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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Major Changes

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

Throughout the Document:

- Replace the abbreviated term "QIDP" (Qualified Intellectual Disabilities Professional) with "QDDP" (Qualified Developmental Disabilities Professional) to align with ADMH-DDD current guidelines and certification process for QDDPs at the state level.
- Replace the abbreviated term "CSD" with "Regional Office staff"
- Replace "Case Manager" with "Support Coordinator" to align with the ADMH updated policies and procedures.
- Replace "Case Management Agencies" with "Support Coordination Agencies" to align with the ADMH updated policies and procedures.
- Updated legally responsible individual terminology to legal liable relative

Appendix A:

- Appendix A-2-b: Updates made to Medicaid oversight to coincide with renewed memorandum of understanding (MOU) between Medicaid and the Operating Agency
- Quality Improvement: Data was updated on the tables to reflect current information

Appendix B:

- Quality Improvement: Data was updated on the following tables to reflect current information:
  - B-3 Participant Access and Eligibility Number of Individuals Served (2 of 4)
  - B-3 Participants transferring from the Living at Home Waiver: Year 1-5 Capacity Reserved
- Appendix B-3-f: Updated language to include details within the referenced Administrative Code
- Appendix B-6-f: Update the evaluation language regarding the level of care criteria for criticality ranking to clarify that length of time is considered the tie-breaker
- Appendix B-6-d: Update IQ requirement language in the 1st paragraph to reflect "72 and below" as approved in the amendment effective 7/2024
- Appendix B-6-f: Update the term HCBS waiting list to "state-wide waiting list".
- Updates to performance measures were made to reflect current responsible agency with updated frequencies and sampling approaches
- For sub-assurance c performance measure, changed the responsible party for data collection to "State Medicaid Agency".
- Because the performance measure for sub-assurance c was updated to reflect the state Medicaid agency as the responsible entity, language was updated in Appendix B-b-i, as appropriate.
- Updated LOC PM (number and percent of participants who have a LOC evaluation completed prior to entry into the HCBS waiver) to reduce the sample size from 100% review to a representative sample with a 95% confidence interval +/-5% margin of error, per CMS' recommendation.

Appendix C:

- Added Self-Directed services language to "the services should be approved in the PCP prior to the request".
- Removed the "TB skin test" requirement from all Self-directed services in the Provider Specification sections, as applicable (i.e. Personal Care, Personal Care Transportation, Adult Companion, Skilled Nursing, In Home Respite services)
- Added Agency after Financial Management Services in various self-directed service descriptions to now reflect proper use of term i.e. "Financial Management Services System".
- Added acronym definition of "BRA" as (Benefits Reporting Agency) in the Benefits and Career Counseling Service definition
- Changes to the BCBA Level descriptors and requirements
- Quality Improvement: Updates to performance measures were made to reflect current responsible agency with updated frequencies and sampling approaches
- Quality Improvement: Updates to Data Sources relative to performance measures to reflect current information
- Quality Improvement: Removed PM "number and percentage of non-licensed/non-certified providers that meet waiver requirements and any applicable requirements of state law" as the OA does not have nor monitor non-licensed/non-certified providers.
- Added Supported Living Service as a waiver service to coincide with the ID waiver
- Supported Employment: The employment small group direct care staff qualifications have been updated to align with NDP new guidance, therefore, completion of 10th grade was added and the high school diploma or equivalent requirement was removed.
- Self-Directed Personal Care: Added language to reflect that the costs of all pre-employment screenings are covered in the

FMSA administrative costs.

- Removed "Self Directed Out of Home Respite" service because this is a provider DDD Certified Residential service, thus there should not be a self-directed service code and/or service description.
- Removed the flexibility of "verbal orders" from the Specialized Medical Supplies and Assistive Technology Service definitions.
- C-2-d: Added 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 waive Policy and Procedure Manual and the Alabama Administrative Code.
- Selected "remote/telehealth" as a service delivery option for remote supports and supported living services. Additionally, service definitions of these services were updated to reflect appropriate utilization of remote supports.
- Updated Appendix C-1-d to provide remote/telehealth safeguard descriptions, as appropriate.

Appendix D:
Quality Improvement plan Updates:

- Updates to performance measures were made to reflect current responsible agency with updated frequencies and sampling approaches
- Updates to Data Sources relative to performance measures to reflect current information
- Updated Appendix D-2-b to reflect the same as D-1-b, clarifying that 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.

Appendix E:

- Replace term self directed liaison with Support Coordinator
- Appendix E-1-a: Added provisions to overtime payment for family/legal guardians/legal liable relative who render services to waiver participants and reside within the same home as the waiver participant
- Appendix E-1-i-iii: Added "The FMSA utilizes administrative costs to cover pre-employment screenings for SDS workers"
- Appendix E-1-j: Added details of Support Coordinator and Self-Directed Liaison roles and responsibilities as related to the waiver participant
- Appendix E-1-n: Updated table to reflect updated number of participants who are expected to select participant directed services

Appendix F:

- Appendix F-1: Updated procedures for Access Rule i.e. - the OA responsibilities for tracking in addition to contracted providers. This includes the update to triage all complaints and grievances through the Office of Waiver Appeals for tracking and trending.
- Appendix F-1: Updated procedures for fair hearing process
- Appendix F-2-b: Updated dispute resolution language
- Appendix F-3-c: Updated grievance/complaints language
- Appendix F-2-b: Minor updates to language to clarify abbreviated terminologies and information within the notice of adverse action
- Appendix F-3-c: Updated language relative to the OA's role/responsibilities in the grievance/complaint system and identified reports and frequency of reports due to Medicaid.

Appendix G:

- Alphabetizing the Incident Types and Timeframes
- Categorized Abuse-Mistreatment, Physical, Sexual, Verbal
- Categorized Assault- Physical, Sexual,
- Categorized Injury-Moderate, Major
- Categorized Fall-Moderate, Major
- Removed Other
- Categorized Restraints by Chemical Emergency and Programmatic, Manual Emergency and Programmatic, and Mechanical Emergency and Programmatic
- Removed COVID testing and diagnosis
- Replace Medication Levels I,II, III with Medication Levels 1, 2, 3
- Removed Medication Documentation Error

- Replaced missing/eloped individual with AWOL/Missing Person
- Removed Behavioral Issue
- Removed Sexual Contact
- Added Confidentiality/Privacy Breach
- Added Infestation
- Added Law Enforcement Involvement
- Added Property Damage
- Added Suicide Threat
- Added Suicide Attempt
- Language updates to reflect current terms and requirements
- Added DDD after ADMH for division/program area clarification
- Updates on Critical Incident and GER timeframes
- Updates to the definition of Manual, Chemical and Mechanical Restraint
- Updates to the monthly restraint data report information and timeframes
- Updates to how incident data will be reviewed, researched and responses
- Updates to the definitions of Level 1,2 and 3 medication errors
- Updates to performance measures were made to reflect current responsible agency with updated frequencies and sampling approaches
- Updates to Data Sources relative to performance measures to reflect current information

Appendix H:
- Updates to Appendix G Health and Welfare to provide more descriptors of current information
- Updates to reflect current process for quarterly summaries, analysis and remediation indicators.
- Updates to reflect the current direction of system design

Appendix I:
- Updates to reflect change from "Individual Residential Budgeting Instrument" to "Residential Rate Tool"
- Updated Appendix I-g-3-ii to include a description of the state financial accountability safeguards.

Appendix J:
- Cost projections updated for WY's in Appendix J-2-d
- Updated the mileage rate for Personal Care Transportation and Supported Employment Transportation services. Also, changed the unit type from "minutes" to "encounter" for Speech and Language Therapy services for all WYs
- Appendix J-2-b and Appendix J-2-c language was updated, as appropriate

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

1. Request Information (1 of 3)

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

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

Alabama HCBS Living at Home Waiver for Persons with Intellectual Disabilities (LAH Waiver)

C. Type of Request: renewal

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: AL.0391
Waiver Number:AL.0391.R05.00
Draft ID: AL.008.05.00

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

Regular Waiver

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

10/01/25

Approved Effective Date: 10/01/25

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:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

This waiver supports individuals in Alabama who have a diagnosis of Intellectual Disabilities and who would otherwise require the level of care offered in an ICF/IID and need HCBS to be integrated fully into their communities. The waiver is operated by the Alabama Department of Mental Health Division of Developmental Disabilities (ADMH/DDD) under an agreement with, and supervision by, the Alabama Medicaid Agency. ADMH/DDD operates five regional offices and contracts with agencies known as 310 Boards/Contracted entities or ADMH employees for support coordination for waiver participants.

This waiver is a support waiver, with a cost cap, for individuals who do not need a formal, paid residential setting, and who can achieve an adequate and appropriate level of support with funding that does not exceed the cost cap.

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:

☐ **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 Tribal Notice for this waiver renewal was sent to the Tribal Chair via certified mail & e-mail on 6/13/2025. The 30-day public comment notice requesting public input of this waiver renewal was announced on 6/13/2025 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.

There is stakeholder concern regarding the proposal to include "services should be approved in the PCP prior to the request" as it relates to Self-Directed Services. Stakeholders suggested ADMH's consideration of emergency situations. ADMH reviewed the concern & will proceed with the proposed change. Handbooks and guidelines will be updated to reflect that the treating physician(s) should provide the individual or EOR with an itemized invoice and explanation of emergent services for reimbursement.

Stakeholders expressed concern regarding the proposed changes inclusive of ADHM's intent to provide clarification of Personnel's role/titles. Additionally, stakeholders support the proposed changes to improve waiver efficiency and outcomes but is seeking proper awareness of ADMH personnel changes to participants, families & stakeholders. ADMH will proceed with proposed changes, & if approved, staff will provide any needed clarification regarding staff roles and responsibilities.

Stakeholders expressed concern regarding changes in data collection frequencies & indicated that reducing data collection could delay identification of emerging issues or patterns that may affect service quality, timeliness, or interventions. The DD Division has a robust Quality Assurance program & the proposed changes support staff's ability to properly measure waiver performances & report to Medicaid for review. Stakeholders expressed concerns and support regarding proposed changes related to utilizing Person-Centered Plan reviews and PCAP Feedback Plans as data sources rather than ADIDIS. Concerns consisted of whether changes would adversely impact relevant data reporting. Updates to data sources will be instrumental in the Quality Assurance staff's ability to retrieve sufficient data necessary in achieving performance measure compliance. ADMH reviewed these concerns and will proceed with the proposed changes.

Stakeholders expressed concerns regarding changes to Positive Behavioral Support Personnel educational and certification requirements across the three levels. It was suggested that the Division's attempt to implement these updates could broaden provider availability, however, they may also reduce the qualification standards, making the impact mixed. ADMH reviewed the concerns & is in support of adding the Alabama Licensed Psychologists to the Positive Behavior Supports Level 1 Provider category, as well adding professionals in training in Level 2. ADMH will extensively review the PBS Waiver Service category prior to removing existing PBS Professional Level Providers, which will require a more collaborative review and approach to address. ADMH re-welcomes the establishment of a multidisciplinary task force as suggested by the stakeholder.

There is stakeholder concern regarding the elimination of allowing verbal orders as an option for non-prescription assistive technology and specialized medical supplies. ADMH reviewed this concern and will proceed with the proposed change. Staff will provide the necessary training, if the change is approved.

Stakeholders expressed concerns regarding the removal of some incident types and suggested that the changes might cause adverse impacts. ADMH reviewed the concerns and determined that the waivers provide basic information regarding the incident management system. Further details are located within in relatable resources (i.e. IPMS manuals, etc.) Stakeholders expressed concerns about redefining Chemical restraints and suggested the use of non-prescription drugs (i.e. Benadryl or NyQuil) to modify, control, or alter behavior. ADMH reviewed this concern and currently considers the use of non-prescription drugs such as Benadryl and NyQuil as a chemical restraint and treats them as such

in our more detailed guidelines on the IPMS process and in training/technical assistance.

Stakeholders are in support of adding Supported Living Service to LAH but suggested additional details for provider specifications. ADMH reviewed the concerns and will implement necessary trainings.

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 5642

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 Ave

Address 2:

City: Montgomery

State: **Alabama**

Zip: 36104

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

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

Signature: Monica Abron

State Medicaid Director or Designee

Submission Date: Jan 12, 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 "Bo" A.

Title:

Commissioner

Agency:

Alabama Medicaid Agency

Address:

501 Dexter Avenue

Address 2:

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:

At the end of each fiscal year (starting 9/20/21), the state will determine the total number of unduplicated slots in the Intellectual Disabilities (ID) Waiver (AL.0001) and the Living at Home (LAH) Waiver (AL.0391) that are unfilled due to attrition ("attrition slots"). ID and LAH services will be supplanted by Community Waiver Program services in the pilot counties where the latter program is implemented, so new applicants for waiver services living in those pilot counties will only apply for the Community Waiver Program. Given that, the state will transfer, from the ID and LAH Waivers to the Community Waiver Program, funding associated with the percentage of the total attrition slots that equates to the percentage of the current waiting list that resides in the counties to be covered by Community Waiver Program in the next fiscal year. The state will use this funding to create additional slots in the Community Waiver Program that at least equal the number of attrition slots eliminated in this waiver. The state will annually update the unduplicated slot count for this waiver through a Technical Amendment to this waiver. Attrition slots not transferred to the Community Waiver Program will be available to replenish reserve capacity slots each fiscal year to the number identified in this Waiver Amendment application, for counties outside of the Community Waiver Program counties. The remainder of available slots will be available for enrollment of people from the Waiting List in areas outside of the Community Waiver Program counties. ADMH has data from recent years showing these available slots represent more than what has been the average number of people per year enrolled from the Waiting List in the counties not served by CWP. Thus, there will be no reduction in access.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Removing "Self Directed Out of Home Respite" as a service because this is a provider DDD Certified Residential service, thus there should not be a self-directed service code and/or service description.

Appendix A: Waiver Administration and Operation

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

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

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

○ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

The Alabama Department of Mental Health, Division of Developmental Disabilities

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

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

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

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

As the administering agency the Alabama Medicaid Agency ensures that the:
*Operating agency adheres to all federal/state guidelines described in the approved waiver document.
*Health and safety of the Individual is protected.
*Individual 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 reimbursement rate for the provision of Waiver services is in accordance with a methodology developed by Medicaid and in accordance with OMB Circular A-87, 45 C.F.R. Part 95 and the Alabama Medicaid Administrative Code Rule Numbers 560-X-35-.01 et seq., and 560-X-52-.01 et seq., as well as, guidance in the Fiscal Procedures Manual(s).

The Medicaid Agency provides ongoing oversight of this waiver program by assuring level of care determinations, person centered plans (PCP), 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 quarterly.

In addition, the Medicaid Agency maintains ongoing oversight and authority over the program by:
* Monitoring the availability and allocation of state/federal funds to ensure costs do not exceed the contracted budget.
* Monitoring processing of all proper payments to providers.
* Submitting all federally required reports to the Centers for Medicare and Medicaid Services (CMS).
* Defining expectations of the Operating Agency to ensure proper compliance with state and federal regulations.
*Conducting joint training with direct service providers (DSPs) enrolled to provide services through the LAH waiver program, as necessary.
*Participating in training provided periodically by the operating agency to discuss policies and procedures in an effort to consistently interpret and apply policies related to the ID waiver program.
*Conducting training for all operating agency staff to disseminate policies, rules and regulations regarding the home and community based waiver programs, as necessary .
* Provide written guidance and interpretations of policies/procedures for the purpose of waiver program administration; provide proposed changes in federal or state Medicaid policy/procedures; meet with the Operating Agency to identify changes to manuals and operating processes to comply with state/federal regulations and review the Operating Agency’s operational policies/guidelines to determine if Medicaid program policy is correctly interpreted and applied prior to providing approval for implementation.
*Performing quarterly and annual reviews conducted by the Medicaid 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 support coordination services and monitoring. Conduct quarterly meetings with the Operating Agency’s Quality Assurance Director to discuss performance of assurances, identify trends and implement quality improvement plans, as necessary.
*Quarterly reviews of grievances/complaints made to the Operating Agency's Office of Waiver Appeals, including the resolution within required timeframes, and participation in stakeholder task forces to assure that proposed improvements meet Medicaid requirements.
*Establishing policies and procedures for the operating agency, direct service providers and targeted case managers to ensure services are provided as specified in the approved waiver document.
*Annually conducting desk reviews of provider agencies serving sampled LAH Waiver participants.
* Conducting review and feedback processes for reports submitted quarterly and/or annually by the Operating Agency. Reports include Performance measure reports, Waiver Provider Management reports, Waiver Client Engagement report, Participant Self-Direction report, Grievance/Complaint System report log, NCI Survey report, Critical Incident report, Person Centered Planning report, Access report, HCBS Quality Measure Set, and Payment Adequacy report.

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, contracted Financial Management Services Agency (FMSA) entities are utilized which provide fiscal intermediary and other services to participants who choose to self-direct their services. FMSAs are selected through a competitive RFP process. The services of the FMSA are described in detail in Appendix E, which will include assuring "Qualified Provider Enrollment" and "Execution of Medicaid Provider Agreements."

Execution of Medicaid Provider agreements and enrollment for all other services are handled by the operating agency (ADMH).

○ **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:

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

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

The Alabama Medicaid Agency and the Alabama Department of Mental Health are responsible for assessing the performance of any contracted and/or local/regional non-state entity that executes Medicaid Provider Agreements. This responsibility includes monitoring compliance with contractual obligations, evaluating service quality, ensuring adherence to Medicaid program requirements, and implementing corrective actions as necessary. 1. The agencies will collaboratively establish performance metrics and reporting requirements. 2. Conduct regular reviews and audits of entity performance and 3. Provide guidance and technical assistance to address deficiencies.

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:

Contracted entities are FMSA entities which will be used to implement self-directed services.

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

On a quarterly basis, the FMSA will provide reports and documentation to the Central office and the self-directed liaison (SDL) and/or Support coordinator, and the self-directing participants, that will identify the amounts paid to and on behalf of employees and include copies of the signed time sheets for those employees for each pay period. The reimbursement to the FMSA will be based on the timecard submissions. If there has been an error in timecard submissions then the error will be corrected by the following pay period. The self-directed liaison, Support Coordinator will be responsible for all follow-up conversations with participants or the representative to 1) notify them of any change to compensation and 2) ensure that time keeping processes are clearly understood.

The SDL/support coordinator closely monitors units paid and remaining as well as account balances to ensure there are sufficient funds in each account to cover the cost of payroll. Goods and Services will be authorized through the self-directed liaison and or Support Coordinator and receipts for items paid for up front by the FMSA will be reconciled. A receipt for each item purchased is required for reimbursement.

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. FMSA is required to submit timecards that have been processed, training documentation, license documentation, and a complete employee packet to the Operating Agency for review. The frequency for this review is quarterly. 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.

The Alabama Medicaid Agency and the Alabama Department of Mental Health will assess the performance of the contracted entity that executes Medicaid Provider Agreements using a combination of performance reviews, audits, reporting evaluations, stakeholder feedback, and review of corrective action plans. Assessments will occur monthly, quarterly, and annually as appropriate for the performance metric or reporting requirement, with conducted as needed in response to issues or noncompliance. These methods ensure ongoing compliance with Medicaid program requirements, support quality improvement, and provide a framework for timely corrective actions.

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	☒	☒	☒
Establishment of a statewide rate methodology	☒	☒	☐
Rules, policies, procedures and information development governing the waiver program	☒	☒	☐
Quality assurance and quality improvement activities	☒	☒	☐

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of waiver program records reviewed by the Medicaid Agency that were compliant with program requirements. Percentage = NUMERATOR [Number of waiver program records reviewed by the Medicaid Agency that were compliant with program requirements] / DENOMINATOR [Number of waiver program records reviewed by the Medicaid Agency]

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record Reviews, on-site; Record Reviews, off-site (AMA audit results)

Responsible Party for data collection/generation*(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 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 programmatic operating procedures pertaining to the waiver issued by the OA that were approved by Medicaid prior to being issued by the OA %= NUM [# of programmatic operating procedures pertaining to the waiver issued by the OA that were approved by Medicaid prior to being issued by the OA.]/ DEN[# of programmatic operating

procedures pertaining to the waiver 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 Medicaid 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**	☐ **Annually**

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

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: 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**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number & percent of special reports (i.e. Ad Hoc) requested by Medicaid & submitted by the OA that have been validated by the designated Medicaid Program Manager for program compliance. Percentage = NUMERATOR[Number of special reports submitted by the OA that have been validated by the Medicaid Program Manager for program compliance] / DENOMINATOR [Number of special reports submitted by the OA]

Data Source (Select one):
Other
If 'Other' is selected, specify:
Quarterly and Ad Hoc Reports submitted by the OA, as documented in the AMA Program Manager Log

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

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

Data Aggregation and Analysis:

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

Performance Measure:

Number & percent of reports specified in agreements, policies & procedures with Medicaid that were submitted timely, in the correct format & inclusive of required information by the OA & validated by the Prog.Manager for compliance.
Percentage=NUMERATOR[Number of reports submitted timely, in the correct format & inclusive of required information by the OA] /DENOMINATOR [Number of reports due]

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:
Reports to State Medicaid Agency on delegated Administrative functions, as documented in the AMA Program Manager Log

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of standard expedited grievances that were resolved within the required timeframes as validated by Medicaid. Numerator [Number of standard expedited grievances that were resolved within the required timeframes as validated by Medicaid] / Denominator [Number of standard expedited grievances submitted by the OA]

Data Source (Select one):
Other
If 'Other' is selected, specify:
Quarterly, submitted by the OA.

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.

The Alabama Medicaid Agency (Medicaid) exercises administrative authority and responsibility of all waiver related policies and the OA's adherence to rules and regulations governing the Living at Home Waiver. Medicaid conducts meetings to disseminate policies, rules and regulations in an effort to ensure consistent application of the policies related to the Living at Home Waiver program.

Medicaid reviews participant files, personnel files and performs home visits as a method to monitor compliance of the level of care determination process; the appropriateness of the Person Centered Plan (PCP); and the monitoring of service

providers contracted with ADMH.

Medicaid monitors the Quality Improvement Strategy (QIS) of the waiver on an ongoing basis. If a problem is identified, Medicaid sends a notice to ADMH addressing the issue(s) and require a response as to their follow-up plan of correction and/or corrective measures to resolve any/all problems identified.

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 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**			☐

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

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

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

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Complete Items B-2-b and B-2-c.

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

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

Specify the percentage:

○ **Other**

Specify:

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

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

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

The Living at Home Waiver (0391) has a cost limit (other than for crisis intervention) of $58,000. This increase from the previous $50,000 is to ensure reimbursement rate increases can be implemented without any participant experiencing a reduction in services due to the rate increases causing them to exceed the existing cap. The $58,000.00 limit allows for the continued synchronization of services and rates between the two waivers (ID and LAH), which allows some individuals with higher level of needs to use the Living at Home Waiver to remain at home. Should individual waiver recipient needs exceed that amount due to additional service needs, and not due to rate increases in existing approved services, then that waiver recipient may be transferred to an appropriate waiver operated by ADMH-DDD.

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

◉ **The following dollar amount:**

Specify dollar amount: 58000

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:

1. The prioritization list indicates the services which the person needs and gives an initial indication of who might not need to exceed the cost limit.
2. The planning team understands the limitation and will not proceed if the planned services need to exceed the limit. There is also flexibility in the services selected, and the scope of the coverage most often lets the team develop a plan within the financial limit.
3. The person centered plan is assessed for cost and will not be approved if it exceeds the limit.

The State notifies the applicant of the opportunity to request a Fair Hearing if enrollment is denied based on their needs exceeding the limit as instructed: If the applicant is determined ineligible for the enrollment into the LAH waiver due to their needs exceeding the limit, the applicant will be offered enrollment in the ID waiver, which also provides all the same services available in the LAH waiver, with some additional services also available. Therefore, the applicant is not denied overall waiver enrollment, including access to any and all of the services available in the LAH. However, under rare circumstances, if the applicant is finally determined to not be eligible for either waiver, the applicant will receive a memorandum regarding denial of eligibility. This notification will state that the application has been denied specifying the reason (it will describe the statutory and/or regulatory requirement that has not been met). The appeal process begins with a written request from the applicant, either to the Division of Developmental Disabilities or to the Alabama Medicaid Agency, with specific timelines involved for each. If the applicant appeals first to the Division of Developmental Disabilities within 15 days of receipt of denial letter, he or she will be entitled to a review by the Associate Commissioner, who will produce a written determination. If the individual is dissatisfied with that determination, he/she has the right to appeal to the Alabama Medicaid Agency within 60 days of notice of action. The notification fully explains the process of appeal to both agencies. An individual who is denied Home and Community-Based Services based on Rule No. 560-X-35-.03, may request a fair hearing in accordance with 42. C.F.R. 431, Subpart E and Chapter 3 of the Alabama Medicaid Administrative Code. A written request for a hearing must be filed within sixty days following notice of action with which an individual is dissatisfied.

