00	496080.00	
Remote Supports Total:							352038.00
Remote Supports (Vendor - Assessment / Plan / Protocols)	☐	Per Vendor	211	1.00	250.00	52750.00	
Remote Supports (Provider - Assessment / Plan / Protocols)	☐	Per Provider	211	4.00	150.00	126600.00	
Remote Supports (Per Residence - Install Technology)	☐	Per Residence	30	3.00	1000.00	90000.00	
Remote Supports (Vendor Technology Support)	☐	15 Minutes	240	38.00	6.50	59280.00	
Remote Supports (Paid Back up Support)	☐	15 Minutes	176	38.00	3.50	23408.00	
Skilled Nursing Total:							872872.00
Skilled Nursing - RN	☐	Hour	28	561.00	36.40	571771.20	

GRAND TOTAL: 56709981.50

Total: Services included in capitation:

Total: Services not included in capitation: 56709981.50

Total Estimated Unduplicated Participants: 1797

Factor D (Divide total by number of participants): 31558.14

Services included in capitation:

Services not included in capitation: 31558.10

Average Length of Stay on the Waiver: 332

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Skilled Nursing - LPN	☐	Hour	28	517.00	20.80	301100.80	
Speech and Language Therapy Total:							56570.80
Speech and Language Therapy	☐	15 Minutes	172	23.00	14.30	56570.80	
Supported Employment Individual Total:							5486178.00
Supported Employment-Individual Exploration	☐	Report	844	1.00	1200.00	1012800.00	
Supported Employment-Individual-Discovery	☐	Report	830	1.00	1360.00	1128800.00	
Supported Employment-Individual-Job Development Plan	☐	Plan	807	1.00	240.00	193680.00	
Supported Employment-Individual-Job Development Report	☐	Report	807	1.00	1600.00	1291200.00	
Supported Employment-Individual-Job Coaching	☐	15 Minutes	841	59.00	32.00	1587808.00	
Supported Employment-Individual-Career Advancement Plan	☐	Plan	586	1.00	240.00	140640.00	
Supported Employment-Individual-Career Advance Report	☐	Report	175	1.00	750.00	131250.00	
Supported Employment Small Group Total:							240403.20
Supported Employment-Small Group (2-3 per group)	☐	15 Minutes	435	64.00	5.06	140870.40	
Supported Employment-Small Group	☐	15 Minutes	432	64.00	3.60	99532.80	

GRAND TOTAL: 56709981.50

Total: Services included in capitation:

Total: Services not included in capitation: 56709981.50

Total Estimated Unduplicated Participants: 1797

Factor D (Divide total by number of participants): 31558.14

Services included in capitation:

Services not included in capitation: 31558.10

Average Length of Stay on the Waiver: 332

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
(4 per group)							
Supported Living Services Total:							**1054236.00**
Supported Living Services - Non-Intensive	☐	Week	33	136.00	50.00	**224400.00**	
Supported Living Services - Intensive	☐	Day	89	111.00	84.00	**829836.00**	

GRAND TOTAL: **56709981.50**
Total: Services included in capitation:
Total: Services not included in capitation: 56709981.50
Total Estimated Unduplicated Participants: **1797**
Factor D (Divide total by number of participants): **31558.14**
Services included in capitation:
Services not included in capitation: 31558.10
Average Length of Stay on the Waiver: 332

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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Breaks and Opportunities (Respite) Total:							**741121.60**
Breaks and Opportunities (Planned Respite) - Hour	☐	Hour	207	46.00	22.00	**209484.00**	
Breaks and Opportunities (Planned Respite) - Day	☐	Day	207	9.00	158.00	**294354.00**	
Breaks and Opportunities (Planned	☐	Hour	72	46.00	19.80	**65577.60**	

GRAND TOTAL: **51091184.70**
Total: Services included in capitation:
Total: Services not included in capitation: 51091184.70
Total Estimated Unduplicated Participants: **2147**
Factor D (Divide total by number of participants): **23796.55**
Services included in capitation:
Services not included in capitation: 23796.55
Average Length of Stay on the Waiver: 338

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite) - Self-Directed per Hour							
Breaks and Opportunities (Planned Respite) - Self-Directed per Day	☐	Day	72	9.00	142.00	92016.00	
Emergency Respite (Out-of-Home)	☐	Day	338	26.00	6.50	57122.00	
Emergency Respite (Out-of-Home) - Self-Directed	☐	Day	248	26.00	3.50	22568.00	
Community-Based Residential Services Total:							121104.00
Community-Based Residential Services	☐	Day	522	29.00	8.00	121104.00	
Integrated Employment Path Services Total:							711900.00
Integrated Employment Path Services (1:1 ratio)	☐	15 Minutes	300	46.00	22.00	303600.00	
Integrated Employment Path Services (1:2 ratio)	☐	15 Minutes	632	10.00	40.00	252800.00	
Integrated Employment Path Services (1:8 classroom)	☐	15 Minutes	311	1.00	500.00	155500.00	
Personal Assistance - Home Total:							576541.80
Personal Assistance-Home	☐	15 Minutes	165	388.00	5.85	374517.00	
Personal Assistance-Home Self-Directed	☐	15 Minutes	199	360.00	2.82	202024.80	
Support Coordination Total:							5900009.28
Support Coordination	☐	Month	1550	10.76	353.76	5900009.28	
Adult Family Home Total:							5154100.00