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:

Should individual waiver recipient needs exceed that amount due to additional service needs, and not due to rate increases in existing approved services, then that waiver recipient may be transferred to ADMH’s ID waiver.

☐ **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	544
Year 2	569
Year 3	594
Year 4	619
Year 5	644

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

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

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Purpose(s) the state reserves capacity for:

Purposes	
Participants transitioning from school or a facility based setting	

Appendix B: Participant Access and Eligibility

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

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

Participants transitioning from school or a facility based setting

Purpose *(describe):*

New admissions to the waiver who are transitioning from school (25) or from a facility based setting/nursing home (10) and in need of support services to live fully integrated within the community which allows them to have meaningful lives.

Describe how the amount of reserved capacity was determined:

The Department of Mental Health, Division of Developmental Disabilities has been focused on supported employment as it relates to children transitioning out of the education system. The Division implemented two Project Search sites within the state. This project is about employment emersion with a focus on training and transitioning senior year students into competitive and integrated employment upon completion of the program. The project involves various state agencies. For its part, the division would like to assist with long term services to the extent a student is eligible for the supports waiver.

In addition, the Department of Mental Health is working with the Alabama Medicaid Agency with the Money Follows the Person Rebalancing Demonstration Program. A key component is the availability of services through various waivers if a person is eligible.

The two target groups historically have not transitioned or outplaced a large number of people eligible for services through this waiver. The reserved slot number therefore has been set low.

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

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

Appendix B: Participant Access and Eligibility

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

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

◉ **The waiver is not subject to a phase-in or a phase-out schedule.**

○ **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

◉ **Waiver capacity is allocated/managed on a statewide basis.**

○ **Waiver capacity is allocated to local/regional non-state entities.**

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

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

Applicants are determined eligible for the Waiver and placed on a waiting list, ranked by criticality with length of time. Time waiting will be the tie breaker. Applicants who are not waiting for Residential (Group Home) Services are selected from the waiting list basically in rank order. Selection criteria are defined in the Administrative Code 580-5-30-.14.

The State incorporates the following provisions from Administrative Code 580-5-30-.14 into the LAH Waiver's selection process:

- Level of Care (LOC): Individuals must meet the ICF/IID level of care as determined through the State's standardized assessment process, which evaluates functional limitations, adaptive behavior, and the need for active treatment. Additional LOC criteria can be found in Appendix B-6-d.
- Diagnosis: Applicants must have a diagnosis of an intellectual disability or a related condition as defined in the Administrative Code, and the condition must result in substantial functional limitations in major life areas relevant to eligibility.
- Evaluation Process: The Alabama Department of Mental Health (ADMH), serving as the State's Developmental Disabilities authority, is responsible for conducting eligibility determinations. Evaluations are completed using standardized instruments, documentation requirements, and decision-making criteria outlined in 580-5-30-.14.
- Medicaid Eligibility: The individual must be Medicaid-eligible or meet Medicaid financial eligibility requirements at the time a waiver slot is offered.
- Risk of Institutionalization: Waiver services are available to individuals who are determined to be at risk of placement in, an ICF/IID in the absence of ID Waiver services.
- Capacity and Slot Availability: Enrollment is dependent on the availability of CMS-approved waiver slots and State appropriations.
- Prioritization of Waiting List Process: When the number of eligible applicants exceeds available waiver capacity, the State uses the prioritization criteria established in 580-5-30-.14. These criteria consider:
- • the individual's risk to health and safety;
  - immediacy and urgency of need for services;
  - risk of institutionalization; and
  - availability and adequacy of natural supports.

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)

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

  Select one:

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

    Specify percentage: [ ]

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in 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)**
- [x] **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:

435.227- 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
435.122
435.134
435.135
435.137
435.138

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

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

Select one:

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

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

Specify percentage: [ ]

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

Specify dollar amount: [ ]

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

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

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

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

Select one:

○ **100% of FPL**

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

Specify percentage amount: [ ]

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the period beginning January 1, 2014 and extending through September 30, 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:

  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.
- ○ **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:

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 Qualified Developmental Disability Professional (QDDP) in the Operating Agency's Regional Office makes the determination of eligibility and level of care. The QDDP 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. QDDPs 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 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.

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

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

Evaluation:

An individual wishing to apply for waiver services contacts the Call Center to start the process. The person is then referred to the Support Coordination staff 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 QDDP) for determination of eligibility and level of care. The Support Coordination 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 QDDP) processes applications for enrollment in the LAH Waiver. Either the Waiting List Coordinator or the Psychological/Behavioral Evaluator (also a qualified QDDP) 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 QDDP 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 QDDP 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 LAH Waiver services.

Applicants who are determined eligible and meeting level of care criteria are placed on the statewide waiting list, ranked by criticality of need and length of time waiting. When the person can be served from the waiting list, individuals on the waiting list are contacted by the Regional Office Waiting List Coordinator in order, based on length of time waiting. 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 individualized Person Centered Plan and Resolution Process form. The use of e-signatures that meets privacy and security requirements will be allowed as a method for signing off on required documents such as the participant or legal guardian signing the PCP to indicate approval of the plan.

Reevaluations:
Annual re-evaluations must include, along with the Comprehensive Assessment and 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 annual ICAP completed within the 90 days prior to redetermination. ICAP is completed by the Support Coordinator who is trained by the Operating Agency to administer the ICAP and is 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 QDDP 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. 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 QDDPs 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 QDDPs, 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 QDDP 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 QDDPs 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:

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.

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 applicants for whom there is reasonable indication that services may be needed in the future who have a level of care evaluation completed. %= NUMERATOR: [# of applicants for whom there is reasonable indication that services may be needed in the future placed on the waiting list during the quarter who has a LOC evaluation completed]/ DENOMINATOR [# of applicants for whom there is..

Data Source (Select one):
Other
If 'Other' is selected, specify:
cntnd from above... reasonable indication that services may be needed in the future] HCBS application data

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
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 = 95% confidence interval; +/-5% margin of error
☐ **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:
 # and % of all level of care (LOC) determinations where the LOC instruments & processes were appropriately applied and according to the approved description in the approved waiver. Percentage = NUMERATOR [# of LOC determinations where the LOC instruments & processes were appropriately applied and according to the approved description in the approved waiver] /DENOMINATOR [# of LOC determinations]

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/- 5% 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 Alabama Medicaid Agency has granted the authority for making level of care (LOC) determinations and conducting annual redeterminations (re-evaluations) to the Alabama Department of Mental Health (ADMH). ADMH is responsible for training and overseeing the 310 Board personnel and Support Coordinators who complete the level of care assessments (ICAPs). The Quality Assurance Division of the Alabama Medicaid Agency provides oversight of these determinations, including conducting quarterly audits based on a randomly selected, representative sample of LOC determinations. This sample is drawn with a 95% confidence level and a +/- 5% margin of error.
Additionally, the Alabama Medicaid Agency holds Quarterly Quality Collaborative meetings aimed at informing, educating, and addressing matters of concern related to the program.

b. Methods for Remediation/Fixing Individual Problems

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

Individual problems regarding performance of level of care evaluations 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.

The Regional Offices have designated staff (QDDPs) 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 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, as applicable.
c. If no improvement is seen in the quarter after the intervention, a performance improvement plan or corrective action plan will be required.

The Living At Home (LAH) Waiver is administered by the Alabama Medicaid Agency (Medicaid) and operated by the Alabama Department of Mental Health (ADMH). Medicaid holds administrative authority over the waiver's management and oversight, including the development and issuance of relevant policies, rules, and regulations. The Quality Assurance Division of the Alabama Medicaid Agency is responsible for several quality management activities within the LAH Waiver Program, which include the following components: (1) Collecting quarterly data to evaluate the appropriateness of level of care determinations through regular audits, (2) Monitoring waiver performance measures through the Quarterly Quality Cycle process to identify and address negative trends, ensuring performance remains above the 86% threshold, (3) Identifying and resolving non-compliance issues or complaints derived from data collection and analysis, (4) Conducting joint training as needed, and (5) Hosting periodic training sessions to ensure consistent interpretation and application of LAH Waiver policies and procedures, as well as to provide updates on relevant policies, rules, and regulations.

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 Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

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

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

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

Each person served through the waiver must make a written choice of institutional or community-based care, which will remain in effect until such time as the individual changes his/her choice. The only exception to making a written choice would occur when the person is not capable of signing the Person Centered Plan and has no legal or responsible party who can sign. In such a case, the support coordinator must document the reason(s) for absence of a signed choice and efforts made to locate a responsible party who could have signed for the person. The use of e-signatures that meets privacy and security requirements will be allowed as a method for signing off on required documents such as the participant or legal guardian signing the PCP to indicate approval of the plan.

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.

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

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 4.1%.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	**Day Habilitation**		
Statutory Service	**Employment Support**		
Statutory Service	**Personal Care**		
Statutory Service	**Prevocational Services**		
Statutory Service	**Respite**		
Other Service	**Adult Companion Services**		

Service Type	Service		
Other Service	Assistance in Community Integration		
Other Service	Assistive Technology Services		
Other Service	Benefits and Career Counseling		
Other Service	Community Experience		
Other Service	Crisis Intervention		
Other Service	Environmental Accessibility Adaptations		
Other Service	Housing Stabilization Service		
Other Service	Individual Directed Goods and Services		
Other Service	Occupational Therapy		
Other Service	Personal Emergency Response System		
Other Service	Physical Therapy		
Other Service	Positive Behavior Support		
Other Service	Remote Supports		
Other Service	Skilled Nursing		
Other Service	Specialized Medical Supplies		
Other Service	Speech and Language Therapy		
Other Service	Supported Employment Transportation		
Other Service	Supported Living Service		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04020 day habilitation

Category 2:

04 Day Services

Sub-Category 2:

04070 community integration

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service Definition *(Scope):*

Day Habilitation services are services which involve the provision of regularly scheduled activities in non-residential settings, separate from the member's residence or other residential living arrangement. This service can be provided in a Day Habilitation Facility or in the Community. Regardless of where the service is delivered, activities are designed to foster the acquisition of positive social skills and interpersonal competence, greater independence and ability to exercise and communicate personal choices and preferences. When delivered in the community, services must be designed to enhance opportunities for community integration, participation and involvement including opportunities for positive interactions and relationships with members of the broader community and opportunities to acquire and maintain valued social roles in one's community. The service provides assistance that supports community participation including achievement of valued social roles that reflect a member's individualized interests and desires with regard to type(s) of community involvement and community contributions the member prefers. Activities build on the strengths and gifts that each member has to offer to the wider community, identified through individualized strengths-based assessment, and enable the member to broaden horizons and develop/pursue adult learning and personal enrichment goals.

For individuals of retirement age, Day Habilitation services may be used to provide retirement activities. Services should provide supports to assist individuals of retirement age to participate in meaningful retirement activities in their communities and to develop relationships through participation in those activities.

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

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

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

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

Reimbursement rates are associated with each level, based on the associated minimum staffing ratios needed to support persons with different ICAP scores, and whether the service is delivered in a facility-based (provider owned or controlled)

setting or integrated community settings. Rates for community-based Day Habilitation (Day Habilitation-Community Access) take account of the more intensive staffing ratios and different costs that are applicable for services delivered in integrated community settings.

For each individual whom the day program transports between his place of residence and the Day Habilitation facility, when his residence is more than 10 miles as measured in a straight radius from the day program site, an additional payment is available per day of transport. The transportation add-on is also available for Community Day Habilitation, with the same 10-mile rule.

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

Members who receive Day Habilitation services may also receive one or more Supported Employment services included in the waiver, Prevocational services and physical, occupational, or speech therapy.

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

• Day Habilitation services may not be authorized for any individual also receiving Community Experience services per their Person Centered Plan.
• Day Habilitation services may not be used to support or provide activities involving paid work, including any situation where work done by an individual is required to be paid under state and federal labor laws and any services that are vocational in nature (i.e., for the primary purpose of producing goods or performing services).
• Volunteering cannot involve volunteering for the provider of the service or volunteering in situations where an individual must be paid under existing state and federal labor laws
* Day Habilitation services (both facility and community-based) must be delivered according to the individual person-centered plan and using the minimum staffing ratios outlined above. Individuals with similar interests and goals may share staff support as part of the provider meeting the minimum staffing ratios outlined above and the maximum group size of 4 individuals.
* Day habilitation services cannot exceed 5 hours per day.
* Day services can only be billed for 247 days (248 days in leap years) per waiver participant.
* Different types of face-to-face waiver services may not be billed for the same unit of time.

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 Day Habilitation Program

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:

Agency

Provider Type:

Certified Day Habilitation Program

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Al. Administrative Code Chapters 580-3-23, 580-3-25, 580-3-26, 580-5-30 and DD Operational Policies and Procedures

Other Standard *(specify):*

Day Habilitation providers must demonstrate:

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

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH/DDD Certification Surveyors

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

Employment Support

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
03 Supported Employment	03021 ongoing supported employment, individual
Category 2:	**Sub-Category 2:**
03 Supported Employment	03022 ongoing supported employment, group
Category 3:	**Sub-Category 3:**
03 Supported Employment	03010 job development

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

17 Other Services | 17990 other

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

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

Service Definition *(Scope):*

The setting in which the individual is receiving Supported Employment services comports fully with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, and specific to the individual's choice and assessed need as set forth in the person-centered plan (PCP). Freedom of choice also includes the right to select any provider with an active provider agreement with the Department of Mental Health Division of Developmental Disabilities if the provider is available, willing, and able to provide the services needed, and choice of the setting in which services and supports are received which shall be integrated in, and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS. The person centered plan describes all the supports and services necessary to support the person to achieve their desired outcomes and attain or maintain a quality life as defined by them, including services that may be provided through natural supports, the Medicaid State Plan or any other applicable plans and should include a choice of non-disability specific options.

There are two variations of Supported Employment covered within this waiver: 1) Individual Assessment/Discovery, 2) Employment Small Group and Employment Individual.

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

Employment Small Group, most often consists of groups of individuals being supported in enclave or mobile work crew activities. This is reimbursed per 15 minutes unit of service. There are two level of staffing for Employment Small Group. Each level has its own individual to staff ratio. Employment Small Group are services and training activities provided in regular business, industry, and community settings for groups. Group size 1:2-3 and 1:4 have a ratio of one provider staff for each and reimbursement is made based on the group size. Examples of Small Group Employment include mobile crews and other business-based workgroups employing small groups of workers. Employment Small Group services must be provided in a manner that promotes integration into the workplace and interaction between participants and people without disabilities in those workplaces. The outcome of this service is sustained paid employment and work experience leading to further career development and community-based individual employment for which the compensation is at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Employment Individual. Employment Individual includes two distinct levels of services: 1)Job Developer and 2)Job Coach and is reimbursed per 15 minutes unit of service. Both Job Development and Job Coaching services must be provided in integrated settings where the participant is paid at minimum wage (or better).Employment Individual services are the ongoing supports to participants who, because of their disabilities, need intensive on-going support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals. Two procedure codes under this heading are specifically intended to support the provision of supported employment at competitive wages in an integrated worksite: Job Coach and Job

Developer. These are different roles and are performed, normally, by different staff. However, some providers may choose to utilize one staff to perform the two distinct services so long as documentation supports the differing activities. The provider agency must also have a QDDP. Supported Employment (both group and individual) services do not include facility based, or other similar types of vocational services furnished in specialized facilities that are not part of the general workplace.

Transportation accommodations to the worksite or supported employment provider's home-base should be a component of the planning process and integrated into the person centered plan. While developing the plan which will reflect employment goals; transportation issues, concerns, and access should be addressed. All avenues of possible sources of transportation should be considered including public transportation and natural supports such as family. If training is needed in order for a person to access transportation then that training should be outlined in the plan.

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

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

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

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

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

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

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

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

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

Discovery/Assessment is limited to no more than a ninety (90) day time period and should not overlap other services and is available for individual participants interested in employment. The expectation is that the majority of the process be performed outside of a facility so a true assessment is completed per individual. Discovery shall be limited to no more than 120 units (30 hours)of service. The provider shall document each date of service, the activities performed that day, and the duration of each activity completed. Reimbursement for Assessment/Discovery should be billed at three distinct intervals during the process. The first billing for services occurs after one third, no more than 10 hours or 40 units, of the assessment/discovery process and requires documentation of activities performed that support the billing during the first period of the assessment process. The second billing for services occurs at the two thirds, no more than 10 hours or 40 units, of assessment/discovery process and also requires documentation of activities performed that support the billing during the second period of assessment process. The information developed through Discovery allows for activities of typical life to be translated into possibilities for integrated employment. Discovery results in the production of a detailed written Profile

summarizing the process, learning and recommendations for next steps. The written Profile is due no later than ninety (90) days after the service commences. The final payment for assessment/discovery is billed after the completion of the report, and can include no more than 10 hours or 40 units of service. This service is limited to two assessments per each waiver participant, with the second assessment being conducted only if the participant changes service providers. To exceed the capped amount, documented justification should be sent to the Employment Coordinator at the Central Office, or the Employment Specialist at the Regional office. Approvals will then follow the established request for service procedures. No waiver participant can receive more than four assessment/discovery services over the lifetime of the waiver.
Expectations and Outcomes:
Once an Assessment/Discovery is complete, the job development should begin with job placement as the expected outcome. Providers must expect to submit reports requested and designed by the DMH/DDD (and the Alabama Medicaid Agency and CMS, should the requests be made). Reports will support the measurement of outcomes.

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

☐ **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 Waiver Hourly Service Provider
Agency	Certified Day Habilitation Program

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Employment Support

Provider Category:

Agency

Provider Type:

Certified Waiver Hourly Service Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Al. Administrative Code Chapters 580-3-23, 580-3-25, 580-3-26, and 580-5-30 and DD Operational Policies and Procedures

Other Standard *(specify):*

Supported Employment (Individual) Service Provider Qualifications
Job Coach and Job Developer workers may be employed by, or under contract with, any agency that qualifies to provide hourly services under the waiver. Any agency or individual undertaking the provider on this service must employ or contract with a QDDP to provide the required supervision and must meet the other requirements in this addendum related to training, plans of care, documentation, and reporting. The primary requirements for the provider agency are to:
a) Handle all payroll taxes required by law
b) Provide training and supervision as required by this scope of services
c) Maintain records to assure the worker was qualified, the service was provided, and provided in accordance with the

Person Centered Plan
d) Implement a plan and method for providing backup at any time it is needed
e) Implement and assure the person and his or her family are and remain satisfied with the service

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

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

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

Benefits and Limitations

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

Individuals who are more capable may need less support over the long term, while individuals who are less capable may need more support, therefore the number of units authorized should be based on the person-centered plan.

Furthermore, it is expected that the job coach will fade his or her support as the individual becomes more integrated into the workplace.

Thus, the maximum hours for an individual will be presumed to be 836 or 3344 units per year.
An employment addendum is required as part of the person-centered plan, and any updates can request modifications to the above limitations. All changes should be reflected on the individual person centered plan. Detailed explanation and rationale will be required.

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

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

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

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

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

The supported employment provider agency should also have a QDDP.

Training Requirements:
The training program for Supported Employment personnel will reinforce the responsibility to insure successful employment of recipients involved in supported employment. The personnel must be certified by a QDDP as having completed training approved by DMH/DDD. This certification must be documented and is subject to review by DMH/DDD and Alabama Medicaid. Minimum training requirements shall include the following areas:

a. Overview of intellectual and developmental disabilities
b. Skills to identify recipient abuse, neglect and mistreatment and reporting procedures
c. Recipient rights and grievance procedures
d. Ability to read, write and follow the individualized person centered plan.
e. Planning and conducting appropriate activities to support the person in finding and maintaining employment.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DMH Certification Surveyors

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Employment Support

Provider Category:

Agency

Provider Type:

Certified Day Habilitation Program

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Al. Administrative Code Chapters 580-3-23, 580-3-25, 580-3-26, and 580-5-30 and DD Operational Policies and Procedures

Other Standard *(specify):*

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

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

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

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

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

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

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

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

Employment Small Group personnel will meet the same requirements as basic direct care staff:
Qualifications:
Completion of the 10th grade
Minimum 1 year experience working with persons with ID
Background check; drug testing.
Training in career development planning and vocational assessment, in addition to what the DMH/DDD standards require.

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

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

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

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

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

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

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

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

i. Documentation: progress on training goals and documentation of training; progress notes on a per day basis rather than a per unit basis.

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

The supported employment provider agency should also have a QDDP.

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DMH Certification Surveyors

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

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

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

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

Service Definition *(Scope):*

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

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

Personal care attendants may transport individuals in their own (the attendant's) vehicles as an incidental component of this service. This service will provide transportation into the community to shop, attend recreational and civic events, go to work and participate in People First and other community building activities. The planning team must assure the most cost effective means of transportation, which would include public transport where available. Transportation by a personal care attendant is not intended to replace generic transportation or to be used merely for convenience.
Personal care under the waiver may also include general supervision and protective oversight reasonable to accomplishing of health, safety and inclusion. The worker may directly perform some activities and support the individual in learning how to perform others; the planning team (composed at minimum of the person and family, and support coordinator) shall determine the composition of the service and assure it does not duplicate, nor is duplicated by, any other service provided to the individual. A written description of what the personal care worker will provide to the person is required to be submitted to the state as part of or in addition to the person centered plan, and will require approval by the Division of Developmental Disabilities and be subject to review by the Single State Agency for Medicaid.

When Personal Care is included in the PCP, the “Provider” field in the PCP will include any participant preference for self-direction worker or agency-employed direct support professional, as well as the name of the chosen FMSA or Personal Care agency. Employment of a relative or friend shall also be noted and justified in the individual's record by the provider agency. In all cases in which a relative or legal liable relative (both self-directed and agency based) is the choice of provider for personal care under the waiver, the Support Coordinator will document that relationship in the PCP. This ensures the person-centered planning team is cognizant of the need to ensure no conflict of interest occurs. The participant’s choice of caregiver is documented at the time of the person–centered planning (PCP) meeting or at
any time the participant desires a change of provider or caregiver.

Payment is for a 15-minute unit of service delivered to the individual, and does not include the worker's time of travel to and from the place of work.

Personal Care Self-Directed Service Definition:

This definition of Personal Care Services is intended to allow participants and their families to recruit, hire, train, supervise,

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

Self-Directed Personal Care may also include general supervision and protective oversight reasonable to ensure the health, safety and inclusion of the individual. The worker may directly perform some activities and support the individual in learning how to perform others; the planning team (composed at minimum of the person and family, and a Support Coordinator) shall determine the composition of the service.

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

Self-Directed personal care attendants may transport individuals in their own (the attendant's) vehicles as an incidental component of this service. For this component to be reimbursed, the personal care attendant must be needed to support the individual in accessing the community, and not merely to provide transportation. Additional payment will be made to the worker for mileage. This service may provide transportation into the community to shop, attend recreational and civic events, go to work and participate in People First and other community building activities. It shall not replace transportation that is already reimbursable under day or residential habilitation nor the Medicaid non-emergency transportation program. Transportation by a personal care attendant is not intended to replace generic transportation or to be used merely for convenience.

The person centered plan or an addendum shall specify any special requirements for training, more than basic training, which may be needed to support the individual. Individuals and their families shall be key informers on the matter of special training, and will be responsible for providing such training to their workers. The participant, EOR and worker must be trained on identifying Abuse, Neglect and Exploitation, who to report to and the timeframes to report any incidents.

Payment is for a 15-minute unit of service delivered to the individual, and does not include the worker's time of travel to and from the place of work.

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

Certified Waiver Hourly Services Provider Agency (Personal Care) requirements:

1. The QDDP will provide and document in the case record on-site supervision of the personal care worker semi-annually. The supervisor will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performance by the worker.
2. Agency personal care is limited to no more than 12 hours/48 units each day for individuals living in the home with relatives or caregivers and those waiver participants living independently. The number of hours provided may exceed 12 hours/48 units per day for those who have an assessed need for additional support, but the approval will be based upon the emergent need.
3. The number of hours/units provided to the individual is based on assessed need for the service documented as an alternative to institutional care and on the reasonable cost effectiveness of his or her plan.
4. When this service is provided to participants living with their parents or guardians, it shall not supplant the cost and provision of support ordinarily provided by parents to children without disabilities, nor shall it supplant educationally related services and support that is the responsibility of local education authorities.
5. Personal Care 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
6. There is otherwise no restriction on the place of service so long as the person is eligible for the waiver in that setting and no duplication of payment occurs. Note that Personal care cannot be provided in any group home or residential setting (i.e. residential habilitation) because the definition of residential habilitation is inclusive of personal care and would therefore be a duplication of services. This is not subject to due process
7. A provider agency may employ a participant’s relative, excluding a legal liable relative and/or a legal guardian, to provide personal care to the participant. If a relative is the choice of agency personal care worker 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.

8. Relatives, or friends, who are employed to provide services must meet the qualifications for personal care workers and, as for all other personal care workers, payment shall only be made for services actually rendered.
9. Personal care services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Self-Directed Personal Care requirements:

1. Self-Directed Personal Care may not be provided to participants who lack the necessary support systems to ensure the responsibilities of employing staff are carried out and that the participant's security and well-being is maintained.
2. Self-Directed Personal Care may also be provided in settings where the individual lives in their own house or apartment alone or with others, with the assistance of family or a circle of support, but the Regional Community Service Office must review and approve this arrangement before it can be reimbursed. The purpose of this review is to assure the support is near and frequent enough to carry out the needed tasks and also to assure there is no conflict of interest.
3. When this service is provided to individuals living with their family/guardians, it shall not supplant the cost and provision of support ordinarily provided by family/guardians to individuals without disabilities.
4. Self-directed personal care is limited to no more than 12 hours/48 units each day for individuals living in the home with relatives or caregivers and those waiver participants living independently. The number of hours provided may exceed 12 hours/48 units per day for those who have an assessed need for additional support, but the approval will be based upon the emergent need.
5. Legal liable relative may not provide more than 40 hours of compensated extraordinary care per week.
6. Personal care services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified Waiver Hourly Services Provider
Individual	Self-Directed Personal Care Worker

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:

Agency

Provider Type:

Certified Waiver Hourly Services Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Must be certified pursuant to Al. Administrative Code Chapters 580-3-23, 580-3-25, 580-3-26, and 580-5-30 and DD Operational Policies and Procedures.

Other Standard *(specify):*

1. Personal care workers may be employed by, or under contract with, any agency qualified to provide services under the waiver, and by home health and other home care agencies, and individuals that may not otherwise be waiver providers.

2. Agency must employ individuals to serve as Personal Care Workers who have the following verified qualifications:

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. TB skin test as required by Alabama Medicaid Agency;
v. If providing transportation, have valid driver's license and insurance as required by State Law. The provider agency shall assure the attendant has a good driving record and is in-serviced on safety procedures when transporting an individual

3. Any agency or individual undertaking the provision of this service must employ or contract with a QDDP to provide the required supervision and must meet the other requirements of this addendum related to training, plans of care, documentation and reporting.

Verification of Provider Qualifications

Entity Responsible for Verification:

DMH/DD Certification

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:

Individual

Provider Type:

Self-Directed Personal Care Worker

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

This service is intended to promote self-determination of waiver participants. The individual and/or family are to select and hire staff, and to provide training and supervision to the worker(s).
Self-directed personal care workers must:

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.

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Services Agency (FMSA)

Frequency of Verification:

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:

Statutory Service

Service:

Prevocational Services

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04010 prevocational services
Category 2:	**Sub-Category 2:**

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

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

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

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

Service Definition *(Scope):*

Prevocational services are designed to create a path to competitive integrated employment, which includes competitive integrated self-employment and customized employment or customized self-employment that otherwise meets the criteria for being competitive and integrated. Competitive integrated employment is employment that meets all of the following criteria: (1) ensures compensation is at least the locally established minimum wage where the member works; (2) occurs in a location typically found in the community; (3) enables the member to interact with co-workers and customers to the same extent as a person without a disability filling a similar position; (4) for wage employment, ensures the employer of record is the business or organization benefiting from the work done by the member; and (5) offers the member an individualized position.

This service can be provided in a Prevocational Facility or in the Community. Prevocational Facilities do not include facilities where individuals are supervised in producing goods or performing services under contract to third parties (e.g., sheltered work performed in a facility). Regardless of where the service is delivered, activities involve the provision of learning and skill-building experiences, including community-based volunteering for an organization other than the service provider, where a member can develop general, non-job-task- specific strengths and skills that contribute to employability in competitive integrated employment. Services are intended to develop and teach general skills for competitive integrated employment, including but not limited to: ability to communicate effectively with supervisors, coworkers and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; general workplace safety and mobility training. Services are expected to specifically involve strategies that enhance a member's desire for, and employability in, competitive integrated employment. Prevocational services, regardless of how and where they are delivered, are expected to help members make reasonable and continued progress toward participation in at least part-time competitive integrated employment.

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

Prevocational services are expected to be furnished in a variety of settings in the community, except for the member’s residence or other waiver-funded residential settings. While a provider may utilize a provider-owned or controlled setting as a hub or base for service delivery, and that setting may include individuals without disabilities who are not receiving HCBS, prevocational services must be delivered consistent with all of the requirements of the HCBS Settings Rule, therefore ensuring each individual’s Prevocational service plan includes opportunities to participate a variety of community-based activities that are consistent with the purpose and intended outcome of the service and that facilitate the individual’s access to the broader community and interactions, in the broader community, including with people not receiving HCBS. This includes opportunities for career exploration specific to pursuing competitive integrated employment.

Participation in prevocational services is not a required pre-requisite for individual or small group supported employment services under the waiver. Prevocational services differ from vocational services (supports for employment as an end in and of itself) in that prevocational services, regardless of setting, are delivered for furthering habilitation goals that will lead to opportunities for competitive and integrated employment and career advancement at or above minimum wage.

Individuals receiving prevocational services may pursue competitive integrated employment opportunities while receiving prevocational services at any time to enter the general workforce.

Individuals participating in prevocational services that involve work shall be compensated in accordance with applicable

Federal and State laws and regulations. Compensation at sub-minimum wage shall comply with the Fair Labor Standards Act and the Workforce Investment and Opportunity Act (WIOA) including WIOA provision for youth with disabilities under age 26.

Reimbursement rates are associated with the minimum staffing ratios needed to support persons based on whether the service is delivered in a facility-based (provider controlled) setting or an integrated community setting, taking account of the different staffing ratios and different costs that are applicable for services delivered in integrated community settings. The minimum staffing ratio for community-based Prevocational services is 1:3 with a maximum group size of 3 individuals. The minimum staffing ratio for facility-based Prevocational Services is 1:15.

Prevocational Facilities do not include facilities where individuals are supervised in producing goods or performing services under contract to third parties (e.g., sheltered work performed in a facility).

Transportation between the individual's place of residence and the provider facility, or site where the individual starts and ends Prevocational services each day, is included as a component part of the service if such transportation cannot be arranged for the individual in another way. Transportation during the service is always a component part of the service.

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

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

An individual’s Person Centered Plan may include two or more types of day and employment services; however, different types of day and employment services may not be billed for the same unit of time.

Individuals receiving Prevocational Services that include facility-based service time may not also have Community Experience services in their Person Centered Plan.

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

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

Prevocational services may be provided to supplement, but may not duplicate, services available and provided to the individual as part of an approved Individualized Plan for Employment (IPE) funded by ADRS or under an approved Individualized Education Plan (IEP) funded under the Individuals with Disabilities Education Act (IDEA). Prior to authorizing this service, the member’s record documents this service is not otherwise available to the member, in a timeframe that is otherwise typical, through a program funded by ADRS under the section 110 of the Rehabilitation Act of 1973 or, for individuals ages 18-22, through a program funded under the Individuals with Disabilities Education Act (IDEA) (20 U.S.C.1401 et seq).

The hours of service cannot exceed 5 hours per day. Prevocational services are limited to a total 2470 hours for a waiver participant. Authorization of units beyond this limit may only be approved if the individual is actively engaged in obtaining competitive integrated employment either through ADRS services, waiver supported employment-individual services or another verifiable funding source.

The expectation is that, before the 2,470 unit limit is exhausted, a referral will be made to ADRS to begin the Milestone program for supported employment job placement and job coaching to stabilization or the individual would utilize the individual supported employment job development services under the waiver.

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 Prevocational Program

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:

Agency

Provider Type:

Certified Prevocational Program

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Al. Administrative Code Chapters 580-3-23, 580-3-25, 580-3-26, and 580-5-30 and DD Operational Policies and procedures.

Other Standard *(specify):*

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

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

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

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

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

The staffing pattern shall be appropriate to the type and scope of program services and shall include staff members who meet the experiential and educational qualifications set forth in the approved job descriptions. The program shall develop and maintain appropriate, up-to-date staffing schedules. Staff to individual daily ratio shall not be more than 1:15 in facility based prevocational. The ratio for community based prevocational service is 1:3 No individual shall ever be left unsupervised unless the activity is part of a structured activity or person centered plan.
Day Habilitation providers must also demonstrate:

- Ability and capacity to offer members regular (daily) opportunities to access the broader community.
- Use of an individualized service planning process that ensures individual member goals are identified and used to guide service delivery and opportunities offered both in the facility and in the broader community.
- Understanding and use of community mapping strategies to identify opportunities for community involvement and

participation that align with each member’s individualized interests and desires with regard to type(s) of community involvement and community contributions they prefer.
In addition to certification, the following requirements apply to the provider's staff:

Activity Program Aide: Job Specifications

a) Must have background checks required by law and regulation
b) Must be at least 18 years of age
c) Must be able to follow the person centered plan with minimal supervision unless there is a change in the person's condition
d) If providing transportation, must have valid driver's license and insurance as required by State Law

Training Requirements:

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

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

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

Training Requirements
The Activity Program Aide (Pre-Vocational) training should demonstrate interaction with recipients concerning education, personal care, pre-vocational training, job safety and social behaviors, in accordance with the recipient's care plan. The minimum training requirements:
1. Planning and coordinating all activities according to the individual habilitation and care plan.
2. Leadership with recipients doing therapeutic or rehabilitative activities programs.
3. Conferring with other professional personnel concerning the progress and needs of the recipients.
4. Providing individual instruction when needed.
5. Health observation including hygiene medication control/universal precautions.
6. Recipient abuse, neglect and mistreatment.

7. Knowledge of equipment and supplies needed for assigned activities.
8. Recipients rights and grievance procedures.
9. CPR first aid, medical emergencies.
10. Training on how to read and comprehend written materials, such as the care plan, and policy and procedures manuals.

Ongoing training will be conducted as needed but at least annually for above training requirements 6 and 8.
Additional Provider Requirements The provider of service
1. Must have required training prior to providing service;
2. Must keep record of required training in the personnel folder; and
3. Must maintain a service log that documents specific days on which services were delivered consistent with the recipient's individual person centered plan.
4. CPR, first aid, medical emergencies.
5. Management of challenging behavior.
6. Physical management techniques.
7. Health observation, including hygiene, medication control/ universal precautions.
8. Recipient abuse, neglect and mistreatment.
9. Habilitation training programs.

Verification of Provider Qualifications

Entity Responsible for Verification:

DMH/DDD Certification Surveyors

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*

Respite care is a service provided in or outside a family's home to temporarily relieve the primary caregiver. Respite care provides short-term care to an adult or child for a brief period of rest or relief for the family from day to day care giving for a dependent family member. Respite is intended for participants whose primary caregivers typically are the same persons day after day and is provided during those portions of the day when the caregivers typically provide care. Relief needs of hourly or shift staff workers will be accommodated by staffing substitutions, plan adjustments, or location changes, and not by respite care. Respite care typically is scheduled in advance, but it can also serve as relief in a crisis situation. As crisis relief, out of home respite can also allow time and opportunity for assessment, planning and intervention to try to re-establish the person in his home, or if necessary, to locate another home for him. In-home respite services can be self-directed and the EOR may hire/supervise/fire the employee delivering the services. A relative may serve as a self-directed respite worker to a waiver participant as long as the 1) the relative is not a legal liable relative or legal guardian, 2) the relative is not a primary caregiver to the participant, 3) the relative is otherwise qualified to provide these services and 4) the relative does not also serve as the same participant's representative/Employer of Record (EOR).

The person centered plan or an addendum shall specify any special requirements for training, more than basic training, which may be needed to support the individual. Individuals and their families shall be key informers on the matter of special training, and will be responsible for providing such training to their workers. The participant, EOR and worker must be trained on identifying Abuse, Neglect and Exploitation, who to report to and the timeframes to report any incidents.

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

Certified Waiver Hourly Services Provider Agency (Respite) and Self-Directed (Respite) limitations:

1. For provider agency provided service, the QDDP will provide and document in the case record on-site supervision of the respite care worker semi-annually. The QDDP will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performance by the worker.
2. In-home respite care, both provider delivered and self-directed, and out of home respite, is provided dependent on the individuals needs as set forth in the person centered plan and requires approval by the Division of Developmental Disabilities, subject to review by the Alabama Medicaid Agency.
3. The limitation on in home and out of home Respite Care in combination shall be 4320 15-minute units of service (equals 1080 hours or 45 days) per participant per waiver year.
4. Out of Home Respite will be accessible to individuals who self-direct their services. To receive Out-of-Home Respite services, a Certified DDD provider must be selected. Note that Waiver recipients will not reside in an adult foster care home, so there can be no duplication of billing for the two services.
5. For self-directed services, the services should be approved in the PCP prior to the request.

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 Waiver Hourly Services Provider (for In-Home Respite)
Agency	Community Residential Facility (for Out of Home Respite)
Individual	Self-Directed In-home Respite Services

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License *(specify):*

Al. Administrative Code Chapters 580-3-23, 580-3-25, 580-3-26, and 580-5-30 and DD Operational Policies

Certificate *(specify):*

Must be certified pursuant to Al. Administrative Code Chapters 580-3-23, 580-3-25, 580-3-26, and 580-5-30 and DD Operational Policies

Other Standard *(specify):*

Respite Care Provider Qualifications:

1. Must employ individuals to serve as In-Home Respite Care Workers who have the following verified qualifications:
   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. TB skin test as required by Alabama Medicaid Agency;
   v. If providing transportation, have valid driver's license and insurance as required by State Law. The provider agency shall assure the attendant has a good driving record and is in-serviced on safety procedures when transporting an individual

2. Any contracted agency undertaking the provision of this service must employ or contract with a QDDP to provide the required supervision and must meet the other requirements of this addendum related to training, plans of care, documentation and reporting.

Documentation:

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DMH/DDD Certification Surveyors

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Community Residential Facility (for Out of Home Respite)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Must be certified pursuant to Al. Administrative Code Chapters 580-3-23, 580-3-25, 580-3-26, and 580-5-30 and DD Operational Policies

Other Standard *(specify):*

Respite Care Provider Qualifications:

1. Must employ individuals to serve as In-Home Respite Care Workers who have the following verified qualifications:
   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. TB skin test as required by Alabama Medicaid Agency;
   v. If providing transportation, have valid driver's license and insurance as required by State Law. The provider agency shall assure the attendant has a good drivingrecord and is in-serviced on safety procedures when transporting an individual

2. Any contracted agency undertaking the provision of this service must employ or contract with a QDDP to provide the required supervision and must meet the the other requirements of this addendum related to training, plans of care, documentation and reporting.

3. Out of Home Respite will be accessible to individuals who self-direct their services. To receive Out-of-Home Respite services, a Certified DDD provider must be selected.

Documentation:

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DMH/DDD Certification Surveyors

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Self-Directed In-home Respite Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Respite Care Workers:

1. Self -Directed In-home Respite 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 provider agency shall assure the attendant has a good driving record and is in-serviced on safety procedures when transporting an individual.

A relative may serve as a self-directed respite worker to a waiver participant as long as the 1) the relative is not a legal liable relative or legal guardian, 2) the relative is not a primary caregiver for the participant, 3) the relative is otherwise qualified to provide these services and 4) the relative does not also serve as the same participant's representative/Employer of Record (EOR).

The EOR is responsible for the supervision, training and general oversight of the Respite worker.

Documentation:

The participant and EOR must maintain documentation of the dates and hours of service provided and provide this to the FMSA 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:

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.

A relative may serve as a self-directed respite worker to a waiver participant as long as the 1) the relative is not a legal liable relative or legal guardian, 2) the relative is not a primary caregiver to the participant, 3) the relative is otherwise qualified to provide these services and 4) the relative does not also serve as the same participant's representative/Employer of Record (EOR).

Frequency of Verification:

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:

Adult Companion Services

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Non-medical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. Providers may perform light housekeeping tasks that are incidental to the care and supervision of the individual.

This service is provided in accordance with a therapeutic goal in the person centered plan, and not purely diversional in nature. This service is needed to prevent institutionalization.

Services include:

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

Unlike Respite, this service is intended to be a regularly occurring service provided at hours of the day when the more involved service of Personal Care is not needed.
Services must be on the plan of care with documentation in the case record of need for service.

The service is 15-minutes of direct companion services provided to the participant, and does not include the worker's time of

travel to and from the place of work.

Self-Directed Adult Companion Services:

Self-Directed Adult Companion Services: This definition of Adult Companion Services is intended to allow participants and their families to recruit, hire, train, supervise, and if necessary, to discharge their own companion workers. The workers will be paid by a fiscal intermediary, also known as a FMSA (Financial Management Service Agency). (EOR).
Self-Directed Adult Companion services may not be provided to participants who lack the necessary support systems to ensure the responsibilities of employing staff are carried out and that the participant's security and wellbeing is maintained. Thus, this service would typically be provided to participants who live in their own homes with family members or other responsible relatives who can assist with the responsibilities of administering a self-directed services program.

Self-Directed Adult Companion may also be provided in settings where the individual lives in their own house or apartment alone or with others (not to include a certified residential setting), with the assistance of family or a circle of support, but the Regional Community Service Office must review and approve this arrangement before it can be reimbursed. The purpose of this review is to assure the support is near and frequent enough to carry out the needed tasks and also to assure there is no conflict of interest.

The person centered plan or an addendum shall specify any special requirements for training, more than basic training, which may be needed to support the individual. Individuals and their families shall be key informers on the matter of special training, and will be responsible for providing such training to their workers. The participant, EOR and worker must be trained on identifying Abuse, Neglect and Exploitation, who to report to and the timeframes to report any incidents.

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

A relative can provide Adult Companion through a traditional provider service and self-direction service (SDS). A legal liable relative can only provide this service through SDS.

Certified Waiver Hourly Services Provider requirements:

1. Companion services are limited to functionally impaired adults (age 21 and over).
2. Companion service is non-medical and does not include hands-on care.
3. Adult Companion services are allowed to be provided by a provider agency and self-directed employee; however, the services times must not overlap (double billing) or exceed the 12 hour/ 48 units per day for the person.
4. The provision of the service, and the number of units of service provided to each client, is dependent upon the individual's needs as set forth in the service plan of care.
5. Adult Companion services are not available to group home residents.

Self-Directed Adult Companion employee requirements:

1. Self-Directed Adult Companion Care may not be provided to participants who lack the necessary support systems to ensure the responsibilities of employing staff are carried out and that the participant's security and well-being is maintained.

2. Self-Directed Adult Companion Care may also be provided in settings where the individual lives in their own house or apartment alone or with others, with the assistance of family or a circle of support, but the Regional Community Service Office must review and approve this arrangement before it can be reimbursed. The purpose of this review is to assure the support is near and frequent enough to carry out the needed tasks and also to assure there is no conflict of interest.

3. When this service is provided to individuals living with their family/guardians, it shall not supplant the cost and provision of support ordinarily provided by family/guardians to individuals without disabilities.
4. Adult Companion services are allowed to be provided by a provider agency and a self-directed employee; however, the services times must not overlap (double billing) or exceed the 12 hour/ 48 units per day for the person.
5. A relative can provide Adult Companion through a traditional provider service and Self-Directed services (SDS). A legal liable relative can only provide this service through SDS.

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

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

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

☐ **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 Waiver Hourly Services Provider
Individual	Self-directed Adult Companion Employee

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Companion Services

Provider Category:

Agency

Provider Type:

Certified Waiver Hourly Services Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Al. Administrative Code Chapters 580-3-23, 580-3-25, 580-3-26, and 580-5-30 and DD Operational Policies

Other Standard *(specify):*

1. Must employ individuals to serve as Adult Companion Workers who have the following verified qualifications:
   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. TB skin test as required by Alabama Medicaid Agency;
   v. If providing transportation, have valid driver's license and insurance as required by State Law. The provider agency shall assure the attendant has a good driving record and is in-serviced on safety procedures when transporting an individual.

For provider agency provided service, the QDDP will provide and document in the case record on-site supervision of the Adult Companion worker semi-annually. The supervisor will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performance by the worker.

Verification of Provider Qualifications

Entity Responsible for Verification:

DMH Certification Surveyors

Frequency of Verification:

Prior to Contract Approval, Annually or Bi-Annually for already approved providers (based on previous survey score), or

more often as needed based on service monitoring concerns.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Companion Services

Provider Category:

Individual

Provider Type:

Self-directed Adult Companion Employee

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

1. Self -Directed Adult Companion 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

The EOR is responsible for the supervision, training and general oversight of the Self-directed Adult Companion Employee.

Training and Documentation Requirements:
This service is intended to promote self-determination of waiver participants.

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. A provider agency may employ a participant's relative, excluding a legal liable relative and/or a legal guardian, to provide adult companion services to the participant

A participant, or the participant's EOR, as applicable, may employ a relative, including a legal liable relative and/or a legal guardian, as a self-directed Adult Companion 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).

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Services Agency:

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.

The family and individual will be supported by a Financial Management Service Agency (FMSA). The FMSA will pay the workers employed by the family and participant, at least bi- weekly. Payment will be made on the basis of receipt of one

time-card per worker, which will document the hours the worker has worked during the bi-weekly pay period with an indication of the service rendered for that time period (i.e. adult companion, personal care).

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

a) Handle all payroll taxes required by law
b) Assist with the documentation of training and other qualifications of workers as required by the waiver, including verification of citizenship
c) Maintain records to assure the worker was qualified, the service was provided in accordance with the person centered plan
d) Furnish background checks on prospective employees
e) Provide the person and family with easy access to resolve problems with payroll and provide a notification route for any other issues that may arise. This means that the FMSA, if it hears that a change may be needed or that a backup plan needs to start, will notify the operating agency, the self directed liaison and the 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.
f) Also, the FMSA will help to assure the person and his or her family are and remain satisfied with the service

Frequency of Verification:

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:

Assistance in Community Integration

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

1. Conducting a community integration assessment identifying the participant's preferences related to housing (type, location, living alone or with someone else, identifying a roommate, accommodations needed, or other important preferences) and needs for support to maintain community integration (including what type of setting works best for the individual, assistance in budgeting for housing/living expenses, assistance in obtaining/accessing sources of income necessary community living, assistance in establishing credit and in understanding and meeting obligations of tenancy).
2. Assisting participant with finding and securing housing as needed. This may include arranging for or providing transportation.
3. Assisting participant in securing supporting documents/records, completing/submitting applications, securing deposits, and locating furnishings.
4. Developing an individualized community integration plan based upon the assessment as part of the overall Person Centered Plan. Identify and establish short and long-term measurable goal(s), and establish how goals will be achieved and how concerns will be addressed.
5. Participating in Person-Centered plan meetings at re-determination and/or revision plan meetings as needed.
6. Providing supports and interventions per the Person-Centered Plan (individualized community integration portion). Identify any additional supports or services needed outside the scope of Community Integration services and address among the team.
7. Supports to assist the individual in communicating with the landlord and/or property manager regarding the participant's disability (if authorized and appropriate), detailing accommodations needed, and addressing components of emergency procedures involving the landlord and/or property manager.
8. Assistance in Community Integration will provide supports to preserve the most independent living arrangement and/or assist the individual in locating the most integrated option appropriate to the individual.

A waiver recipient receiving this service will not also be authorized to receive the Housing Stabilization service.

Community Transitions Services are non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include: (a) security deposits that are required to obtain a lease on an apartment or home; (b) essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; (e) moving expenses; (f) necessary home accessibility adaptations; and, (g) activities to assess need, arrange for and procure need resources. Community Transition Services are furnished only to the extent that they are reasonable and necessary as determining through the service plan development process, clearly identified in the service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources. Community Transition Services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

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

Assistance in Community Integration Service must be:

a. Authorized and included in the participant's service plan;
b. Necessary for the participant's safe transition to the community;
c. Exclusive of expenses for monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for pure diversion or recreational purposes; or that are not necessary for the participant's safe transit
d. A waiver recipient receiving this service will not also be authorized to receive the Housing Stabilization 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
Agency	DMH Transition Services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistance in Community Integration

Provider Category:

Agency

Provider Type:

DMH Transition Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Bachelor's degree in a Human Services field, Business Administration, or Public Administration, with experience (24 months or more) in the identification and/or the accessing of housing resources.
Human services 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
Duties require constant contact with officials in the state mental health system, other agencies, housing authorities/organizations and the general public.