GRAND TOTAL: 51091184.70

Total: Services included in capitation:

Total: Services not included in capitation: 51091184.70

Total Estimated Unduplicated Participants: 2147

Factor D (Divide total by number of participants): 23796.55

Services included in capitation:

Services not included in capitation: 23796.55

Average Length of Stay on the Waiver: 338

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Family Home	☐	Day	74	398.00	175.00	5154100.00	
Assistive Technology and Adaptive Aids Total:							6091914.00
Assistive Technology and Adaptive Aids (per cost)	☐	Item	1550	721.00	5.28	5900664.00	
Assistive Technology and Adaptive Aids (per item)	☐	Hour	125	9.00	170.00	191250.00	
Co-Worker Supports Total:							1486080.00
Co-Worker Supports	☐	15 Minutes	387	6.00	640.00	1486080.00	
Community Integration Connections and Skills Training Total:							5232952.80
Community Integration Connections and Skills Training (1:1 ratio)	☐	15 Minutes	300	56.00	14.30	240240.00	
Community Integration Connections and Skills Training (1:2 ratio)	☐	15 Minutes	333	69.00	20.00	459540.00	
Community Integration Connections and Skills Training (1:3 ratio)	☐	15 Minutes	1136	3.00	200.00	681600.00	
Community Integration Connections and Skills Training (1:1 ratio)	☐	15 Minutes	246	56.00	14.30	196996.80	
Community Integration Connections and Skills Training (1:2 ratio)	☐	15 Minutes	376	69.00	15.00	389160.00	
Community Integration Connections and Skills	☐	15 Minutes	62	252.00	209.00	3265416.00	

GRAND TOTAL: 51091184.70

Total: Services included in capitation:

Total: Services not included in capitation: 51091184.70

Total Estimated Unduplicated Participants: 2147

Factor D (Divide total by number of participants): 23796.55

Services included in capitation:

Services not included in capitation: 23796.55

Average Length of Stay on the Waiver: 338

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Training (1:3 ratio)							
Community Transportation Total:							***4996888.00***
Community Transportation (volunteer)	☐	*Mile*	*50*	*1.00*	*4250.00*	***212500.00***	
Community Transportation (Paid Driver)	☐	*Month*	*42*	*125.00*	*50.00*	***262500.00***	
Community Transportation - Self Directed (Not Inc CIE)	☐	*Month*	*116*	*102.00*	*84.00*	***993888.00***	
Community Transportation - Self Directed (Inc CIE)	☐	*Month*	*80*	*252.00*	*175.00*	***3528000.00***	
Family Empowerment and Systems Navigation Counseling Total:							***507000.00***
Family Empowerment and Systems Navigation Counseling	☐	*15 Minutes*	*39*	*13.00*	*1000.00*	***507000.00***	
Financial Literacy and Work Incentives Benefits Counseling Total:							***177000.00***
Financial Literacy and Work Incentives Benefits Counseling	☐	*15 Minutes*	*295*	*4.00*	*150.00*	***177000.00***	
Housing Counseling Services Total:							***75000.00***
Housing Counseling Services	☐	*15 Minutes*	*300*	*1.00*	*250.00*	***75000.00***	
Housing Start-Up Assistance Total:							***141200.00***
Housing Start-Up Assistance (Cost)	☐	*Unit*	*200*	*2.00*	*200.00*	***80000.00***	
Housing Start-Up Assistance (Per Hour)	☐	*Unit*	*306*	*1.00*	*200.00*	***61200.00***	
Independent Living Skills							***157593.60***

GRAND TOTAL: ***51091184.70***

Total: Services included in capitation:

Total: Services not included in capitation: *51091184.70*

Total Estimated Unduplicated Participants: ***2147***

Factor D (Divide total by number of participants): ***23796.55***

Services included in capitation:

Services not included in capitation: *23796.55*

Average Length of Stay on the Waiver: *338*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Training Total:							
Independent Living Skills Training	☐	15 Minutes	72	9.00	142.00	**92016.00**	
Independent Living Skills Training - Self-Directed	☐	15 Minutes	72	46.00	19.80	**65577.60**	
Individual Directed Goods and Services Total:							**660000.00**
Individual Directed Goods and Services	☐	Item	1100	3.00	200.00	**660000.00**	
Minor Home Modifications Total:							**161500.00**
Minor Home Modifications	☐	Job	38	1.00	4250.00	**161500.00**	
Natural Support or Caregiver Education and Training Total:							**162500.00**
Natural Support or Caregiver Education and Training	☐	Cost	325	1.00	500.00	**162500.00**	
Occupational Therapy Total:							**36078.90**
Occupational Therapy	☐	15 Minutes	29	87.00	14.30	**36078.90**	
Peer Specialist Services Total:							**2382500.00**
Peer Specialist Services	☐	15 Minutes	953	250.00	10.00	**2382500.00**	
Personal Assistance-Community Total:							**2253438.46**
Personal Assistance-Community	☐	15 Minutes	419	554.00	5.00	**1160630.00**	
Personal Assistance-Community Self-Directed	☐	15 Minutes	272	544.00	4.72	**698408.96**	
Personal Assistance-Community Self-Directed - Family	☐	15 Minutes	106	1815.00	2.05	**394399.50**	