Verification of Provider Qualifications

Entity Responsible for Verification:

AL Department of Mental Health

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Assistive Technology Services

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Assistive technology means an item, piece of equipment to include Specialized Durable Medical Equipment (including any equipment not covered by Medicaid State Plan Services), service animal or product system, whether acquired commercially, modified or customized that is used to increase, maintain, or improve functional capabilities of participants.

Assistive technology services means a service that directly assist an individual in the selection, acquisition, or use of an assistive technology device that may include: (A) the evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant; (B) services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants; (C) services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices; (D) coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the service plan; (E) training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and (F) training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants.

Written orders from a physician or other licensed health care provider for non-prescription assistive technology items authorized in an individual's person-centered plan is required.

Providers of this service must maintain documentation of items purchased for each individual.

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

1. Written orders from a physician or other licensed health care provider for non-prescription assistive technology items authorized in an individual's person-centered plan are required for this service.
2. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the recipient.
3. Payment is for the cost of the item provided. There is a $5,000 per year, per individual maximum cost.
4. These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.
5. Self-Directed Assistive Technology is only available to those participants who are self-directing personal care, companion and/or LPN/RN services.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Medical Equipment and Services Providers
Agency	Assistive Technology Provider
Agency	Self Directed Home Medical Equipment Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology Services

Provider Category:

Agency

Provider Type:

Home Medical Equipment and Services Providers

Provider Qualifications

License *(specify):*

Alabama Code Chapter 34-14C-1 through 8

Certificate *(specify):*

Alabama Code Chapter 34-14C-1 through 8

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Initially and annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology Services

Provider Category:

Agency

Provider Type:

Assistive Technology Provider

Provider Qualifications

License *(specify):*

Business License

Certificate *(specify):*

Al. Administrative Code Chapters 580-3-23, 580-3-25, 580-3-26, and 580-5-30 and DD Operational Policies

Other Standard *(specify):*

ADMH Certified/Enrolled Providers

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH

Frequency of Verification:

Initial and annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology Services

Provider Category:

Agency

Provider Type:

Self Directed Home Medical Equipment Agency

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

FMSA

Frequency of Verification:

Upon purchase.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Benefits and Career Counseling

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03030 career planning
Category 2:	**Sub-Category 2:**
17 Other Services	17990 other
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

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

The Benefits Reporting Service (BRS) is designed to assist waiver participants/families to understand general information on how SSI/SSDI benefits are affected by employment. The BRS will be employed by a provider agency. The Benefits Reporting Agency (BRA) will receive referrals from a variety of sources, including Support Coordinators, families, service

providers, and CWIC housed in each region of the state. Once the participant enters employment, the BRS will be available to answer questions, assist in the execution the work incentive plan, and assist with the submission of income statement and/ or Impairment Related Work Expenses (IRWE) to SSA as required to the extent needed as indicated by the individual. The BRS must document services and activities.

The second service, Benefits Counseling, is a more intensive service provided by a Community Work Incentives Coordinator (CWIC) who will receive referrals from the BRA, Support Coordinators, family and/or service providers. CWICs will provide intensive individualized benefits counseling, benefits analysis, develop a work incentive plan and ongoing benefits planning for a participant changing jobs or for career advancement. The CWIC will work in conjunction with the BRA to develop trainings and webinars based on SSA information provided and may assist or provide trainings and education as needed. The CWIC will be available to work with waiver participants to provide information on waiver benefits and employment and may also assist with the submission of income statement and/ or Impairment Related Work Expenses (IRWE) to SSA as required to the extent needed as indicated by the individual .
BRA services and CWIC services must be documented and billed in 15 minute increments.

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

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

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

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **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	DMH or DVRS Certified Work Incentives Counselor
Agency	Supported Employment Provider

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

DMH or DVRS Certified Work Incentives Counselor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

AL Department of Mental Health Certification Surveyors

AL Department of Rehabilitation Services

Frequency of Verification:

CWIC: as needed to remain certified per the Social Security Administration.

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Supported Employment Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH/DD Certification Surveyors

Frequency of Verification:

Initially and biennially based or more frequently based on certification scores.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Experience

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Community Experience services are provided on either an individual or small group basis and are services that support non-work-activities and opportunities for community participation, involvement and relationships with the broader community that are customized to the individual’s interests and goals.

The intent of this service is to engage in non-paid activities that allow the person to either acquire new adaptive skills or support the person in utilizing and maintaining existing adaptive skills in order to enable the person to become actively involved in their community and acquire/maintain valued social roles. Community Experience services are directly linked to goals and expectations for community involvement, participation and membership identified in the person-centered plan. The intended outcome of these services is to facilitate and support access to the community and connections with members of the broader community, including increased skills and increased engagement with natural supports, paving the way for reduced need for paid supports. These services assist the participant in acquiring, retaining, or improving socialization and networking skills, independent use of community resources and community participation outside the place of residence. This service is specifically designed to offer waiver participants a choice to receive non-workday services exclusively in non-disability-specific, fully integrated settings.

Community Experience is provided outside of the person's residence and can be provided during the day, evening, or weekends.

Community Experience-Individual is delivered in a 1:1 staffing ratio for those at Day Habilitation Level 4 with a need for this intensity of staffing ratio, which is determined necessary through functional and health risk assessments (and a behavioral assessment that supports this specialized staffing if related to behavioral challenges) prior to approval. Community Experience Small Group services are provided to groups of no more than four participants, with a staff to participant ratio of 1:4 (maximum group size; minimum staffing ratio).

For self-directed services, the defined provider-managed staffing ratios apply only while the person-centered planning team is determining the number of units and reimbursement rates the participant qualifies for, based on assessed needs. These will

then be used to develop the individual budget. Once the budget is completed, the self-directing participant may decide whether the service will take place on a 1:1 basis or as part of a small group.

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

The person centered plan or an addendum shall specify any special requirements for training, more than basic training, which may be needed to support the individual. Individuals and their families shall be key informers on the matter of special training, and will be responsible for providing such training to their workers. The participant, EOR and worker must be trained on identifying Abuse, Neglect and Exploitation.

Participants who choose to self-direct the Community Experience service will continue at this time to have both employer and budget authority

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

1. Community Experience services may not involve paid work of any kind.
2. Community Experience is not available to any waiver participant who is also receiving services that include a facility-based component (i.e. Day Habilitation and/or Prevocational Services). If a waiver participant is receiving either of these services, the provider has an ability to provide these services in the community as well as in the facility, eliminating the need for a separate authorization of Community Experience services. Community Experience services are not facility-based and may not take place in a provider owned or controlled facility.
3. Community Experience cannot be billed during the same unit of time as any other face-to-face waiver service. Community Experience Services do not include educational services otherwise available through a program funded under 20 USC Chapter 3, section 1400 of the Individuals with Disabilities Education Act (IDEA). Community Experience services must not duplicate any Supported Employment services provided through the waiver.

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 Day Habilitation Program
Individual	Self Directed Community Experience (Individual)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Experience

Provider Category:

Agency

Provider Type:

Certified Day Habilitation Program

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Al. Administrative Code Chapters 580-3-23, 580-3-25, 580-3-26, and 580-5-30 and DD Operational Policies

Other Standard *(specify):*

1. Must employ individuals to serve as Community Experience Workers who have the following verified qualifications:
   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. TB skin test as required by Alabama Medicaid Agency;
   v. If providing transportation, have valid driver's license and insurance as required by State Law. The provider agency shall assure the attendant has a good driving record and is in-serviced on safety procedures when transporting an individual

Any contracted agency undertaking the provision of this service must employ or contract with a QDDP to provide the required supervision and must meet the other requirements of this addendum related to training, plans of care, documentation and reporting.

Verification of Provider Qualifications

Entity Responsible for Verification:

DMH Certification Surveyors

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Experience

Provider Category:

Individual

Provider Type:

Self Directed Community Experience (Individual)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Participants may hire employees of their choice for this service who must meet the same qualifications as Community Experience workers employed by a Day Habilitation Agency, or may choose to purchase the service from a Day Habilitation agency.

1. Self -Directed Community Experience 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. TB skin test, as required by Alabama Medicaid Agency
   v. If providing transportation, have valid driver's license and insurance as required by State Law. If providing

transportation, have valid driver's license and insurance as required by State Law. The FMSA shall ensure these requirements are documented

The EOR is responsible for the supervision, training and general oversight of the Self-directed Community Experience Worker.

Documentation:

The participant and EOR must maintain documentation of the dates and hours of service provided and provide this to the FMSA 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:

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.

Frequency of Verification:

Workers employed by individuals and families will have their qualifications verified initially by the FMSA, and no further verification is necessary unless a situation or qualification changes and the participant or family reports it to the FMSA. 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:

Crisis Intervention

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10030 crisis intervention
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

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

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

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

Service Definition *(Scope):*

Crisis Intervention provides immediate therapeutic intervention, available to an individual on a 24-hour basis, to address personal, social, and/or behavioral problems which otherwise are likely to threaten the health and safety of the individual or of others and/or to result in the individual's removal from his current living arrangement.

Crisis intervention may be provided in any setting in which the individual resides or participates in a program. The service includes consultation with family members, providers and other caretakers to design and implement individualized crisis treatment plans and provide additional direct services as needed to stabilize the situation.

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

When the need for this service arises, the service will be added to the person centered plan for the person. A separate crisis intervention plan will be developed to define in detail the activities and supports that will be provided. All crisis intervention services shall be approved, at least by phone followed up in writing, by the regional community service office of the DMH prior to the service being initiated.

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

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

For provider agency provided service, the QDDP will provide and document in the case record on-site supervision of the personal care worker semi-annually. The supervisor will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performance by the worker.

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

These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization

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

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

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

- ☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified Waiver Provider or DMH/DDD (State Agency) Regional Team

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Crisis Intervention

Provider Category:

Agency

Provider Type:

Certified Waiver Provider or DMH/DDD (State Agency) Regional Team

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Al. Administrative Code Chapters 580-3-23, 580-3-25, 580-3-26, 580-5-30, Behavioral Services Procedural Guidelines (BSPG), Psychological and Behavioral Service (PBS), IPMS, and DD Operational Policies and Procedures.

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DMH/DDD Certification Surveyors

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Environmental Accessibility Adaptations

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

All services shall be provided in accordance with applicable State or local building codes and ADA standards.

Payment is for the cost of material and labor. The unit of service would be the job. This service does not require a prescription from the participant's physician

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

1. Rental and leased property are excluded from modifications as it the landlord's responsibility for ensuring property is accessible, however, in the event that costs prohibits adaptations, some modification could be considered, such as, modular ramps or any that could be moved if the individual changes residence.
2. Adaptations to the work environment covered by the Americans with Disabilities Act, or those that are the responsibility of other agencies, are not covered.
3. Adaptations or improvements to the home which are of general utility and not of direct medical or remedial benefit to the waiver individual, such as carpeting, roof repair, central air conditioning, etc. are excluded from this benefit.
4. Adaptations that add to the total square footage of the home are excluded from this benefit.
5. Covered adaptations of rented or leased homes must be those extraordinary alterations that are uniquely needed by the individual and for which the property owner would not ordinarily be responsible.
6. Total costs of environmental accessibility adaptations shall not exceed $5,000 per year, per individual.
7. All other community resources should be explored and exhausted prior to expending waiver funding.
8. Self-Directed Environmental Accessibility Adaptations are only available to those participants who are self-directing personal care and/or LPN/RN services.

9. A relative may serve as a self-directed provider as long as the 1) the relative is otherwise qualified to provide these services and 2) the relative does not also serve as the same participant's representative/Employer of Record (EOR).

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	Contractor
Agency	Self Directed Contractor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Agency

Provider Type:

Contractor

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

All construction, wiring, plumbing meets applicable building codes.

Verification of Provider Qualifications

Entity Responsible for Verification:

Alabama Licensing Board for General Contractors

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Agency

Provider Type:

Self Directed Contractor

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

All construction, wiring, plumbing meets applicable building codes.

Verification of Provider Qualifications

Entity Responsible for Verification:

Alabama Licensing Board for General Contractors.

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Housing Stabilization Service

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Housing Stabilization Service enables waiver participants to identify housing options, select housing based on their need and income, and/or maintain their own housing as set forth in the participant's approved person centered plan (PCP). Services must be provided in the home or a community setting. The service includes the following components:

1. Conducting a Housing Coordination and Stabilization Assessment identifying the participant's preferences related to housing (type, location, living alone or with someone else, identifying a roommate, accommodations needed, or other important preferences) and needs for support to maintain housing (including accessing housing, meeting terms of lease, and eviction prevention), budgeting for housing/living expenses, obtaining/accessing sources of income necessary for rent, home management, establishing credit and understanding and meeting obligations of tenancy as defined in lease terms.
2. Assisting participant with finding and securing housing as needed. This may include arranging or providing transportation.
3. Assisting participant in securing supporting documents/records, completing/submitting applications, securing deposits, and locating furnishings.
4. Developing an individualized housing stabilization plan based upon the Housing Coordination and Stabilization Assessment as part of the overall Person Centered Plan. Identify short and long-term measurable goal(s), establishes short and long-term goals, establish how goals will be achieved and how concerns will be addressed, and identifies where other provider(s) or services may be needed in order to achieve the goal(s).
5. Participating in Person-Centered plan meetings at redetermination and/or revision plan meetings as needed.
6. Providing supports and interventions per the Person-Centered Plan (individualized housing stabilization portion). Identify any additional supports or services needed outside the scope of Housing Stabilization Services and address among the team.
7. Communicating with the landlord and/or property manager regarding the participant's disability (if authorized and appropriate), detailing accommodations needed, and addressing components of emergency procedures involving the landlord and/or property manager.
8. If at any time the participant's housing is placed at risk (i.e., eviction, loss of roommate or loss of income), Housing Stabilization Services will provide supports to retain housing or locate and secure new housing or sources of income to continue community based supports which includes locating new housing, sources of income, etc.

A waiver recipient receiving this service will not also be authorized to receive the Assistance in Community Integration service.

Stable housing is critical for preventing unnecessary institutionalization and is a recognized social determinant of health. Stable housing promotes better outcomes in terms of such factors as physical health and mental health which, if compromised, can lead to increased risk of institutionalization.

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

Housing Stabilization Service must be:

a. Authorized and included in the participant's service plan;
b. Necessary for the participant's safe transition to the community, or to increase independence;
c. Exclusive of expenses for monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for pure diversion or recreational purposes; or that are not necessary for the participant's safe transit
d. A waiver recipient receiving this service will not also be authorized to receive the Assistance in Community Integration 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
Agency	DMH Transition Services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Housing Stabilization Service

Provider Category:

Agency

Provider Type:

DMH Transition Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

AL Department of Mental Health

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Individual Directed Goods and Services

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Individual Directed Goods and Services are available only to those participants who self-direct one or more service and must be specified in the self-directed budget. Through this service, self-directing participants can choose to establish a Budget Savings Account with their budget dollars and use their savings to purchase allowable goods and services.

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

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

It is preferable that individual goods and services needs are identified during the yearly redetermination for services. During the person-centered planning meeting, the person's budgetary and employer authority will be discussed along with what is considered acceptable and not acceptable uses of this service and a list will be provided to the person (and family) indicating items that are strictly prohibited. It is during this time that the person may identify items of interest.

In order to purchase allowable goods and services, self-directing participants will establish a Budget Savings Account. Participants may re-allocate funds in the Individual Budget to the Budget Savings Account and/or may accumulate funds through a process known as wage negotiation. To ensure proper use of waiver dollars within a participant's savings account,

purchases for goods and services are subjected to prior approval processes as specified in the associated Self-Directed Handbook.

As a part of the person-centered planning process, the participant's decisions related to these expenditures must be documented in the PCP and individual budget documentation. The Self-Directed Liaison will use this information to document the Spending Plan for the individual. The Individual Budget and Spending Plan will be provided to the participant, the participant's Support Coordinator and the FMSA.

Participants and their representatives have the responsibility to make sure their expenditures do not exceed the amount of their Budget Savings Account. The FMSA will monitor the participant's spending and will provide regular reports to help participants and representatives monitor their savings utilization. Any modifications to the to the Individual Budget and Spending Plan must be preceded by a change in the PCP. The Support Coordinator will collaborate with participants to make the needed changes.

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

1. Individual Goods and Services are limited to those individuals self-directing services.
2. The support coordinator must document the need for any item or service, including how it addresses achieving one of the approved outcomes in the PCP.
3. Items, goods or services that are not for the primary benefit of the participant are prohibited.
4. Items, goods or services that are unrelated to the person's assessed long-term support needs and outcomes related to those needs are prohibited.
5. Experimental or prohibited treatments are excluded, as well as room and board; items solely for entertainment of recreation; cigarettes and alcohol.
6. Individual Goods and Services can only be funded through the PCP individual budgeting process, through either a planned re-allocation of funds available in the overall self-directed budget or through savings generated by wage negotiations. The individual budget must document the source of the funds for each expenditure.
7. The limits on amount, frequency and duration for each item or service should be documented in the PCP and the self-directed individual budget.
8. Dollars can be accumulated past the fiscal year, however, cannot exceed $10,000.00 at any given time. The Support Coordinator /liaison will be responsible for monitoring the balances of the savings to ensure proper utilization.
9. Expenditures at any given time are limited to the balance of the individual's savings account maintained by the FMSA.
10. Available state plan services and waiver service funds must be expended prior to utilizing the Individual Goods and Services funds. The Support Coordinator should ensure that state plan services are utilized first, followed by waiver funded services as appropriate. Individual Goods and Services can be used to pay for items that are in excess of those allowed by state plan services or when a participant has reached his yearly cap.
11. Individual Goods and services can be utilized prior to expenditure of waiver funds in the event there are no providers accessible in the participant's area. This must be documented in the case record.
12. If an individual returns to traditional waiver services the ability to access any dollars from the savings account and utilize this service will be terminated.
13. Dollars not utilized will be refunded to the Division of Developmental Disabilities.

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Home Health Care Agency or Other Merchants or Contractors

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Al. Administrative Code Chapters 580-3-23, 580-3-25, 580-3-26, and 580-5-30 and DD Operational Policies

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Annually or at the time of purchase.

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

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

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

A relative, may provide self-directed goods or services to a self-directing waiver participant as long as the 1) the relative is otherwise qualified to provide these services and 2) the relative does not also serve as the same participant's representative/Employer of Record (EOR).

Verification of Provider Qualifications

Entity Responsible for Verification:

Self Directed Liaison
Financial Management Services Agency (FMSA)

Frequency of Verification:

Annually or at the time of purchase

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Occupational Therapy

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

Consultation/Training Services to direct caregivers will be allowed when the service to caregivers is for the direct benefit of the recipient and is necessary to enable the recipient to be cared for outside of an institution.

These services are limited to services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

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

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

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	Licensed Occupational Therapist

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:

Licensed Occupational Therapist

Provider Qualifications

License *(specify):*

Occupational Therapists are licensed under the Code of Alabama, 1975 Sec. 34-39-5

Certificate *(specify):*

Al. Administrative Code Chapters 580-3-23, 580-3-25, 580-3-26, and 580-5-30 and DD Operational Policies

Other Standard *(specify):*

ADMH must verify that the therapist has not been debarred from providing services by Medicaid or Medicare at the time of initial hiring followed by monthly reviews of INDIVIDUALS EXCLUDED FROM PARTICIPATING IN THE ALABAMA TITLE XIX (MEDICAID) PROGRAM located on AMA website and the OIG website. Documentation of the monthly checks is required for each worker.

Verification of Provider Qualifications

Entity Responsible for Verification:

DMH/DDD Certification Surveyors

Frequency of Verification:

Prior to Contract Approval Annually for already approved providers or more often as needed based on service monitoring concerns.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Emergency Response System

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Personal emergency response system (PERS) is a service that provides a direct telephonic or other electronic communications link between someone living in the community and health professionals to secure immediate assistance in the event of a physical, emotional or environmental emergency. PERS may also include cellular telephone service used when a conventional PERS is less cost-effective or is not feasible. This service may include installation, monthly fee (if applicable), upkeep and maintenance of devices or systems as appropriate. The use of these technologies requires assurance that safeguards are in place to protect privacy, provide informed consent, and that documented needs are addressed in the least restrictive manner.

PERS Minimum Requirements: 1) Provide an alert button or other mechanism that can be activated by the person to indicate the needs for emergency assistance and/or utilize technology to detect a possible adverse event indicating the need for immediate response. 2) Immediately transmit/communicate the alert to a central clearinghouse that maintains 24/7 immediate/real time recognition of and response to the alert and includes a "failsafe" procedure that assures that every alert for assistance is responded to in a timely manner as defined in the person's person centered plan or PERS parameters. 3) A call tree that reflects the person's needs and preferences. 4) Assurance that any agency or individual who creates, collects, records, maintains, stores, or discloses any individually identifiable participant data complies with the Health Insurance Portability and Accountability Act (HIPAA) and all other data privacy laws and requirements. 5) Address the documented risk factors and preferences of the person.

The person centered plan must identify options available to meet the need of the individual in terms of preference while also ensuring health, safety, and welfare. Personal risk factors should be discussed, information regarding data collection should be discussed, customized list of individuals/providers to be notified of alerts should be customized, who will be allowed access to data (service provider/staff), and choice should be afforded between providers both equipment and monitoring. The person centered plan should also include the purpose of the PERS, back-up system for PERS in times of electronic outages or failure, training of caregiver (paid and unpaid), provider/caregiver response time for different events, safeguards for protection of the person's privacy related to remote support and data collection. If remote support includes video (in person's bedroom), informed consent must be addressed (and documented) and privacy concerns should be addressed.

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

1. Emergency Response System installation and testing is approximated to cost $500.00;
2. Emergency Response Monthly Service Fee (excludes installation and testing) is approximated to cost no more than $83.00/month;
3. Emergency Response system purchase is approximated to cost $1,500.00.
4. The maximum cost for all PERS per year is $3000.00
5. This service will not be authorized for person's receiving residential habilitation.
6. PERS will not replace supervision and monitoring of activities of daily living which are provided to meet requirements of another service (i.e. personal care; day habilitation).
7. Self-directed PERS is only available to those participants who are self-directing personal care and/or LPN/RN 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	Self Directed authorized PERS vendor
Agency	Service Provider Agency and authorized PERS vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System

Provider Category:

Agency

Provider Type:

Self Directed authorized PERS vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The PERS provider should assure that these devices, where applicable, meet Federal Communication Commission standards or Underwriters Laboratory standards or the equivalent.

The installation of PERS systems should be done by qualified installers representing the health agency managing the personal emergency response system. In the event these installers are not available the vendor should seek experienced technicians to complete necessary line adaptations.

Verification of Provider Qualifications

Entity Responsible for Verification:

FMSA

Frequency of Verification:

At time of purchase.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System

Provider Category:

Agency

Provider Type:

Service Provider Agency and authorized PERS vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The PERS provider must assure that these devices, where applicable, meet Federal Communication Commission standards or Underwriters Laboratory standards or the equivalent.

The installation of PERS systems must be done by qualified installers representing the health agency managing the personal emergency response system. In the event these installers are not available the health agency must use experienced

technicians to complete necessary line adaptations.

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH

Frequency of Verification:

At time of purchase.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Physical Therapy

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

therapy, and outcomes or milestones to be reached by the participant. The PT should recommend exercises to the participant/family that will be completed at home that will help to ensure maximum potential is reached. The evaluation of an individual to determine level of functioning by applying diagnostic and prognostic tasks and providing treatment training programs that are designed to: preserve and improve abilities for independent function, such as range of motion, strength, tolerance, coordination and facility performing activities of daily living; and prevent irreducible progressive disabilities through means such as the use of orthotic and prosthetic appliances, assistive and adaptive devices, positioning, behavior adaptations and sensory stimulation. If an evaluation from a physical therapist is required for Environmental Accessibility Adaptations, expenses for the evaluation is covered by this physical therapy service.

Therapist may also provide consultation and training to staff or caregivers (such as individuals family and/or other caregiver). Services to direct caregivers will be allowed when the service to caregivers is for the direct benefit of the recipient and is necessary to enable the recipient to be cared for outside of an institution.

These services are limited to services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization

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

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

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

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **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	Licensed Physical Therapist

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:

Licensed Physical Therapist

Provider Qualifications

License *(specify):*

Physical Therapists are licensed under the Code of Alabama, 1975 Sec.34-24-212

Certificate *(specify):*

Al. Administrative Code Chapters 580-3-23, 580-3-25, 580-3-26, and 580-5-30 and DD Operational Policies

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH must verify that the PT has not been debarred from providing Medicaid/Medicare services at initial hiring followed by monthly reviews of INDIVIDUALS EXCLUDED FROM PARTICIPATING IN THE ALABAMA TITLE XIX (MEDICAID) PROGRAM located on AMA website and/or the OIG website. Documentation of the checks is required.

Frequency of Verification:

Prior to Contract Approval, Annually for already approved providers or more often as needed based on service monitoring concerns. Exclusion lists must be checked 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:

Positive Behavior Support

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10040 behavior support
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

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

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

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

Service Definition *(Scope):*

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

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

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

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

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

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	Individual employed or contracted by a certified agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Positive Behavior Support

Provider Category:

Agency

Provider Type:

Individual employed or contracted by a certified agency.

Provider Qualifications

License *(specify):*

AL Licensed
Behavior Analyst

Certificate *(specify):*

Board Certified Behavior Analyst or Assistant

Other Standard *(specify):*

Three levels of provider may provide Positive Behavior Support services. The qualifications are as follows:

Level 1: Providers must have either a Ph.D. or M.A. and be certified as a Behavior Analyst (BCBA) by the Behavior Analysis Certification Board. BCBAs must also maintain an active licensure as a Behavior Analyst in Alabama or Alabama Licensed Psychologists.

Behavior Analyst Certification Board
7950 Shaffer Parkway
Littleton, CO 80127
Fax (720) 468-4145, Website www.bacb.com

Level 2: Providers must be a Board-Certified Assistant Behavior Analyst (BCaBA), or have either a Doctoral or Master's level degree in the area of Behavior Analysis, Psychology, Special Education, Social Work, Counseling, Speech/Language Pathology, or a related field and three years experience working with persons with Intellectual/Developmental Disabilities. Level 2 providers with a Doctorate in the above identified disciplines do not require supervision. Other Level 2 providers require supervision averaging at a minimum of one hour per week by either a Level 1 provider or a Level 2 Doctoral provider.

Level 3: Providers must be either a Registered Behavior Technician (RBT) or a QDDP (per the standard at 43 CFR 483.430). Level 3 providers require supervision averaging at a minimum of one hour per week by either a Level 1 provider or a Level 2 Doctoral provider or professionals in training.

All PBS service providers must complete a Positive Behavior Supports Orientation Training. This will consist of training to ensure providers are aware of the minimum standards of practice outlined in the AL Behavioral Services Procedural Guidelines adopted by the Department. The AL Behavioral Service Procedural Guidelines (BSPG) were established as standards and safeguards for providing behavioral services for persons with intellectual disabilities in the state of Alabama.

The AL Behavioral Services Procedural Guidelines must be adhered to as the minimum requirements for all individuals enrolled in HCBS waiver programs that receive behavioral services, supports, and planning, to include use of specialized staffing as well as any rights restrictions used to address behavioral challenges. It is recommended a copy of the Guidelines be made available at the site where services are taking place, for all who are involved in day-to-day behavioral services, and all HCBS provider and related staff should be trained on its contents. Providers must also complete any additional orientation training refresher courses when BSP Guidelines have been updated. The DMH will maintain a record of their PBS orientation attendees. The provider agency will maintain a record of their qualified PBS Service Providers and who is supervising the Level 3 provider and will make available upon request/audit.

Verification of Provider Qualifications

Entity Responsible for Verification:

DMH/DDD Certification Surveyors

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

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:**

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**

○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

The 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:

These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

- 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 a 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, Regional Office Staff 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 Regional Office Staff 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.

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	Paid Back Up Support Worker
Agency	Technology Installer
Individual	Paid Back Up Support Worker

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 Worker

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 of Remote Supports technology with previous experience and current capability to provide Remote Supports services.

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:

Technology Installer

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 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: Other Service
Service Name: Remote Supports

Provider Category:

Individual

Provider Type:

Paid Back Up Support Worker

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 in Remote Support service

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: 05 Nursing

Sub-Category 1: 05020 skilled nursing

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service Definition *(Scope):*

Nursing procedures that meet the person's health needs as ordered by a physician in the participant's person-centered plan that are within the scope of the State's Nurse Practice Act and provided by a registered professional nurse (RN), or licensed practical or vocational nurse (LPN) under the supervision of an RN licensed to practice in the State. The RN must complete an in-home assessment to determine if services may be safely and effectively administered in the home and identify the need for service and the amount of time needed. The RN must will use the Person Centered Plan complying with the physician's orders and person-centered plan and consistent with the findings of the in-home assessment. LPNs may provide skilled care for the recipient under the supervision of the RN and consistent with the Nursing Person Centered Plan. The RN will use the Person Centered Plan prior to assigning services to the LPN. The RN must make monthly supervisory visits to evaluate the appropriateness of services rendered by the LPN. There is no restriction on the place of service.

Skilled Nursing services are billed at an hourly rate, except that when the administration of a Home Visit Intramuscular (IM) Injection occurs as a distinct service at time during which no other skilled nursing procedures are provided, it is billed at a distinct quarterly hour rate.

Skilled Nursing services does not include delegating nursing skills to Personal Care, Adult Companion and/or Respite Care workers including:

- Providing direct medical care (i.e., tube feeding, injections) to waiver participant.
- Directly distributing medication to waiver participant either orally or via injection.

The RN/LPN may provide the following to immediate family members:

- Education to family about the participant's medications.
- Education about potential drug interactions with other medications and/or foods.
- Education about wound care and turning the individual to prevent bed sores.
- Education about how to check vitals such as temperature, blood pressure and oxygen level using appropriate medical equipment.

The RN/LPN may provide the following training to immediate family members, Personal Care, Adult Companion and/or Respite Care workers:

- Education on how to assist with Activities of Daily Living.
- Education on basic first aid.
- Education about how to operate basic medical equipment such as a lift chair, Hoyer lift, wheelchair etc.
- Education about transferring individuals (from bed to chair; from chair to vehicle, etc.).
- Education about assistance with self-administered medications.

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

- RN/LPN Services must be prescribed by a physician and based upon the individual's assessed need. The need for continued nursing must be ordered by the individual's physician every year at the time of the annual redetermination.

• These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Registered or Licensed Practical Nurse
Individual	Registered or Licensed Nurse Employed by a Self Directing Participant or Family

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:

Agency

Provider Type:

Registered or Licensed Practical Nurse

Provider Qualifications

License *(specify):*

Nurses are licensed under the Code of Alabama; 1975 Sec.34-21

Certificate *(specify):*

Nurses typically are employed by certified waiver providers, certified under Al. Administrative Code Chapters 580-3-23, 580-3-25, 580-3-26, and 580-5-30, Nurse Delegation Program and DD Operational Policies and Procedures.

Other Standard *(specify):*

The service(s) of the nurse must be documented by a nursing note that includes the identity and Medicaid number of the individual, 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 individual's condition, follow-up measures, communications with family, care-givers or physicians, training or other pertinent information. The nurse must sign and date the note. A record of the RN/LPN visit will be captured by an Electronic Visit Verification Monitoring system.

Must employ individuals who have the following verified qualifications:

ii. Be at least 18 years of age

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

iv. Must pass a pre-employment drug screen;

v. TB skin test as required by Alabama Medicaid Agency.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Alabama Board of Nursing verifies nursing licenses. DMH/DDD Certification Surveyors verify waiver provider certification. The Employer must verify that the RN/LPN has not been debarred from providing Medicaid/Medicare services

at initial hiring followed by monthly reviews of INDIVIDUALS EXCLUDED FROM PARTICIPATING IN THE ALABAMA TITLE XIX (MEDICAID) PROGRAM located on AMA website and/or the OIG website. Documentation of the checks is required.

Frequency of Verification:

Nursing licenses are renewed annually. Exclusion lists are viewed monthly and require documentation that the check was completed. Waiver provider certification occurs prior to Contract Approval, Annually or Bi-Annually for already approved providers (based on previous survey score), or more often as needed based on service monitoring concerns.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:

Individual

Provider Type:

Registered or Licensed Nurse Employed by a Self Directing Participant or Family

Provider Qualifications

License *(specify):*

The FMSA (Financial Management Services Agency) will hold the provider enrollment by permission of the Alabama Medicaid Agency.

Certificate *(specify):*

Other Standard *(specify):*

The service(s) of the nurse must be documented by a nursing note that includes the identity and Medicaid number of the consumer, the date of service, the beginning and ending time of the service, and the nursing service(s) provided within that time. In addition the nursing note should include, as appropriate, the nurse's assessment, changes in participant's condition, follow-up measures, communications with family, care-givers or physicians, training or other pertinent information. The nurse must sign and date the note. A record of the RN/LPN visit will be captured by an Electronic Visit Verification Monitoring system.

Must employ individuals who have the following verified qualifications:

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;

A relative or legally responsible caretaker who is also a licensed nurse cannot provide Skilled Nursing waiver services to the participant.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Alabama Board of Nursing verifies nursing licenses. The FMSA (Financial Management Services Agency) will verify the nurse is Licensed. The Employer must verify that the RN/LPN has not been debarred from providing Medicaid/Medicare services at initial hiring followed by monthly reviews of INDIVIDUALS EXCLUDED FROM PARTICIPATING IN THE ALABAMA TITLE XIX (MEDICAID) PROGRAM located on AMA website and/or the OIG website. Documentation of the checks is required. Licenses for Nursing are renewed annually. The FMSA verification will be annual as well. The Exclusion list must be checked monthly by the FMSA and documented.

Frequency of Verification:

Licenses for Nursing are renewed annually. The FMSA verification will be annual as well. The Exclusion list must be checked monthly by the employer. Documentation is required to ensure the checks are completed each month.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialized Medical Supplies

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14032 supplies
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Specialized medical supplies are those which are specified in the person centered plan and are necessary to maintain the individual's health, safety and welfare, prevent further deterioration of a condition, or increase an individual's ability to perform activities of daily living. This includes personal protective equipment (PPE). Specialized medical supplies are supplies that address the participant's physical health and any ancillary supplies. All items shall meet applicable standards of manufacture and design.

Written orders from a physician or other licensed health care provider for non-prescription specialized medical supply items authorized in an individual's person-centered plan is required.

Providers of this service must maintain documentation of items purchased for each individual.

These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

1. Written orders from a physician or other licensed health care provider for non-prescription specialized medical supply items authorized in an individual's person-centered plan is required.

2. Supplies reimbursed under this service shall not include common over-the-counter personal care items, supplies otherwise furnished under the Medicaid State plan, and items which are not of direct medical or remedial benefit to the recipient and does not include items such as soap, cotton swabs, toothpaste, deodorant, shampoo or sanitary items.
3. Costs for medical supplies are limited to $2400 per year, per individual and must be prescribed by the participant's physician.
4. This service is not available to participants under the age of 21 years as medical supplies are covered through EPSDT for this age group.
5. Self-directed medical supplies services are available only to those participants who are also self-directing personal care and/or LPN/RN services

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

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Self Directed Medical Supplies Vendor
Agency	Specialized Medical Supplies Vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Supplies

Provider Category:

Individual

Provider Type:

Self Directed Medical Supplies Vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Authorized Medical Supplies Vendor

Verification of Provider Qualifications

Entity Responsible for Verification:

FMSA

Frequency of Verification:

Initially and Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Supplies

Provider Category:

Agency

Provider Type:

Specialized Medical Supplies Vendor

Provider Qualifications

License *(specify):*

Business License

Certificate *(specify):*

Certified by the Board of DME and DMH Certification

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH

Frequency of Verification:

Initially and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

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:**

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

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

Service Definition *(Scope):*

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

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

Services must be listed on the care plan and prescribed by the participant's physician and related to a participant's particular diagnosis. An evaluation is required by the speech therapist to determine the need for service. If there is a need for service, the Speech Therapist must develop the treatment plan outlining the frequency of service and length of time expected to meet outlined goals and expected outcomes. The need for service must be documented in the case record and the outcome is expected improvement for the waiver participant. Speech and Language Therapy is limited 30 visits in any one planned therapy program. The service is expected to terminate when the goals of the developed treatment plan are met or when no further progress is anticipated. However, a request for an extension of therapy, up to an additional 30 visits, complete with proper justification showing the progress toward the goal(s) must be submitted by the case manager to the Regional Office Staff for approval following the regular RFA established process. Services shall be provided and billed as an encounter unit of service and with only one encounter daily.

Documentation of service provided by the Speech Therapist is required for each encounter and each note must be signed by the therapist. Notes must be maintained in the individual's file. Speech/Language Therapy must be due to an acute episode and should terminate once therapy becomes maintenance in nature. Speech/language therapy under the waiver is not available to children under the age of 21 when provided as the result of an EPSDT screening, because that service is covered under the State Plan, and is not available to adults when the service is covered under the State Plan. Group therapy will not be reimbursed.

These services are limited to services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Providers of service must maintain a service log that documents specific days on which speech and language therapy services were delivered and detailed documentation of what the service entailed. Therapist must keep notes and document participant progress toward the planned goals. Documentation of progress toward specific goals are required.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **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	Licensed Speech Therapist

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:

Licensed Speech Therapist

Provider Qualifications

License *(specify):*

Speech Therapists are licensed under the Code of Alabama, 1975 Sec. 34-28A-1, Ch. 870-x-1-7

Certificate *(specify):*

Al. Administrative Code Chapters 580-3-23, 580-3-25, 580-3-26, and 580-5-30 and DD Operational Policies and Procedures

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DMH/DDD Certification Surveyors.

Frequency of Verification:

Prior to Contract Approval, Annually for already approved providers or more often as needed based on service monitoring concerns.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Supported Employment Transportation

HCBS Taxonomy:

Category 1:	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:**

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

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

Service Definition *(Scope):*

Employment transportation is the provision of service to permit waiver participants access to and from their place of employment in the event that the support team is unable to facilitate transportation through other means. The Team's efforts to secure transportation must be documented in the case record. The provision of this service must be necessary to support the person in work related travel and cannot be reimbursed for merely transportation. This service shall not duplicate or replace the Medicaid non-emergency medical transportation program. In addition, this does not preclude other arrangements such as transportation by family or friend. It is the expectation that, as part of the person-centered planning process and employment outcomes, that long term transportation to and from the worksite will be facilitated and arranged.

Payments for this service will be reimbursed based on the IRS mileage rate and requires documentation (i.e. vendor receipt or travel log) of service or by mile. The unit of service is a mile.

Transportation must be provided by public carriers (i.e. charter bus or metro transit bus) or private carriers (i.e. Taxicab). Commercial transportation, including day or residential provider agency - Must have a business license. All drivers must have a valid driver’s license of appropriate type (e.g. commercial) for transport in Alabama. A list of transportation resources by county is posted on the Department of Mental Health's website. Information regarding the provider’s cost of an insurance waiver to cover any harm that might befall the participant as a result of being transported, and the driver’s license and insurance, is documented by the service provider and verified during ADMH certification. Since the payment made for mileage includes the provider’s cost of an insurance waiver to cover any harm that might befall the participant as a result of being transported, no invoice is necessary.

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

The unit of service is a mile, to be reimbursed at the IRS federal mileage rate and is based on adequate documentation. Documentation for reimbursement includes actual receipts from public or private transportation providers or mileage logs and should also include progress toward obtaining long term transportation as part of measuring the employment outcomes.

Payment made for mileage includes the provider’s cost of an insurance waiver to cover any harm that might befall the participant as a result of being transported. The attendant must have a valid driver’s license and his/her own insurance coverage as required by State law. The provider agency shall assure the attendant has a good driving record and receives in-service training on safety procedures when transporting a participant. It shall not replace transportation that is already reimbursable under the day habilitation nor Medicaid non-emergency medical transportation program. This service is reserved for only those waiver participants who are employed. The planning team must also assure the most cost effective means of transportation, which would include public transport where available. Employment Transportation is not intended to replace generic transportation or to be used merely for convenience.

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

☐ **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	Taxi or Common Carrier (Uber, Lyft)
Agency	Certified Waiver Hourly Services Provider
Agency	Public Mass Transit
Agency	Certified Day Habilitation Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Employment Transportation

Provider Category:

Agency

Provider Type:

Taxi or Common Carrier (Uber, Lyft)

Provider Qualifications

License *(specify):*

Valid driver's license (called a Class D).

Certificate *(specify):*

Other Standard *(specify):*

Taxi drivers and chauffeurs in Alabama are required only to have a regular current, valid driver's license (called a Class D) and a business license, to operate.

Verification of Provider Qualifications

Entity Responsible for Verification:

AL Department of Public Safety: Local Driver's Licensing Office or Probate Court.

Frequency of Verification:

Every four years.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Supported Employment Transportation

Provider Category:

Agency

Provider Type:

Certified Waiver Hourly Services Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Al. Administrative Code Chapters 580-3-23, 580-3-25, 580-3-26, and 580-5-30 and DD Operational Policies and Procedures

Other Standard *(specify):*

Must have valid driver’s license and insurance as required by State Law.

Verification of Provider Qualifications

Entity Responsible for Verification:

DMH/DDD Certification Surveyors

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Employment Transportation

Provider Category:

Agency

Provider Type:

Public Mass Transit

Provider Qualifications

License *(specify):*

CDL License

Certificate *(specify):*

Other Standard *(specify):*

Those who want to drive school buses, church buses, shuttles or charter buses carrying 16 or more passengers, must get a Commercial Driver's License Endorsement Class C on their regular driver's license.

Verification of Provider Qualifications

Entity Responsible for Verification:

AL Department of Public Safety: Commercial Driver's License Office.

Frequency of Verification:

Every four years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Employment Transportation

Provider Category:

Agency

Provider Type:

Certified Day Habilitation Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Al. Administrative Code Chapters 580-3-23, 580-3-25, 580-3-26, and 580-5-30 and DD Operational Policies and Procedures

Other Standard *(specify):*

If providing transportation, must have valid driver's license and insurance as required by State Law.

Verification of Provider Qualifications

Entity Responsible for Verification:

DMH/DDD Certification Surveyors

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Supported Living Service

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08010 home-based habilitation
Category 2:	**Sub-Category 2:**

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

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

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

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

Service Definition *(Scope):*

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

The service shall support the individual's full integration into the community, ensure the person's choice and rights, and comport fully with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, including the provision of opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources. Further, supports shall be provided in a manner which ensures an individual's rights of privacy, dignity, respect and freedom from coercion and restraint; and which optimizes individual initiative, autonomy, and independence in making life choices. Any modification to one or more of these HCBS setting standards must be supported by the individual's specific assessed need and fully documented in the person-centered plan (PCP), along with a plan to reduce or eliminate the modification as soon as prudent, as required by federal regulation.

The service also includes oversight and assistance in managing self-administered medication and/or medication administration as permitted under Alabama's Nurse Practice Act and performance of other non-complex health maintenance tasks, as permitted by State law. The Supported Living Services provider shall monitor the health care needs of the person supported and support the person to attend to their own health care needs and/or work with natural supports to ensure the person's health care needs are addressed.

This service is appropriate for people who need intermittent staff support to remain in their own home and do not require 24/7 staffing. However, access to emergency supports as needed from the provider on a 24/7 basis is an essential component of this residential service and is what differentiates it from Personal Assistance services. The provider must also ensure each Supported Living Services participant has an emergency preparedness plan in place at all times, that is shared with the support coordinator, and the individual is supported to learn and practice this plan at regular intervals.
Individual receiving Supported Living Services may choose to receive services in a shared living arrangement. Other persons in the shared living arrangement may need differing levels of support, differing types of waiver services, or may participate in different HCBS programs, as permitted in state licensure law and regulation, as long as there is a willing, qualified provider who can safely and appropriately meet the needs of each individual in the home. No more than 3 persons receiving services will be permitted per residence.

All individual goals and objectives for Supported Living Services, along with a description of needed Supported Living Services supports to achieve these goals and objectives, shall be established through the person-centered planning process and documented in the PCP. The Circle of Support must consider the person's level of independence, availability of natural supports, ability to utilize technology, ability to rely on housemates, neighbors, etc. in establishing a Supported Living arrangement and the service delivery schedule. The Supported Living service plan must be reviewed at least annually (and more often should a change of needs or circumstances warrant). Consideration should be given to the use of a Personal Emergency Response System and/ or other technology to increase independence, when appropriate. The PCP must reflect

the routine supports that will be provided by Supported Living staff while recognizing flexibility may be needed and desired by the person supported.

The person may choose to live with one or two other persons supported and share living expenses or choose to live alone as long as sufficient financial resources are available to support the chosen arrangement. Payment to providers is based on a monthly fee and service delivery that must be appropriate to meet the individual needs and goals. Transportation may be necessary for some individual and is included in the rate paid to the provider.

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.

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

Reimbursement for Supported Living Services shall not include the cost of maintenance of the dwelling. Residential expenses (e.g., phone, cable TV, food, rent, mortgage, home/renters insurance, etc.) shall be paid by the person(s) supported and other residents in the home (if applicable), through mutual agreement reached by the persons sharing the dwelling.

A person who is receiving Supported Living Services shall not be eligible to receive Personal Care, Respite or Transportation as separate services, except for Supported Employment Transportation and Personal Care at the Worksite. With these exceptions and the additional exception of transportation to and from medical services covered through the Medicaid State Plan, transportation shall be a component of Supported Living Services and shall be included in the reimbursement rate for the service.

The Supported Living Services provider shall not own the person's place of residence under any circumstances. The provider shall not be a co-signer of a lease on the person's place of residence unless this is necessary for person to obtain lease and , the provider signs a written agreement with the person that states that the person will not be required to move if the primary reason is because the person desires to change to a different provider. The Supported Living Services provider shall not own, be owned by, or be affiliated with any entity that leases or rents a place of residence to a person supported if such entity requires, as a condition of renting or leasing, the person to move if the person desires to change to a different Supported Living Services provider.

Supported Living Services shall not be provided in any setting defined as an institutional setting under the federal Medicaid HCBS Settings Rule including inpatient hospitals, nursing facilities, and Intermediate Care Facilities for individuals with Intellectual Disabilities (ICFs/IID).
Certain family member(s) of the person supported cannot be reimbursed to provide Supported Living Services i.e. spouse to spouse, parent to child, child to parent or either appointed as legal guardian and/or living with the person. Other family member(s) may be reimbursed to provide Supported Living Services if they otherwise meet the provider qualifications and hiring requirements for this service or are employed by an approved provider of Supported Living Services services.

Supported Living Services shall not be provided in a home where a person supported lives with family members unless such family members are also persons receiving waiver services. Family member shall be interpreted to mean the mother, father, grandmother, grandfather, sister, brother, son, daughter, or spouse, whether the relationship is by blood, by marriage, or by adoption. Provision of personal care and companion services may be subject to EVVMS for service delivery Supported Living Services shall not be provided out-of-state. A minimum of two face-to-face direct service visits lasting at least one hour in the home per week are required for each person receiving Supported Living Services, along with 24/7 availability of provider staff in case emergency supports are needed.

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

☒ **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	Supported Living Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Living Service

Provider Category:

Agency

Provider Type:

Supported Living Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Al. Administrative Code Chapters 580-3-23, 580-3-25, 580-3-26, and 580-5-30 and DD Operational Policies and Procedures.

Other Standard *(specify):*

The Supported living provider must meet the general requirements for the In-Home Residential specifications outlined from previous waivers. An applicant wishing to provide SLS Supported Living Services does not need to provide evidence of compliance with fire and health standards because the service will be provided in the individual's home, but not in the home with the family for Supported Living Services. Instead, a new applicant shall submit to the Division a written plan in the form of a proposal, together with an application for programmatic certification, describing how the programmatic standards referenced above will be met. Certification surveys will follow the standards for Hourly Service Providers, and may include visits to the homes of individual's being served.

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

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

Programs delivering SLS Supported Living Services shall have a written mission statement for dissemination to prospective individual and their families. This mission statement shall address:

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

Supported Living Services services will be delivered/supervised by a QDDP in coordination with the individual's person centered plan.
Providers must have documented record of having completed training prior to providing services. Providers of service must maintain a service log that documents specific dates on which services were delivered, consistent with the individual's person centered plan.

The Department of Mental Health, Division of Developmental Disabilities requires certification of programs delivering Supported Living as a in home residential type service. Site inspections and/or Life Safety inspections shall be scheduled in accordance with policy and procedures of the ADMH/DDD only when there are documented concerns regarding the

individual's health, safety and/or welfare.
Programmatic re-surveys are conducted at one or two year intervals depending on the previous survey outcome.

Each Supported Living Services program must develop and maintain appropriate, up-to-date staffing to provide adequate services as outlined in the PCP. Program staff ratios and staff work schedules shall be maintained to meet the needs of individual's. An emergency, on-call staff person, in addition to those normally required to maintain appropriate staffing patterns, shall be available on a 24/7 basis for each individual's. Staff scheduling and work place assignments shall be so arranged as to provide services to meet individual's needs. Since this service provides supported living, the staffing pattern shall be appropriate to the type and scope of programmed services and shall include staff members who meet qualifications set forth in the approved job descriptions.