GRAND TOTAL: 51091184.70

Total: Services included in capitation:

Total: Services not included in capitation: 51091184.70

Total Estimated Unduplicated Participants: 2147

Factor D (Divide total by number of participants): 23796.55

Services included in capitation:

Services not included in capitation: 23796.55

Average Length of Stay on the Waiver: 338

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Physical Therapy Total:							**278678.40**
Physical Therapy	☐	15 Minutes	224	87.00	14.30	**278678.40**	
Positive Behavior Supports Total:							**1205860.00**
Positive Behavioral Supports: Non-Crisis Consultation Services	☐	15 Minutes	342	108.00	15.00	**554040.00**	
Positive Behavioral Supports: Crisis Intervention and Stabilization	☐	15 Minutes	299	109.00	20.00	**651820.00**	
Remote Supports Total:							**2089843.50**
Remote Supports (Vendor - Assessment / Plan / Protocols)	☐	Per Provider	159	1.00	250.00	**39750.00**	
Remote Supports (Provider - Assessment / Plan / Protocols)	☐	Per Residence	142	4.00	150.00	**85200.00**	
Remote Supports (Per Residence - Install Technology)	☐	15 Minutes	619	3.00	1000.00	**1857000.00**	
Remote Supports (Vendor Technology Support)	☐	15 Minutes	305	39.00	6.50	**77317.50**	
Remote Supports (Paid Back up Support)	☐	15 Minutes	224	39.00	3.50	**30576.00**	
Skilled Nursing Total:							**1113112.00**
Skilled Nursing - RN	☐	Hour	35	572.00	36.40	**728728.00**	
Skilled Nursing - LPN	☐	Hour	35	528.00	20.80	**384384.00**	
Speech and Language							**72029.10**

GRAND TOTAL: 51091184.70

Total: Services included in capitation:

Total: Services not included in capitation: 51091184.70

Total Estimated Unduplicated Participants: 2147

Factor D (Divide total by number of participants): 23796.55

Services included in capitation:

Services not included in capitation: 23796.55

Average Length of Stay on the Waiver: 338

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Therapy Total:							
Speech and Language Therapy	☐	15 Minutes	219	23.00	14.30	**72029.10**	
Supported Employment Individual Total:							**7008976.00**
Supported Employment-Individual Exploration	☐	Report	1081	1.00	1200.00	**1297200.00**	
Supported Employment-Individual-Discovery	☐	Report	1100	1.00	1360.00	**1496000.00**	
Supported Employment-Individual-Job Development Plan	☐	Plan	1031	1.00	240.00	**247440.00**	
Supported Employment-Individual-Job Development Report	☐	Report	1100	1.00	1600.00	**1760000.00**	
Supported Employment-Individual-Job Coaching	☐	15 Minutes	1077	54.00	32.00	**1861056.00**	
Supported Employment-Individual-Career Advancement Plan	☐	Plan	747	1.00	240.00	**179280.00**	
Supported Employment-Individual-Career Advance Report	☐	Report	224	1.00	750.00	**168000.00**	
Supported Employment Small Group Total:							**289875.26**
Supported Employment-Small Group (2-3 per group)	☐	15 Minutes	569	59.00	5.06	**169869.26**	
Supported Employment-Small Group (4 per group)	☐	15 Minutes	565	59.00	3.60	**120006.00**	
Supported Living Services Total:							**1306388.00**

GRAND TOTAL: **51091184.70**

Total: Services included in capitation:

Total: Services not included in capitation: 51091184.70

Total Estimated Unduplicated Participants: **2147**

Factor D (Divide total by number of participants): **23796.55**

Services included in capitation:

Services not included in capitation: 23796.55

Average Length of Stay on the Waiver: 338

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Living Services - Non-Intensive	☐	Week	50	125.00	50.00	**312500.00**	
Supported Living Services - Intensive	☐	Day	116	102.00	84.00	**993888.00**	

GRAND TOTAL: **51091184.70**

Total: Services included in capitation:

Total: Services not included in capitation: 51091184.70

Total Estimated Unduplicated Participants: **2147**

Factor D (Divide total by number of participants): **23796.55**

Services included in capitation:

Services not included in capitation: 23796.55

Average Length of Stay on the Waiver: 338