Supported Living services will be supervised by a QDDP in coordination with the individual's person- centered plan. The role of the QDDP is to ensure services are delivered as outlined in the PCP and are based on individual's need.

Qualifications:
1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with Medicaid and ADMH Policies/Procedures.

5. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

6. All providers must comply with ADMH/DD policies, procedures, and rules for waiver service providers, including quality monitoring requirements .

Documentation:

Providers must have documented record of having completed training prior to providing services. Providers of service must maintain a service log that documents specific dates on which services were delivered, consistent with the individual's person centered plan. All service visits should be signed by the individual being served at each visit. Each visit signature must be original. Copied signatures will not be accepted.

An applicant wishing to provide Supported Living Services under this waiver does not need to provide evidence of compliance with fire and health standards because the service will be provided in the individual's participant's home. Instead, a new applicant shall submit to the Division a written plan in the form of a proposal, together with an application for programmatic certification, describing how the programmatic standards referenced above will be met. Certification surveys will follow the standards for Hourly Service Providers, and may include visits to the homes of individual's being served.

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

ADMH/DD Certification

Frequency of Verification:

Annual or biennially according to survey scores.

Appendix C: Participant Services

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

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under 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:

Local agencies established under Act 310 of the Alabama Statutes and Regional Offices of the Division of Developmental Disabilities.

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
Remote Supports
Supported Living Service

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, whether or not recordings will be made, and if recordings will be made, what the provider's required policies and processes are to limit who has access to the recordings. 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 state prohibits the use of video equipment in dressing, bathing and toileting areas.

☒ **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):

Background checks are verified at initial application/certification and at least every two years by the ADMH-DDD Certification Team. A sample size of 10%, which always includes the Executive Director, is reviewed for each agency. Agencies not receiving a full two-year certification will be required to receive the background check verifications at their one-year follow up certification visit.

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 Certification Administration Division of the Operating Agency. Direct care staff must have a national background check. ADMH will check the exclusion list at AMA and the OIG websites to ensure the applicant provider has not been previously debarred.

Author: DMH Office of Certification
Authority: Code of Ala. 1975, §22 50 11.

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):

The Alabama Department of Human Resources (ADHR) is responsible for maintaining the abuse registry. Alabama Code 38-9G-1.

The Alabama Department of Mental Health Developmental Disabilities Division (ADMH-DDD) requires all staff members working at contracted provider agencies and all self-directed care workers be screened prior to working with individual participants. ADMH-DDD requires documentation of the clearance be maintained in the person's personnel record and is reviewed during Certification reviews or available when requested by ADMH-DDD staff members conducting reviews of the person or agency.

The contracted provider entity is responsible for ensuring continuity of care when their employee has abused, neglected, and/or exploited a waiver participant. When this includes termination of employment, and/or recommended inclusion on the abuse registry, the contracted provider must ensure another employee covers the services provided to the participant for continuity of care/services.

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 Living At Home (LAH) 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 Care (and Personal Care Transportation) and Self-Directed Adult Companion.

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 and that legal liable relatives exercise substituted judgement in provider selection through interdisciplinary team meetings and structured person-centered planning meeting processes, and ongoing quality assurance monitoring. 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. These efforts are designed to protect the waiver participant's choice and autonomy while maintaining compliance with federal and state HCBS standards.

Payment may be made to legal liable relative for furnishing the following Self-Directed services: Personal Care (and Personal Care transportation where applicable) and Adult Companion Services only.

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 the 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 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 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 can only provide self-directed waiver services as specified in C-2-d.

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; 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; 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.

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR § 431.51:

The Operating Agency holds semi-annual orientations for individuals and agencies interested in enrolling in any of the programs and services offered by the Alabama Department of Mental Health, including the waiver programs. This orientation is advertised on the Department's website as a necessary step in becoming enrolled, with details and contact information included in the advertisement.

If applicant providers have questions about the class registration process, they may contact the DD Certification Division at the telephone number listed on the department's website.

Links found on ADMH website:

ADMH Continuing Education Website for Mental Health Providers and Professionals
* Instructions for Accessing and Completing the Online Course
* Prospective Community Provider Orientation Registration Form
* To Confirm Receipt of Your Registration

Prospective providers are encouraged to visit other areas of the Alabama Department of Mental Health website, including Certification Administration, Life Safety and Technical Services, Nurse Delegation Program, and the Bureau of Special Investigations, which are all areas involved in the certification process. There are many other resources available through each of the department's service divisions - Developmental Disabilities and the division of Mental Illness and Substance Abuse.

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:
 # and % of new contracted providers that met initial licensure and/or certification standards, other standards established by Medicaid, & any applicable requirements of state laws prior to service provision.Percentage= NUMERATOR[# of new contracted providers that met initial licensure and/or certification standards, other standards established by Medicaid & applicable requirements of state laws]..

Data Source (Select one):
Other
If 'Other' is selected, specify:
cntnd from above...prior to service provision] / DENOMINATOR[All new contracted providers] Certification Reviews/ Record Reviews and On-Site Observations

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 existing contracted providers that continued to meet licensure and/or certification standards, other standards established by Medicaid & any applicable requirements of state law. Percentage=NUMERATOR[# of existing contracted providers that continued to meet licensure and/or certification standards & other standards established by Medicaid]/DENOMINATOR[# of existing contracted providers]

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

Record Reviews and On-Site Observations

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

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 self-directed employees/staff that meet state and waiver requirements. Percentage = NUMERATOR [Number of self -directed employees that meet state and waiver requirements]/DENOMINATOR [Number of self-directed employees/staff]

Data Source (Select one):
Other
If 'Other' is selected, specify:
FMSA 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: 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**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percentage of non-licensed/non-certified providers that meet waiver requirements and any applicable requirements of state law. Percentage =

NUMERATOR [Number of non-licensed/non-certified providers that met waiver 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**

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:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

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

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

Performance Measure:
Number and percentage of new self-directed employees/staff that meet waiver training requirements. Percentage = NUMERATOR [Number of new self-directed employees/staff that meet waiver training requirements]/ DENOMINATOR [Number of new self-directed employees/staff]

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: 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**
	☒ **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 percentage of providers that meet training requirements in accordance with state requirements and the approved waiver. Percentage = NUMERATOR [Number of providers that meet training requirements in accordance with state requirements and the approved waiver] / DENOMINATOR [Number of providers that require training]

Data Source (Select one):
Other
If 'Other' is selected, specify:
Certification Reviews (Sample)

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 enrolled self-directed employees who continue to meet waiver training requirements. Percentage = NUMERATOR [Number of currently enrolled self-directed employees that continue to meet waiver training requirements]/ DENOMINATOR [Number of currently enrolled self-directed employees]

Data Source (Select one):
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: 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**
	☒ **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 and either annually or biennially, or placed on provisional status, depending on their survey score.

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. 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 certification.

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.

Where issues are noted, technical assistance/training is offered to providers to improve service quality.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

◉ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 §§ CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings in which 1915(c) HCBS are 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 waiver services are afforded choice of disability and non-disability specific settings. LAH waiver individuals reside in their own homes, but may also reside in other private residential settings (which are provider owned or controlled by definition) chosen by the individual. Individuals may receive waiver services in these settings as well as in day habilitation facilities. All activities for the following are based out of Day Habilitation Facilities: Community Experience (Community-Based) Community Day Hab (Community-Based) Prevocational Facility Based (Facility-Based), and Prevocational Community Based (Community-Based). Waiver services are not provided in non-relative foster care settings/homes for participants enrolled in the LAH waiver and will only be provided in the participant's own private residence or other settings that meet HCBS requirements.

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.

Individuals who receive waiver services are afforded choice of disability and non-disability specific settings. LAH waiver individuals reside in their own homes, but 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 day habilitation facilities. All activities for the following are based out of Day Habilitation Facilities: Community Experience (Community-Based) Community Day Hab (Community-Based) Prevocational Facility Based (Facility-Based), and Prevocational Community Based (Community-Based).

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.
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    - 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.
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- 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.
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- ADMH-DDD will provide AMA transition updates on at least a quarterly basis.

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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:

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• 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.

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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.

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:

Individual Service 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:

If employed by 310 Board/Contracted Agency or ADMH:
o Bachelor's degrees in human services field and 24 months or more of experience working with vulnerable populations in community settings(s).
Preference should be given for experience working with individuals with intellectual disabilities and/or working in support coordination, case management, or roles with similar responsibilities.
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.

If employed by 310 Board:
o Bachelor's degrees in human services field
Preference should be given for experience working with individuals with intellectual disabilities and/or working in support coordination, case management, or roles with similar responsibilities.
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.

☐ **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.

A) The individualized planning process is a uniquely blended approach that includes the use of a variety of tools that individuals/families/legal representatives can utilize to prepare for the person centered plan meeting. The tools are designed to prompt the individual and families/legal representatives to goals and objectives that will help identify service needs based on individual desires and preferences prior to the planned meeting. B) The individual directs the meeting and may invite any person he/she deems appropriate for inclusion and sets the time and place for the meeting. Support Coordinators invite all to attend the meeting. C) ADMH DDD applied for and received the NCAPPS grant for Technical Assistance to evaluate, enhance and/or develop a Person Centered Planning process, policies, tools, etc. ADMH DDD has also engaged an SME and consultant to assist with its work to set forth a new vision for PCP. Statewide implementation occurred on 10/1/20, with an ongoing evaluation processes for quality improvement.

FOCUSED CONVERSATIONS
Gather information directly from people to determine how they receive Support Coordinator services.
Here are some suggested questions for people and those who know them best. In addition, there are also some questions or areas the organization will want to address.

Suggested questions for the person:
1. What does your support coordinator do?
2. How does he/she help you?
3. How does that work for you?
4. Tell me about what happens when your support coordinator visits.
5. Are you satisfied with the services and supports you receive?
6. Are these the services you want?
7. Do you have enough services? Are they meeting your needs and expectations?
8. Can you change services or providers if you so choose?
9. How do you want your life to be in the future?
10. What is important to you to accomplish or learn?
11. Whom do you talk with about your future?
12. What are your hopes and dreams for yourself?
13. What assistance (if any) do you need to make these things happen?
14. What have you done that you feel good about?
15. What have you accomplished over the past few (one to three) years that has made you feel good about yourself?

Appendix D: Participant-Centered Planning and Service Delivery

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):

Overview: There is a global service plan (Person Centered Plan) that is developed with the individuals, family/guardian and friends as appropriate and other persons that provide services and supports to the individual, as appropriate in the planning process, i.e. PT, OT. The Support Coordinator facilitates and writes the PCP. Once the individual's goals and objectives are identified, waiver and non-waiver services are categorized. The Support Coordinator then briefly summarizes all areas of needed services and supports on the individual Person Centered Plan along with services and supports that the individual is currently receiving regardless of the funding source.

a. Who Develops the Plan, who participates in the process, and the timing of the plan?
The individual's team chosen by the individual (family/guardian & friends, as appropriate, Support Coordinator, QDDP, and/or all other persons providing services and supports to the individual) is responsible for development of the individual's person centered plan. Invitations are extended to, and efforts are made to include, all persons that the individual requests to be invited to his/her meeting. Other specialty areas may not be present at the meeting but may provide written input such as a physician's report or PT/OT evaluations, etc. Each individual has input on planning the annual person-centered planning meeting and is in control of when and where the meeting occurs.

b. The types of assessments that are conducted to support the person-centered plan development process, including securing information about participant needs, preferences and goals, and health status?

The Support Coordinator collects a history of the individual and family prior to the team meeting. Assessments may include: Functional needs assessment, Level of care screening tool, ICAP, Medical Assessments, Clinical Assessments (if indicated, vocational assessments (as appropriate), IEP (if appropriate) informal assessments and observations, informal conversations with the individual/guardian/family, friends and providers, Person Centered Planning Tools. Optional Tools for the planning are: My Preferences-What works for Me; What Doesn't Work for Me, Places I Go, Decisions and Choices I Make Vs. Others Make for Me, My Gifts and Competencies, Lifecourse Trajectory, Lifecourse Integrated Support Star and Tools for Developing a Vision. The PCP meeting itself produces extensive information identifying the individual's preferences, goals and objectives.
From the information gathered before and during the team meeting, a person-centered plan is developed, which is essentially an action plan.

c.Once there is a determination of needs from the person centered planning process, information is provided to the individual and/or family by the case management agency or Support Coordinator (Support Coordination or an intake specialist), regarding providers in their respective area, that offer the services and supports they are requesting. Direct service providers and the Regional Community Services Office also make information available. Visits are arranged, upon request, to the various service provider's sites to give individuals an opportunity to make an informed decision about their services and supports.

d. How the plan development process ensures that the service plan addresses participant goals, needs (including health care needs) and preferences?

The person centered plan is developed with the individual, family/guardian and friends as appropriate and other persons that provide services and supports to the individual as appropriate. The plan identifies individual strengths as well as areas where the individual requires supports. The individual's information that is gathered before and during the team meeting is very thorough and identifies all areas of needed services and supports, and clearly delineates the individual participant's preferences. Individuals are assisted in obtaining preventive and routine health services including physical examinations, immunizations and screenings that are consistent with their age and risk factors as recommended by their personal physician. Preventive health care strategies/interventions contained in the person centered plan, based on the person's current health status and age, are implemented and will be carried out according to the Centers for Disease Control recommendations regarding preventive/screening practices. Emphasis will be placed on age specific screening tests. Each person's person-centered plan indicates his/her health needs and outlines specific actions and time frames to address these needs. Actions taken are documented. Health needs include, but are not limited to, physical, neurological, dental, nutrition, vision, hearing, speech/language, PT/OT and psychiatric services. As part of the person centered plan, health care plans and supports are modified in a timely manner based upon acute health care changes.

e. How waiver and other services are coordinated?
The service plans address all supports and services an individual is to receive, including both services provided through the waiver and services provided through other means. For each need, the plan must describe the service or

support which will meet that need, and who will provide it. Support Coordinators are responsible for coordinating services provided by other agencies or individuals and monitoring the provision of services during routine monitoring visits.

f. How the plan development process provides for the assignment of responsibilities to implement and monitor the plan.
The action plan will outline what everyone is to do to implement the plan, and the Support Coordinator's responsibilities will include monitoring the plan's implementation. The direct service provider has the first responsibility for monitoring its own services to assure the implementation of the person centered plan and the participant's health and welfare. External monitoring, however, is also in place. The Support Coordinator, as stated above, monitors/reviews services, and does so on a quarterly basis as a minimum. In addition, The Regional DMH Office provides a 6 month minimum visit/review to each service site and a semi-annual random review of the Support Coordinator records. Additionally, The DMH Programmatic Certification offices have monitoring of the person centered plan responsibility. If a provider fails to comply that specific indicator will be marked accordingly which impacts the assurance score and ultimately the overall certification score. Other monitoring and technical assistance reviews are completed by DMH Advocacy office and DMH Quality Enhancement office. When concerns are identified to the state/regional office, technical assistance needs are established and timeframes for the needed follow-up actions or additional reviews as appropriate.

g. How and when plans are updated, including when the participant's needs change?
Person Centered Plans are subject to continuous revision based on changes in the individual's condition and/or on assessed need or newly identified goal. However, at a minimum, the entire team performs a formal review at least annually. The Support Coordinator will maintain at least quarterly contact with each individual or their family or guardian. During quarterly contact, the Support Coordinator will monitor the individual's health and welfare. Progress notes will document the contact and whether the outcomes stated in the person's plan are occurring.

It is also the Support Coordinator's responsibility to review the provider's notes at least quarterly, and note any problems, discrepancies, dramatic changes or other occurrences that would indicate a need for renewed assessment. This review of the provider notes will include making further inquiries and taking appropriate action if there is reason to believe the person's health or welfare is potentially at risk.

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.

The team, through the development of profile information, brings out and documents elements of risk, and describes those actions and actors who will compensate for risk elements. This function is accomplished through profiles such as:

"What is important to me?" (the participant)
"What is my current health?" (with prompts for both positive and negative attributes)
"What are my daily routines?"
"What choices do I get to make?"
"What works for me and does not work for me?"
"What are our hopes and fears?" (Optional - used specifically to discuss risks)
"What are the barriers and opportunities?" (Optional - used specifically to discuss risks)
"What do the team and others need to know and do to support me?"

Information pulled into the plan may show several risks, but do so in the most objective, person centered way possible, without setting up a section for "problem behavior" or "risk abatement." When the team develops the action plan, and an objective is going to involve a degree of risk, the objective describes who is going to do what to minimize that risk, whether that be providing experiential learning for the participant, or paving the way by discussing issues beforehand with people with whom the participant is going to come into contact with, or ensuring that direct support staff have the necessary training and resources to support the participant in meeting the objective safely. The family and the provider QDDPs frequently take the lead in designing strategies to accommodate and mitigate risk. Any restriction is noted in the person centered plan and must be monitored by all parties within the timeframes to assess the effectiveness of the plan. All restrictions are expected to fade within a given timeframe, depending on individual behaviors. Both are required elements of the PCP.
In addition, an Individual Safety Assessment is completed during the plan meeting. This assessment addresses more straight forward risk factors such as ability to evacuate in case of a fire, ability to call for help, or does the person need special modification for emergency planning. Each individual should be trained and understand their emergency plan.

Each person should have an individualized emergency plan. People are supported to become knowledgeable about how to access emergency medical care and to access it as needed. Medication ordered by a physician to respond in a potential emergency is available in the appropriate dose, quantity and form. Organizations have emergency plans to deal with a variety of situations and accommodate the individual needs of people. Emergency contact numbers are readily available and accessible to staff and people receiving supports. Information (general topics) which will be discussed in a person-centered planning meeting is presented and communicated to the person in a method he/she understands and/or to the legally authorized representative prior to the scheduled meeting, except in the event an emergency meeting is necessary.

In addition to administrative requirements in Chapter 580-5-33-.3 through .10 and .12 through .13, the organization provides training to staff on the services to be provided and how the person wants to be supported. This training includes:

(a) Review of the person-centered plan.

(b) Information about the specific conditions and required supports of the person to be served, including his/her physical, psychological or behavioral challenges, his/her capabilities, and his/her support needs and preferences related to that support.

(c) Reporting and record keeping requirements.

(d) Procedures for arranging backup worker when needed.

A person-centered plan is developed and approved for the person receiving services; there is documentation establishing that the plan is followed and is modified as needed.

(a) The person-centered plan is adequately detailed so that the worker can provide the services required by the individual.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

An individual coming into services, initially and after the person centered planning process, is provided information about services and supports by the Support Coordinator. Other providers and/or the Regional Office may also provide information, but the lead responsibility resides with the Support Coordinator. The individual and family verify their choice(s) of provider(s) by signing a document that lists that (those) choice(s). If the participant requests assistance the Support Coordinator will set up a meeting between the participant and providers to discuss the services and allow the participant to assess the provider. The use of e-signatures that meets privacy and security requirements will be allowed as a method for signing off on required documents such as the participant or legal guardian signing the PCP to indicate approval of the plan. The individual and/or family/guardian are again provided information and an opportunity to exercise choice at the individual's annual review meeting, as well as, choosing providers when other services are added to the PCP. If the individual decides prior to the annual review meeting that he /she wants to change current services, a special team meeting is convened, and upon request, Regional Office Staff and/or a DMH Advocate will attend to address concerns and ensure information is provided about other available services and supports.

The individual's signature on the free-choice of provider form, and on the person centered plan, assures the person is aware of his/her right to choose the services and providers he/she wants.

The list of providers is made available through the ADMH website, along with pamphlets and brochures (when available). If the participant requests assistance, the Support Coordinator will set up a meeting between the participant and providers to discuss the services and allow the participant to assess the provider. https://mh.alabama.gov/providers-search/

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR § 441.301(b)(1)(i):

Medicaid nurses conduct a scientifically calculated random record review each month of all plans of care for persons initially enrolled or re-determined for waiver services during the previous month. These records are made available through the case management entity and the Regional Community Services Office. Service Plans are also required to be maintained by the service provider and can be made available upon request. In addition, Medicaid Quality Assurance staff perform a separate review of a random sample of plans of care and related documents annually for each provider, to assure the individuals receiving services under the waiver have a person centered plan 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 person centered plan prior to delivery.

The DMH Regional Waiver Coordinator reviews participant’s plans throughout the year to ensure the Operating Agency is meeting the required quality indicators as approved in the waiver document. Additionally, the Operating Agency’s Certification personnel reviews a sample of participant’s person-centered-plan as part of the site review.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update, when the individual's circumstances or needs change significantly, or at the request of the individual, to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

○ **Every three months or more frequently when necessary**

○ **Every six months or more frequently when necessary**

◉ **Every twelve months or more frequently when necessary**

○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR § 92.42. Service plans are maintained by the following *(check each that applies):*

☐ **Medicaid agency**

☒ **Operating agency**

☒ **Case manager**

☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan, participant health and welfare, and adherence to the HCBS settings requirements under 42 CFR §§ 441.301(c)(4)-(5); (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The services and supports that are provided to an individual are based on a person-centered plan (PCP) developed by a team based on the goals identified during the planning process.

Monitoring the implementation of the PCP and the participant's health and welfare is the responsibility of the support coordinator, the direct service provider, and members of the planning team as specified in the action plan (who is to follow-up on specific objectives is spelled out in the PCP), the support coordinator, Regional Community Services Office (RCSO), Certification staff, and Protection and Advocacy. The support coordinator reviews the services provided to an individual against the PCP quarterly at a minimum The support coordinator has an in-person follow-up with the individual at least once per quarter, and reviews individual satisfaction with the services provided, the adequacy of these services, and the individual's need or desire, if any, for the planning team to reconvene. If issues arise that adversely affects the individual's health or welfare, such as lack of staff based on the PCP, the Behavior Support Plan and/or the staffing plan, the support coordinator will notify the DMH Regional Community Services Office, which will intervene immediately.

The RCSO monitors both the implementation of the plan and the participant's health and welfare as part of the Participant-Centered Planning and Service Delivery waiver assurances. This includes checking redetermination records monthly and identifying if critical information is present to ensure plans are updated per regulations. On an on-going bases the RCSO monitor will pull a sample of waiver participant’s PCP to ensure compliance with the waiver which includes reviewing staffing patterns, ensuring individual emergency plans are being followed, and incidents are being reported. If there is an instance where staffing is inconsistent with the individual plan the RCSO monitoring report will summarize the findings, including notation if a plan of action is needed, if so when is it needed and what is it to cover, and notation of planned follow-up by the RCSO if needed, and when and how (in person, letter or telephone). The RCSO may request that an incident report be submitted for further review. If it is determined that the lack of staffing or emergency plan implementation put the participant at risk of harm to self or others then a “for cause review” by recommendations of the Associate Commissioner can be requested.

ADMH ensures each participant’s plan is implemented as written and that all participants receive waiver services based on needs which include both waiver and non-waiver services. Participants and their representatives are informed of and are able to exercise free choice of a qualified and willing providers. Support Coordinators maintain documentation of provider selection and follow-up as needed, but at least annually during the waiver redetermination, with participants to ensure ongoing choice and address any changes needed. Monitoring activities ensure participants have access to non-waiver services which also includes dental, primary and specialty health care.

The Certification staff reviews a sample of participant records, including the PCP and health and incident records, as a component of the comprehensive provider certification process. As part of the DDD certification process, Certification staff will review a sample size of individual records to ensure the individualized emergency plans are developed for everyone and address a variety of situations based on the person, as well as ways to accommodate the individual needs of that person.

Additionally, ADMH-DDD Support Coordination Liaisons in each region review a representative sample of Person-Centered Plans (PCP) utilizing a PCP Feedback Tool annually. The PCP Feedback Tool is a quality assurance tool utilized to provide feedback to support coordination to improve the quality of individualized plans. Data from these tools are pulled quarterly and used to inform technical assistance and training opportunities for support coordination services.

Every person on the team has a responsibility to monitor both plan implementation and participant health and welfare, and this includes both the QDDPs of the direct care provider and the Support Coordinator. However, the operating state agency also monitors both of these, as described, and in this way ensures that the best interest of the participant is safeguarded. While it is a function of the support coordinator to review the person-centered-plan and follow-up to ensure goals are being addressed, there are other layers of authority that review, monitor, and ensure plans are being implemented.

The DMH Regional Waiver Coordinator reviews participant’s plans throughout the year to ensure the Operating Agency is meeting the required quality indicators as approved in the waiver document. Additionally, the Operating Agency’s Certification personnel reviews a sample of participant’s person-centered-plan as part of the site review.

Finally, if a complaint or request for review is made to the ADMH Internal Rights Protection and Advocacy Program and inadequate staffing or lack of implementation of an emergency plan is noted then the DDD will investigate.

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 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:
Person-Centered Plan Reviews/ PCAP Feedback Tools

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% confidence level 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 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:
PCAP Feedback Tools

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% confidence level 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):*

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 needs changed and whose service plans were revised accordingly. Percentage= NUMERATOR [Number of participants whose needs changed and whose service plans were revised accordingly] / DENOMINATOR [Number of participants whose needs changed that were reviewed]

Data Source (Select one):
Other
If 'Other' is selected, specify:
Person-Centered Plan Reviews/ PCAP Feedback Tools

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% confidence level 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**

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 service plans are updated at least annually. Percentage = NUMERATOR [Number of participants whose service plans were updated at least annually] / DENOMINATOR [Number of participants reviewed]

Data Source (Select one):
Other
If 'Other' is selected, specify:
Redetermination data

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

	Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of participants whose service plans were reviewed with the participant according to the timeframes specified in the waiver. Percentage = NUMERATOR [Number of participants whose service plans were reviewed with the participant according to the timeframes specified in the waiver] / DENOMINATOR [Number of participants reviewed]

Data Source (Select one):
Other
If 'Other' is selected, specify:
Person-Centered Plan Reviews/PCAP Feedback Tools

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% confidence level 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:

Performance Measure:
Number and percent of PCP's that include the signatures of the required participants in the development of the plan as indicated by the approved waiver. Percentage = NUMERATOR [Number of PCP's reviewed that include the required participant signature in the PCP development process] DENOMINATOR [Number of plans reviewed]

Data Source (Select one):
Other
If 'Other' is selected, specify:
Redetermination 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:

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 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):
Other
If 'Other' is selected, specify:

Certification/ Certification Review Tool

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☒ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level 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**

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 waiver participants that receive services and supports in the duration specified in the service plan. Percentage = NUMERATOR [Number of waiver participants that receive services and supports in the duration specified in the service plan] / DENOMINATOR [Number of participants reviewed]

Data Source (Select one):
Other
If 'Other' is selected, specify:
Person-Centered Plan Reviews/PCAP Feedback Tools

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% confidence level with a margin of error of +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of waiver participants that receive services and supports in the type specified in the service plan. Percentage = NUMERATOR [Number of waiver participants 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:
Person-Centered Plan Reviews/PCAP Feedback Tools

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% confidence level 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**	☐ **Annually**

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

Performance Measure:
Number and percent of waiver participants that receive services and supports in the amount specified in the service plan. Percentage = NUMERATOR [Number of waiver participants 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:
Person-Centered Plan Reviews/ PCAP Feedback Plan

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of waiver participants that receive services and supports in the scope specified in the service plan. Percentage = NUMERATOR [Number of waiver participants that receive services and supports in the scope specified in the service plan] / DENOMINATOR [Number of participants reviewed]

Data Source (Select one):
Other
If 'Other' is selected, specify:
Person-Centered Plan Reviews/PCAP Feedback Tools

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% confidence level 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**	☐ **Annually**

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

Performance Measure:
Number and percent of waiver participants that receive services and supports in the frequency specified in the service plan. Percentage = NUMERATOR [Number of waiver participants 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:
Person-Centered Plan Reviews/PCAP Feedback Tools

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% confidence level with a margin of error of +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

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

Data Aggregation and Analysis:

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

e. ***Sub-assurance: The state monitors service plan development in accordance with its policies and procedures.***

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the

method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number & percent of participant records that have a signed freedom of choice form that specifies that choice was offered among waiver services and institutional care. Percentage= Numerator [Number of participant records that have a signed freedom of choice form that specifies that choice was offered among waiver services and institutional care] /Denominator [Number of participant records reviewed]

Data Source (Select one):
Other
If 'Other' is selected, specify:
Person-Centered Plan Reviews/ PCAP Feedback Tools

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% confidence level 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 participant records that have a signed freedom of choice form that specifies that choice was offered among services and providers. Percentage = NUMERATOR [Number of participant records that have a signed freedom of choice form that specifies that choice was offered among services and providers] / DENOMINATOR [Number of participant records]

Data Source (Select one):
Other
If 'Other' is selected, specify:
PCAP Feedback Tool

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

☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level 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 participants that answered "yes, all services" to being able to choose that kind of services they received. Percentage = NUMERATOR [Number of participants that answered "yes, all services" to being able to choose or change what kind of services they received] / DENOMINATOR [Number of participants interviewed]

Data Source (Select one):
Other
If 'Other' is selected, specify:
Certification Review Tool

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☒ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level 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 participant was offered and made a choice between traditional and self-directed care. Percentage = NUMERATOR [Number of service plans that document the waiver participant was offered and made a choice between traditional and self-directed care] / DENOMINATOR [Number of participant service plans reviewed]

Data Source (Select one):
Other
If 'Other' is selected, specify:
Person-Centered Plan Reviews/PCAP Feedback Tools

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% confidence level 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:

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 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" 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:

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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.

Participants in the waiver will be offered an opportunity to self-direct services as the common law employer of record with budgetary authority if there is sufficient support available. A participant may self-direct select supports and services and also receive traditional supports and services from a provider agency, as long as both services are in the person centered plan and are not duplicative.

Self-Directed services include supports: Personal Care (and Personal Care transportation where applicable), Adult Companion Services, Skilled Nursing (RN, LPN), Specialized Medical Supplies, Assistive Technology, Environmental Accessibility Adaptations, PERS, In-home Respite, Community Experience, and Individual Goods and Services for further supports and maintenance.

Each participant may select self-directed services, or request more information about it, during the initial and each subsequent planning meeting. Participants newly enrolled into the waiver will be offered the opportunity from the beginning by the Support Coordinator, and individuals already enrolled in the waiver and receiving services will be offered the opportunity by the Support Coordinator no later than their next team meeting, which occurs, at a minimum, once per year. Support Coordinators will inform the individual about self-directed service options, provide and review the Self-Directed Handbook with the individual, provide in depth explanation of services, consult and answer questions about the service option. If a participant or his/her family wants more information before making a choice, there will be a self-directed liaison (SDL) available to provide it in each region of the state.

A fiscal intermediary (Financial Management Service Agency or FMSA) will be available for each participant who chooses to self-direct services. The FMSA will be paid as an administrative cost. The FMSA will provide an enrollment specialist, who will explain the enrollment process, assist in the completion of the employer paperwork, provide appropriate method to submit paperwork to the FMSA for initial set up and subsequent submission of employee paperwork, train the EOR on all aspects of self-direction of services, including EOR responsibilities, required documentation, and timesheet or electronic visit verification processing.

In addition to the services of the FMSA, participants who self-direct will have a self-directed liaison (SDL) available to provide technical assistance to trouble shoot and assist with problems the participant may have. The SDL model is adopted as an initial step for those interested in self-directing services and typically assist the first ninety-days. The Regional Office staff will check random samples to ensure compliance. Self-Directed waiver services should not supplant the cost and provision of support ordinarily provided by family/legal liable relative/legal guardians to individuals without disabilities.

Participants who select self-direction will have a budget based on the person-centered plan developed during the person-centered planning process. Units of service will be authorized and converted into a dollar amount. Self-directing participants can choose to establish a Budget Savings Account, managed by the FMSA, with their budget dollars and use their savings to purchase other allowable goods and services through the service Individual Directed Goods and Services, as long as those are designed to help the participant become more independent, better manage their disability, become more integrated in their community, be safer, and/or be healthier. Participants may re-allocate funds in the Individual Budget to the Budget Savings Account and/or may accumulate funds through a process known as wage negotiation. The PCP must provide explicit details about how each planned use of the budget savings will benefit the participant and which specific outcome in the PCP each planned use will support. The savings plan will be developed based on items/services needed and identified in the PCP, and must be approved by the Support Coordinator and SDL and/or support coordinator. This plan can be revised as participant needs change. To ensure proper use of waiver dollars within a participant's savings account, purchases for goods and services are subjected to prior approval processes as specified in the associated Self-Directed Handbook. The reimbursement or purchase of goods and services on behalf of the waiver participant will be made through the FMSA. When reimbursing the participant a valid receipt will be needed. If the participant cannot pay for the good or service up front, then the FMSA will work out a process to procure a receipt and pay the vendor. A valid receipt will be sent to the Support Coordinator and SDL to ensure the good or service was rendered or received.

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 relative 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.

The support coordinator should provide an overview to the families/representatives/legal guardians and participant's employee(s) on how to identify and report critical incidents and report incidents. All incidents should be sent to the case manager and/or Regional Office. The same follow-up procedures found in Appendix G apply.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ◉ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Information describing benefits, responsibilities and liabilities, together with an overview of the FMSA role and process, will be available in a brochure and on the Operating Agency's web site. This information will also describe how waiver participants and/or their families can find more information and go about accessing the service. The brochures and Self-Directed Handbook will be provided to support coordinator to take with them to all planning meetings, so that they may share the information with participants and team members. Once an individual and/or family indicates interest, a referral will be made to the regional office and self-directed liaison for that region, who will initiate the referral to the FMSA. The FMSA will provide the individual/family member a packet of forms, which he or she will help them complete if necessary. The Support Coordinator will develop and explain the service budget to the individual and/or family member.

Individuals are informed by their Support Coordinator that the self-directed services documents/ information is accessible in alternative languages. Individuals can request translated documents from their Support Coordinator. All requests for translated documents are processed and made available to the participant from the Support Coordinator within 14 business days. Translated self-directed documents in Spanish, Korean and Mandarin languages are available on ADMH's website.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☒ **Waiver services may be directed by a legal representative of the participant.**

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**
Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Representative may include family members with whom the participant lives in the same home or a different home as the waiver participant, or someone who is not related to the participant. A representative has to be able to assure the Regional Office that he or she has no conflict of interest and will support the participant's best interests. Second, there must be evidence that he or she is competent, willing and able to fulfill all the responsibilities, including providing sufficiently close supervision to a) assure the participant's health and welfare and b) sign the worker's timesheets with assurance each timesheet is accurate and truthful. Third, the representative must be chosen by the participant, but can neither be paid for being a representative nor be someone who is paid to provide any other service to the participant. In cases where the person chosen by the participant as the representative may be questionable, a background check may be indicated.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Environmental Accessibility Adaptations	☒	☒
Adult Companion Services	☒	☒
Assistive Technology Services	☒	☒
Community Experience	☒	☒
Skilled Nursing	☒	☒
Respite	☒	☒
Personal Emergency Response System	☒	☒
Personal Care	☒	☒
Specialized Medical Supplies	☒	☒
Individual Directed Goods and Services	☒	☒

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☒ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

The Financial Management Service Agency (FMSA) procurement is through a competitive RFP issued by ADMH/DDD. The vendor organizations awarded the contracts demonstrated clear superiority of experience and capabilities. Based on experience, cost, and references. Each contract is set for two years then the RFP process has to be completed again.

PMPM cost for FMSA services is based on the number of participants enrolled. The initial enrollment fee and the PMPM fee is based on the number of enrollees. The higher the number enrolled, the PMPM fee is reduced.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The payments for the services provided by the FMSA will be based on an invoice submitted monthly. The FMSA monthly rate includes enrollment per participant set up plus a monthly processing fee. Payments are calculated according to a per-participant-per-month sliding fee schedule and therefore may vary. The rate as of FY24 is $80 per month. 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 provides technical assistance to address all concerns within three (3) business days of initial contact. If the person/ family are not satisfied with the assistance provided by customer services, they may file a formal written complaint. The written complaint should include a summary of concern(s) and should be submitted to the appropriate staff. The FMSA agrees to 1) Acknowledge receipt all formal written complaints within one (1) business day of receipt from person/ family, 2) Conduct a thorough investigation into the issue involved and will discuss potential resolutions with person/ family within seven (7) business days and 3) Implement the chosen resolution of the investigation to ensure complete satisfaction within three (3) business days.

The FMSA will enroll individuals and employers of record. The FMSA process all worker applications. The FMSA furnishes background checks on prospective employees. The FMSA assures prospective employees meet waiver requirements.
The FMSA will enroll self-directed employees that meet requirements and have valid licenses if applicable.
The FMSA will procure goods and/or services on behalf of the participant.
The FMSA will maintain separate savings accounts for each participant and monitor its usage on a regular basis.
The FMSA will also report budget balances to the individual, support coordinator, regional office and self-directed liaison.
The FMSA will perform monthly exclusion checks for all workers as required by federal regulations and Medicaid policies.
The FMSA utilizes administrative costs to cover pre-employment screenings for SDS workers

The family and individual will be supported by a FMSA. The FMSA will pay the self-directed workers employed by the family and participant, on a bi-weekly basis as appropriate. Payment will be made on the basis of receipt of one time card per self-directed worker, which will document the hours the worker has worked during the bi-weekly pay period with an indication of the service rendered for that time period. 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.

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.

On a quarterly basis, the FMSA will provide reports and documentation to the Central office, the self-directed liaison, the Support coordinator, and the self-directing participants, that will identify the budgetary savings balance, amount deposited and expended from the budgetary savings account. When there is an issue with payment of employees the FMSA will provide amounts paid to and on behalf of employees including copies of the signed time sheets for those employees for each pay period to the EOR. 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 and/or self-directed liaison 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 individual and/or employer of record and FMSA closely monitors units paid and remaining as well as account balances to ensure there are sufficient funds in each account to cover the cost of payroll. Goods and Services will be authorized through the self-directed liaison and or Support Coordinator and receipts for items paid for up front by the FMSA will be reconciled. A receipt for each item purchased is required for reimbursement.

Appendix E: Participant Direction of Services

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j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional

information requested *(check each that applies)*:

☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Support Coordinators will have sufficient training and printed information to explain the self-directed option to families and participants. The Support Coordinator explains in full to the family/individual what services can be directed and what "self-directing" services means and provides the Self-Directed Handbook to the individual. If the family is interested in this option, the Support Coordinator will notify the Regional Office and SDL to make a referral to FMSA. At any time, the individual or family needs clarification or more information, the Support Coordinator, the liaison, the regional office or the Central Office can provide more information.

The Support Coordinator is an essential link to families and individuals who are interested in self-directing services. There is printed material that is available online, but word of mouth has been the most effective way of informing people about the program. Support Coordinators work closely with the self-directed liaison to ensure individuals questions are provided vital information regarding self-diretion. Support Coordinators will coordinate with the individual and the Regional Office to transfer from “traditional” to “self-directed” service delivery option. THe Support Coordinator will adequate knowledge to support the individual. The supports for the self-directed option consist of explaining the benefits and costs (requirements) to the family or participant, explaining how the process works, and exactly what the self-directed option entails in terms of responsibility and liability. This discussion ranges from recruiting, hiring, supervising, and possibly firing staff, to keeping time sheets, developing backup plans, managing their staff within the funds available, and how to utilize the Goods and Services waiver service. Also, the Support Coordinator, participant, employer of record (if different from participant) and Team will develop the budget for the participant during the person centered assessment and planning process based upon the participant’s assessed need and desire and include it in the person centered plan. All these pieces work together to establish a person into self-directed services. The Support Coordinator is generally the first person that a caregiver contacts with concerns and the Support Coordinator then reports issues to the appropriate source.

ADMH Regional Office staff function as self-directed liaisons. Their salaries and benefits are expensed at 50% State and 50% Federal as waiver admin employees. Their services are not a component of another service.

☐ **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
Day Habilitation	☐
Environmental Accessibility Adaptations	☐
Adult Companion Services	☐
Assistive Technology Services	☐
Supported Employment Transportation	☐
Physical Therapy	☐
Community Experience	☐
Skilled Nursing	☐
Occupational	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Therapy	
Housing Stabilization Service	☐
Remote Supports	☐
Respite	☐
Personal Emergency Response System	☐
Personal Care	☐
Assistance in Community Integration	☐
Specialized Medical Supplies	☐
Individual Directed Goods and Services	☐
Positive Behavior Support	☐
Supported Living Service	☐
Crisis Intervention	☐
Benefits and Career Counseling	☐
Prevocational Services	☐
Speech and Language Therapy	☐
Employment Support	☐

☒ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

The Operating Agency will hire a limited number of individuals who have knowledge and experience in the field of Intellectual Disabilities, who have no conflict of interest, and who are willing to be trained to provide detailed information and day-to-day support to families and participants who indicate an interest in using this service option.

ADMH Regional Office staff function as self-directed liaisons. Their salaries and benefits are expensed at 50% State and 50% Federal as waiver admin employees. Their services are not a component of another service. They will be trained by state staff and by the FMSA, in order to have the detailed knowledge with which to assist support coordinators, participants and their families. . When the family and / or participant choose(s) to proceed, the self-directed liaison will provide the packet of needed forms and explain and demonstrate each one. This is extremely detailed, and the family may ask the liaison to help them complete the forms. Additionally, the FMSA will complete enrollment with the individual and discuss how to manage the budget.

The Support Coordinator, Self-directed liaison (SDL), regional office staff, and the FMSA will collaborate to ensure

the processes are in place to assure the health and welfare of participants, and to ensure that payments and services are legal and sufficient.

The liaisons will meet with the Central Office on a routine basis for review of cases. The liaisons may be asked to consult with the regional office and / or the FMSA about progress or problems in any particular situation. Any concerns regarding the effectiveness of a liaison will be brought to the attention of Operating Agency's central office. The participant and/or employer of record will be communicating directly with the support coordinator and the regional office, and if they wish, an advocate, so any problem they may experience with the liaison can and should be reported through those channels.

Self-Directed Liaisons (SDL) in conjunction with the Support Coordinator are essential links to families and waiver participants who are interested in having a more control over the day-to-day operations and services. There is printed material available online, but word of mouth has been the most effective way of informing people about the program. Support Coordinators work closely with the SDL during the initial phase of self-directed enrollment and will notify the regional office that a participant has made a choice to be transferred from “traditional” to “self-directed” services.

Individuals are informed by their Support Coordinator that the self-directed services documents/ information is accessible in alternative languages. Individuals can request translated documents from their Support Coordinator. All requests for translated documents are processed and made available to the participant from the Support Coordinator within 14 business days. ADMH plans to update their website to include translated self-directed documents in Spanish, Korean and Mandarin languages by September 30, 2024.

The SDL in conjunction with the Support Coordinator and FMSA will to provide assistance to anyone interested in self-directing services. This includes identifying the services that can be directed, informing interested parties about their role and responsibility (i.e., timecard submission, documentation, etc.), communicating with participants and notifying Support Coordinators or the region and central offices of any concerns, and assisting participants with their budget. This includes identifying the services that can be directed, informing interested parties about their role and responsibility (i.e. timecard submission, documentation, etc.), communicating with participants and notifying case management or the region and central offices of any concerns, and assisting participants with their budget. The Support Coordinator and SDL works with the fiscal management agency as well. Working with the participant and caregivers, the SDL also provides technical assistance to anyone participating in the program.

After sufficient time has passed, typically ninety-days, and the family gains confidence to handle all aspects of SDS, the SDL will fade and responsibility for assistance will fall to the support coordinator.

ADMH Regional Office staff functions as self-directed liaisons. Their salaries and benefits are expensed at 50% State and 50% Federal as waiver admin employees. Their services are not a component of another service.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one)*.

○ **No. Arrangements have not been made for independent advocacy.**

◉ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

The Alabama Department of Mental Health operates an advocacy program independent of the Division of Developmental Disabilities (the Operating Agency). This program monitors participants to ensure their rights are not violated and operates a toll-free Advocacy Access Line during normal state business hours and a voice mail response system for after-hour callers for participants to request assistance or report issues. The number for this hotline is provided to all participants upon entry to the waiver program and will also be included with the brochure and manual provided to self-directing participants.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

Any participant who is self-directing his or her services may request to discontinue this model at any time by contacting the support coordinator, liaison, or the regional office, all of which will notify the Operating Agency immediately. The support coordinator provides the participant with free choice of providers who will take over delivering the services. If appropriate and desired by the participant, the staff which has been providing the services may be employed by the provider agency selected. The transfer will be as fast as can be arranged depending on the circumstances: if the participant's staff can be employed by an agency to continue the service, this will be done within two weeks. If all new staff needs to be recruited, vetted, hired and trained prior to employment, the process may take a month or more. During that time the original backup plan will need to be implemented, and other providers within the county may also be asked to help staff the participant's needs.

The circumstances under which a participant chooses to voluntarily terminate his/her use of the self- direction model will always be assessed, first by the support coordinator, then as needed, by the regional office or advocacy section, as a routine component of trying to improve the service delivery system.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Participants may be discharged involuntarily from participant direction because of:
1. Health or Welfare issues: the participant's and/or family's desire to continue self-directing will always be considered primary, but the support coordinator, liaison, or regional office will report adverse information to the Operating Agency, and if in the considered judgment of the Operating Agency the participant's health or welfare is in jeopardy, for any reason from abuse to change of condition, that individual will be returned to a traditional form of services.

2. Consistent participant failure to correctly utilize the FMSA services to pay his or her staff, after efforts have been made to provide support and training and have repeatedly failed, will result in termination of self-direction and return to a traditional form of services. Likewise, a participant who consistently discharges staff and ultimately is unable to hire anyone will also be returned to traditional services.

3. Anyone who engages in false approval and reporting of time cards, or in any other way acts to deceive or defraud, will be terminated from self-direction. If the person engaging in the fraud was not the waiver participant, referral will be made to the Medicaid Fraud Unit. If that person was the waiver participant, he or she will simply be returned to traditional services.

4. The method of returning a person to traditional services when they are involuntarily terminated from self-direction is the same as the method used when a person is voluntarily terminated. The support coordinator will provide the participant with free choice of providers who will take over delivering the services, unless it happens that a new service configuration is needed. For example, it may be necessary for the individual to move to a group home, either for care of an accelerated health condition or because the previous setting was exploitive. If appropriate and desired by the participant, the staff which has been providing the services may be employed by the new provider agency, but that will depend on the conditions that led to the termination. The transfer will be as fast as can be arranged depending on the circumstances: if the transition is prolonged, respite will be used as a bridge.

5. Participants who are terminated from self-direction are not provided the opportunity for a Medicaid fair hearing, because self-direction is only one method of receiving the services as long as the participant can be and is transitioned to the same essential set of services and his or her needs are met, no adverse action has occurred.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		65
Year 2		70
Year 3		75
Year 4		80
Year 5		85

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**

☒ **Refer staff to agency for hiring (co-employer)**

☐ **Select staff from worker registry**

☒ **Hire staff common law employer**

☒ **Verify staff qualifications**

☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

The FMSA will provide a background check to the participant and/or representative as a component of the administrative service for which it is paid.

☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

Does not vary.

☒ **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 participant's budget is developed through the traditional person-centered planning process as described in Appendix D-1 and is documented as part of the person -centered plan (PCP). The self-directed individual budget (Individual Budget) will then be developed based on authorized units from the individual's PCP. The format of the person-centered plan is the same for all individuals regardless of the service delivery type (traditional or self-directed).

The total dollar amount of the Individual Budget is calculated based on the participant's assessed level of need, as documented in the PCP, for each of the services the participant chooses to self-direct. The individual budget is calculated based on the authorized services identified in the person-centered plan. The Support Coordinator will inform the individual of the total amount available:

1. For each service the participant chooses to self-direct, the units of each service authorized in the PCP, based on the assessed need, are multiplied by the standard approved rate for the service.
2. For each service the participant chooses to self-direct that does not have a standardized rate, (Personal Emergency Response System, Assistive Technology, Specialized Medical Supplies and Environmental Accessibility Adaptations), the PCP team must provide a detailed projected dollar cost based on the specific assessed needs of the participant for these services and consistent with the service specifications and limitations.
3. The Self-Directed Liaison will add the amounts from steps #1 and #2 to determine the total dollar amount of the individual budget. The participant is not responsible for the cost of any fees related to FMSA support.

Once the total dollar amount of the Individual Budget is set, participants may exercise both employer authority and budget authority, as defined in the waiver, to determine how to spend the funds to best meet their needs. The Support Coordinator and Support Team will assist participants and their representatives, as needed, to develop a Spending Plan that details how the dollars will be used. As a part of the person-centered planning process, each of the following must be considered:

- The waiver provides the self-directing participant with employer decision making authority over workers who provide waiver services, including directly hiring workers of their choice and training, managing, and scheduling those workers. The participant will also set staff wages and benefits as long as those are consistent with state limits. These decisions can impact the amount of services the participant can afford.

- The waiver also provides the self-directing participant with the decision making authority to re-allocate funds among the services included in the individual budget in a manner that best suits their needs. Any re-allocations must be documented in the PCP.

- Through the waiver service entitled Individual Goods and Services, self-directing participants can choose to establish a Budget Savings Account with their budget dollars and use their savings to purchase other allowable goods and services, as long as those are designed to help the participant become more independent, better manager their disability, become more integrated in their community, be safer, and/or be healthier. The PCP must provide explicit details about how each planned use of the budget savings will benefit the participant and which specific outcome in the PCP each planned use will support. Participants may re-allocate funds in the Individual Budget to the Budget Savings Account and/or may accumulate funds through a process known as wage negotiation. Wage negotiation means that participants can negotiate with their workers to pay a lower hourly rate than the maximum allowable waiver rate for that service. If a lower hourly rate is agreed upon by the participant and worker, the difference between the worker's pay rate and the maximum allowable rate will be stored by the FMSA in the participant's savings account and maintained until it is used for an approved individual-directed good or service purchase. Participants are permitted to have up to $10,000 in their savings account at any given time. This Budget Savings Plan, approved as part of the PCP, may not include planned spending in excess of the annual limit set by ADMH/DDD for each enrollment year. This amount can be accrued in the current fiscal year and one fiscal year prior. If the participant disenrolls from self-direction, any remaining funds in their savings account at the time of disenrollment will be refunded to the State of Alabama.

As a part of the person-centered planning process, the participant's decisions related to these expenditures must be documented in the PCP and individual budget documentation. The Support Coordinator will use this information to create the Spending Plan for the individual. The Individual Budget and Spending Plan will be provided to the participant by the Support Coordinator and to the FMSA by DDD via electronic authorization. Participants and their representatives have the responsibility to make sure their expenditures do not exceed the amount of their Individual Budget. The FMSA will monitor the participant's spending and will provide regular reports to help

participants and representatives monitor their budget utilization. Any modifications to the Individual Budget and Spending Plan must be preceded by a change in the PCP. The Support Coordinator will collaborate with participants to make the needed changes.

The self-directed budget will be developed based on authorized units from the individual's person- centered plan (PCP). The process for developing the PCP will not be different from that of traditional waiver services. The participant is always included in his/her PCP meetings, along with a guardian if applicable. The participant is also consulted for others he/she wants to invite and may include parents, representatives and significant others, who will also then be included. For participants who self-direct one or more services, the SDL may also participate in the PCP meeting if the Team requests. The individual's support team will meet and develop the person-centered plan based on expressed desires and needs.

The individual budget methodology will be made public via ADMH's website, including the notification that the participant is not responsible for the cost of any fees related to FMSA support. This information will be available by August 1, 2024.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The individual will be notified of self-directed services during the service plan development process. The plan development process requires signatures of all members of the support team, including the individual if able, indicating the services have been reviewed and all involved are in agreement. The self-directed services budget amount will be determined, and the participant will be informed during the enrollment meeting with the 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. The Operating Agency will not approve changes to the budget based on financial misuse of dollars such as excessive employee pay rate or to pay employee overtime payment, employee bonuses, etc. The self-directed budget does not serve as a limit on the amount of waiver services that an individual may receive. The support team will determine the appropriate level of service and the self-directed services budget will be built based the participant's assessed need and units authorized. Budget changes will not be approved for purchase of goods and services not authorized.

At the time the participant chooses to self-direct any service, the Self-Directed Liaison (SDL) will provide the participant/EOR with education and documentation describing the budget development process, including the process to make changes to the budget.

A participant/EOR is notified via USPS of a denial or a budget reduction using the adverse action letter. An "Appeals Request Form" is included with the adverse action notification. The Appeals form details the process for requesting a fair hearing and the deadline to submit the request. Notifications are made within the seven business days of the decision.

If rates are increased for self-directed services, the participant's budget would be updated accordingly. ADMH provides written notices of rate increases to self-directing participants/EORs and to Support Coordinators. The participant/EOR then is provided the choice to decide how to use the increased budget funds within the program guidelines (e.g., to purchase additional service hours, increase the compensation of the employees, purchase other IDGS.) This must be documented and authorized in the PCP. The PCP authorizations and individual budget revisions are provided to the FMSA for implementation.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- (◉) **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- (○) **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Safeguards for preventing premature depletion of the individual's budget are multi-layered. Individual Goods and Services will only be authorized if there is enough savings in the individual's budget and there is not a concern of premature depletion. The FMSA will maintain the individual's budget and savings account and will monitor it monthly to ensure utilization remains steady. Individual balance reports will be generated monthly and submitted to the liaison/support coordinator for review. If there appears to be either overutilization or underutilization, the participant will be contacted to outline concerns. If either over utilization or underutilization is an on-going problem, the individual and representative will be consulted and informed of the possibility of involuntary discharge of self-directed services, and a transfer to traditional waiver services will be made.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Following is a description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, subpart E.

Any waiver applicant or recipient has the right to request a fair hearing if denied home and community-based services or if a decision by the operating agency adversely affects his/her eligibility status or receipt of services. If an applicant is determined not eligible by the operating agency, he or she is provided with notification of the determination, the reason and authority for the determination, and an explanation of the appeal rights and procedures available to the applicant. The formal process of notification and appeal is in accordance with 42 C.F.R. Section 431, Subpart E and Chapter 3 (560-X-3) of the Alabama Medicaid Administrative Code. There is an appeal process conducted by the operating agency at the applicant's choice, with the right to further appeal to the Medicaid Agency being explained to the applicant.

Waiver recipients are provided with the necessary information regarding their opportunities to request a fair hearing as part of the planning process.

When a change in the individual's needs suggests a change in the waiver services and person centered plan, the person's treatment team discusses proposed change(s) with the person and his family/representative prior to implementation. This discussion will include an explanation of the reason for the change, further assessment of the impact of the change, and an effort to elicit agreement on the part of the person and/or his family/representative.

Whenever there is a decision by the operating agency to reduce, suspend, or terminate waiver services to coincide with the person's current need or the person's loss of eligibility for the service, the Department of Mental Health (DMH) will issue a written notice at least 10 days prior to the action to the individual and or family/caregiver indicating the individual'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 can be obtained from the operating agency. All complaints and grievances will be triaged through the Office of Waiver Appeals for tracking and trending.

Pursuant to 42 CFR 435.91, new waiver applicants, as well as current waiver participants who are due for redetermination, receive an NOA regarding a denial of their application for, or re-determination of, Medicaid eligibility. In addition, when any other waiver services or benefits are denied, participant is also sent an NOA along with a notice of the right to appeal. This notice includes and attachment, (Form 248), which explains their rights to request a conference or review of case and/or a fair hearing, depending on their preference. A request for a hearing must be received by Medicaid within sixty (60) days following the effective date of the original agency action with which the applicant or participant is dissatisfied. If the hearing request is received within ten (10) days following the effective date of a termination or within ten (10) days of a notice to increase liability, benefits can be continued, or the liability remain unchanged, upon receipt of the request. However, if the hearing decision supports the termination or liability increase, the participant will be responsible for repayment of the costs of all erroneous benefits paid after the initial effective date of the termination or change in liability.

If an individual receives a Notice of Action (NOA) and Appeals Request Form (ARF) related to services that are denied, suspended, reduced or terminated from the operating agency (OA), he/she may request an appeal if he/she disagrees with the decision. The NOA explains the reason for the denial, termination, suspension, or reduction in waiver services and the appeal rights are made available. If the participant feels the decision was made in error, they may appeal the decision by submitting the ARF or written request (i.e. handwritten or typed statement, letter and/or email requesting an appeal) to ADMH's Office of Waiver Appeals for a review (i.e. Informal Conference) no later than 15 calendar days after the effective date printed on the NOA. Services will continue until the final outcome of the decision for those individuals who are already receiving services when they submit an appeal within 10 days after the effective date of action unless:

(a) It is determined that the sole issue is one of Federal or State law or policy; and

(b) The agency promptly informs the beneficiary in writing that services are to be terminated or reduced pending the decision.

A review (i.e. Informal Conference) may involve an in-person interview, a teleconference, or simply a review of the documents, depending on the nature of the appeal and the information to be considered. Upon receipt of an appeal request by the ADMH Associate Commissioner of the Developmental Disabilities Division or designated appointee (i.e. Waiver Appeals Coordinator), contact is made internally to request the information relative to the denial decision. The ADMH Associate Commissioner of the Developmental Disabilities Division or designated appointee (i.e. Waiver Appeals Coordinator) will send a letter of receipt to the requester of the appeal, or if received after 15 calendar days, send a letter to the requester of the appeal noting ineligibility of a review due to being received beyond the deadline. ADMH's Waiver Appeals Coordinator will assemble a review panel and provide each panel member with an appeal packet inclusive of documents related to the adverse determination. The ADMH Waiver Appeals Coordinator will schedule an Informal Conference with the individual (and/or representative) and appropriate staff/panel members to discuss the adverse determination. After the Informal Conference, a written decision from the ADMH

Associate Commissioner of the Developmental Disabilities Division will be mailed (certified) to the individual/guardian within 21 days after the review of all information is completed and a decision to either reverse or uphold the denial is determined. If the individual/guardian disagrees with the decision, he/she can submit a request for a Fair Hearing to the Alabama Medicaid Agency (Medicaid). A written hearing request must be received by Medicaid no later than 15 calendar days from the date of the ADMH Associate Commissioner's response letter.

FAIR HEARING PROCESS

When the appropriate Medicaid Waiver Program Administrator receives a written request for a Fair Hearing, the date-stamped envelope is retained, an entry made in a waiver log, and a copy of the written request is emailed to the ADMH Waiver Appeals Coordinator with a request to send all pertinent information relative to the appeal. The ADMH Waiver Appeals Coordinator develops a fair hearing summary packet which will include a full summary, denial notice, and all other pertinent documents related to the action with which the individual/guardian is dissatisfied. The Medicaid Waiver Program Administrator will notify the Medicaid Office of General Counsel (i.e. Fair Hearings Coordinator) and send (via email) the information received from the ADMH Waiver Appeals Coordinator.

Note: If the request for a Fair Hearing is received by the ADMH or the Medicaid Office of General Counsel, a copy of the written request is emailed to the appropriate Medicaid Waiver Program Administrator for processing.

Once the Medicaid Office of General Counsel (i.e. Fair Hearings Coordinator) is in receipt of the documentation, notification and documentation is submitted to the ADMH Office of General Counsel. The Medicaid Fair Hearing Coordinator will create a Scheduling Request to be sent to the Administrative Law Judge (ALJ) and copied to the primary witnesses. Once the ALJ has received the Scheduling Request, he/she will create a Scheduling Order. This signed document will confirm the date and time of the hearing, and it will be mailed to the individual/guardian, ADMH, and Medicaid.

The ADMH Office of General Counsel will be responsible for taking the leading role during the hearings and Medicaid will maintain the responsibility of coordinating, scheduling and hosting the hearings, to include the scheduling and coordinating of the ALJ. Once the hearing has been held, the ALJ will make a recommendation and send a copy of the recommendation to the individual/guardian, ADMH, and Medicaid. ADMH may provide comments on the recommendation to the Medicaid Office of General Counsel. After reviewing the recommendations, a concurrence/non- concurrence letter will be signed by the Medicaid Commissioner and mailed to the individual/guardian, with a copy to the ADMH. If the individual/guardian is still dissatisfied after the Fair Hearing, he/she may appeal to the Circuit Court. ADMH will be responsible for defending any appeal of the administrative decision.

ADMH is responsible for logging and tracking informal conference and fair hearings.

Regulations found at 42 CFR 431.222 allow the State to consolidate individual requests for a hearing into a single group hearing for cases where the sole issue involved is one of federal or state law or policy. However, the state does offer a hearing in these cases. The Alabama Medicaid Agency need not grant a request for a hearing if the sole issue is a federal or state law or policy which requires an automatic change adversely affecting some or all recipients.

The organization has a mechanism that provides people supported and their legally authorized representatives with information regarding filing complaints & 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 & 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. Reports are generated quarterly, listing the complainant, the nature of the complaint, and the finding of the investigation, timeframe of resolution and if warranted, a notation of the resolution of standard and expedited appeals, grievances and/or complaints. Reports are provided to the staff of the Alabama Medicaid Agency quarterly. 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.

The Alabama Department of Mental Health- Division of Developmental Disabilities, is the Operating Agency for this waiver program. The notice of adverse action mentioned in Appendix F-1 includes an optional appeal to the ADMH Associate Commissioner of the Division of Developmental Disabilities (and/or Office of Waiver Appeals) within 15 calendar days after the effective date printed on the Notice. The individual/family has the option to appeal in writing to the Associate Commissioner and/or designated appointee (i.e. Waiver Appeals Coordinator), 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 individual/family disagrees with the Associate Commissioner's decision, they may appeal to the Alabama 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 individual/family. Participation in this process is at the option of the individual/family. If they choose not to participate, they may send their request for appeal directly to the Alabama 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 action as specified in the notice.

Participants are informed that the dispute resolution mechanism is not a pre-requisite or substitute for requesting a Fair Hearing. The Support Coordinators reviews grievance procedures, including the dispute resolution process, appeals, and the right to a Fair Hearing when a participant enters the waiver, and annually at redetermination.

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 individual), 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 individual. If the individual 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.

ADMH-DDD is responsible for receiving, logging and tracking waiver individuals and certified provider appeals, informal conferences, fair hearing requests, complaints and grievances to monitor program performance and regulatory compliance with the waiver. ADMH-DDD is responsible for analyzing, logging & tracking appeals, complaints, grievances, informal conferences and fair hearings to identify trends and patterns to support quality management and mitigate preventable recurrence of issues. ADMH-DDD must provide proposals and quality improvement initiatives and recommendations to Medicaid informed by the aggregate results and trends identified by the Office of Waiver Appeals from tracking appeals, complaints, grievances and fair hearings.

Reports are generated quarterly, listing the complainant, the nature of the complaint, and the finding of the investigation, timeframe of resolution and if warranted, a notation of the resolution of standard and expedited appeals, grievances and/or complaints. These reports are provided to the staff of the Alabama Medicaid Agency quarterly.

Prior to, and during the person-centered planning meeting, the participant is made aware that filing a grievance or making a complaint is not a pre-requisite or substitute for a Fair Hearing once they are selected from the wait list and services begin.

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
Abuse - Mistreatment (Emotional/Psychological Abuse)	Immediate
Abuse – Physical	Immediate
Abuse – Sexual	Immediate
Abuse – Verbal	Immediate
Assault – Physical	Immediate
Assault – Sexual	Immediate
AWOL/Missing Person	Immediate
Choking	Immediate
Confidentiality/Privacy Breach	Immediate
Death (natural)	Immediate
Death (unexpected)	Immediate
Emergency Room Visit	Immediate
Exploitation	Immediate
Fall (Moderate and Major Injury)	Immediate
Fire	Immediate
Hospital Admission	Immediate
Infestation	24 Hours
Injury – Major	Immediate
Injury – Moderate	Immediate
Law Enforcement Involvement	Immediate
Medication Error Level 1	24 Hours
Medication Error Level 2	24 Hours
Medication Error Level 3	Immediate
Natural Disaster	Immediate
Neglect	Immediate
Property Damage	24 Hours
Seizure	Immediate
Self-Neglect	Immediate
Suicide Attempt	Immediate
Suicide Threat	24 Hours
Restraint – Chemical – Emergency	24 Hours
Restraint – Chemical – Programmatic	24 Hours
Restraint – Manual – Emergency	24 Hours
Restraint – Manual – Programmatic	24 Hours
Restraint – Mechanical – Emergency	24 Hours
Restraint – Mechanical – Programmatic	24 Hours

All DMH certified community providers and Employers of Record (EOR) shall report incidents involving individuals that occur while services are being provided. Incidents are reported electronically through the Therap™ Incident Reporting and Management Solution. Reporting of incidents is also required when they occur in settings other than those specified above (e.g., overnight visits or outings with families).

There are no different reporting requirements for children and adults on this waiver. All critical incidents involving allegations of abuse, neglect, mistreatment (emotional/psychological abuse), and/or exploitation include reporting to ADHR by the responsible provider within one hour, which is responsible for receiving reports for children and vulnerable adults.

A critical incident investigation is either conducted by ADMH or the responsible provider. Investigators from the state and at provider agencies must go through a training course before conducting investigations. All investigations are then reviewed by Regional Incident Review Committees that determine when the investigation is “closed” by verifying the findings. This decision is made by the committee based on the incident definition and evidence provided. The Regional Incident Review Committees also determine if an incident allegation is substantiated. In addition, in 2023, Act 2022-161

(Shirley's Law) created a central registry containing the names of those who have abused, neglected, exploited, or committed crimes against the elderly and other adults in need of protective services. This allows ADMH to check for substantiated instances of abuse, neglect and/or exploitation. The central registry is similar to the child abuse and neglect central registry maintained by DHR pursuant to Ala. Code § 26-14-8. ADMH monitors updates to these registries on a monthly basis for any substantiations.

Administrative Code Regulations:

580-3-23, 580-3-25, 580-3-26, 580-5-30, Community Incident Prevention and Management System (IPMS), and DD Operational Policies and Procedures: 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 wellbeing of all individualwaiver participants receiving services through its certified community agencies, and will take appropriate action on any mistreatment (emotional/psychological abuse), neglect, abuse or exploitation of those individualwaiver participants.

The DDD prohibits abuse, neglect, mistreatment (emotional/psychological abuse), and exploitation of individualwaiver participants 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 System 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 system as part of their DMH certification requirements.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Participant Training and Education

Each individual receiving services from a provider agency is required by regulation to be informed of their rights and responsibilities annually. Rights include being free from abuse, neglect and exploitation. Each individual 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 do not like. The Office of Advocacy Services of the Department of Mental Health conducts routine random monitoring, and Regional Offices of the Division of Developmental Disabilities conduct routine monitoring, both of which monitoring processes include speaking to individuals about their satisfaction with services.

Administrative Code Regulations:

580-3-23, 580-3-25, 580-3-26, 580-5-30, and DD Operational Policies and Procedures: Promotion and Protection of Individual Rights

The DDD will ensure the organization effectively and consistently implements a policy and procedure that clearly defines its commitment to and addresses the promotion and protection of individual rights afforded all citizens by the constitution and laws of the Country and State of Alabama.
580-3-23, 580-3-25, 580-3-26, 580-5-30, and DD Operational Policies and Procedures: Dignity and Respect
The DDD will ensure the organization's policies and procedures, and implementation of these, reflect and reinforce the use of courteous practices towards individuals.

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.

Incident Manager housed in the Regional Offices review each incident report for all reportable incident described in G-1 a. and determine if the report requires follow-up and/or an investigation. All allegations of abuse, neglect, mistreatment, or exploitation are incidents that, by regulation, require an investigation. Other incidents may require an investigation, based on the nature of the incident and action already taken by the provider. All defined incidents must be reported, by the regulations governing certification of providers.

For incidents involving suspected physical abuse/assault, suspected sexual abuse/assault, major injury, AWOL/missing person, natural disaster (if Level of Harm 3 or 4), fire (if Level of Harm 3 or 4), and medication error (Level 3), a qualified ADMH-DDD staff is responsible for completing an investigation. For incidents involving suspected verbal abuse, neglect, self-neglect, mistreatment (emotional/psychological abuse), or exploitation, unless instructed by law enforcement, the ADMH Bureau of Special Investigations, the Department of Human Resources, or the ADMH-DDD, the provider (or ADMH-DDD if the individual is enrolled in self-directed services only) is responsible for investigating. Providers conducting investigations are required to complete ADMH investigation training before conducting internal investigations. Also, all provider findings and evidence are reviewed by ADMH-DDD before an incident is closed. ADMH Advocacy may also participate in investigations.

Investigations include, as applicable:
1. A review of the person-centered service plan of the service recipient and other reported incidents in the past year;
2. A review of the circumstances leading up to and following the incident;
3. Interviews with all witnesses to the incident (employees, service recipients, and community citizens);
4. Interviews with family members or guardians of the service recipient;
5. Interviews with other relevant parties, including provider agency supervisory, management, and health care personnel and the assigned support coordinator for the service recipient;
6. Reports of ADAP related to investigations of incidences that have occurred in group home settings;
7. Reviews of relevant documents and medical records maintained by the service provider, support coordinator, or external health care entities, including hospitals and outpatient medical providers; and,
8. Reviews of law enforcement reports, death certificates, and autopsy reports (as appropriate).

INVESTIGATION TIMEFRAMES
For Comprehensive Mortality Review Reports, when a death occurs, this is due within 15 working days of death. Within five working days after receiving the Comprehensive Mortality Review, will review and take additional action, if needed, and/or close the review. Based on circumstances, this five day period may be extended with written notice to the RCS Director, for example, an autopsy is completed but is not available, or further action is needed but has not yet occurred.

Critical incident General Event Reports (GERs) must be submitted within 24 hours of occurrence in most instances, with some exceptions where 48 hours are given for submission. For incidents requiring investigation, there are 15 working days to complete the investigation and associated report, unless an extension is requested from ADMH-DDD for a valid reason. Next, the ADMH-DDD Regional Incident Review Committee will review submitted reports and make determinations regarding the conclusions and request follow-up if needed. Any recommendations associated with the report are requested from the provider. They have 30 calendar days to submit evidence of remediation. Once this is provided, the evidence is reviewed, and the incident can be “closed.” For the full investigation, review, and remediation activities, there is a timeline of 60 calendar days.

NOTIFICATION OF INVESTIGATION FINDINGS
A basic summary of the conclusion, evidence to support the conclusion, and recommendations for corrective action is provided to the relevant service provider. The responsible provider is required to provide evidence of corrective action to ADMH-DDD. The summary is included in the individual's record and should be available to the individual when requested. This information is also available in Therap, which is accessible to the relevant support coordination agency.

Administrative Code :580-3-23, 580-3-25, 580-3-26, 580-5-30-.10 (5), IPMS, and DD Operational Policies and Procedures: 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).

The Alabama Department of Mental Health, DD Division is responsible for the oversight of the ADMH's Critical Incident Management System.

Alabama Medicaid Agency: annual review of DDDs investigations, certification files containing quality enhancement plans and technical assistance reports, and mortality reviews. Quarterly review of Advocacy's reports.

DDD providers submit reportable incidents to ADMH-DDD Office of Quality Assurance staff, and other appropriate entities through Therap. These incidents are tracked by quality assurance staff, IPMS Managers, from completion to closure. In addition to the above, regional quality assurance specialists conduct a random sample review of incidents monthly and 100% review of all restraint incidents to ensure appropriate information is included and analyzed in critical incidents. The Statewide Incident Coordinator compiles and analyzes data on a monthly and quarterly basis with the assistance of IPMS Managers for each region to identify any problematic trends or patterns. This information is presented in regional monthly IRC meetings. This information is then utilized to inform the agenda and information presented in the Statewide Incident Review Committee, which is led by the Associate Commissioner and includes internal and external stakeholders. This committee identifies patterns and trends that may require systematic intervention at the statewide level. Individual provider and recipient issues identified are managed administratively by quality assurance staff; and systemic educational development and training needs are managed by quality assurance staff

The Alabama Medicaid Agency receives notification within certain timelines based on the severity of the incident from ADMH-DDD's Statewide Incident Coordinator by providing an e-mail to the Alabama Medicaid Agency LTC QA Director. These timeframes are outlined in the IPMS Manual. The ADMH Office of Advocacy may investigate an incident independently, and they submit a summary of findings to ADMH-DDD at least quarterly. ADHR receives notification within certain timelines based on the type of the incident by the responsible provider, which is outlined in the IPMS Manual.

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 (BSPG) describe the procedures referenced as restraint, along with the requirements for monitoring and documenting those procedures. Providers are required to train all staff who must implement restraints in the appropriate application of the procedures. If a person is found to be implementing the restraint incorrectly or outside the boundaries of an individual's Behavior Support Plan (BSP), whoever witnesses the event is obligated to report it & the provider is required to submit an incident report. An investigation regarding the inappropriate use, misuse, or unauthorized use of restraint will be conducted. DDD staff review any instances of this & follows up on the investigation, adding recommendations when necessary to those implemented by the provider to remedy the situation & prevent further occurrence. Any Emergency use of Restraint must be reported via the Incident Prevention & Management System (IPMS) procedures. If 3 of these occur within a 6-month period, the individual's 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 & evaluate whether restraints should be added to the person's BSP. At any time Regional Office staff are conducting their usual monitoring of providers & they witness or become aware that any restraint has been used without authorization, it's reported & investigated. Certification staff routinely reviews the use of any restrictive procedure during surveys to ensure appropriateness & adequate due process.

Every staff person who works with an individual for whom restraints are a part of their BSP must receive specific training regarding how to implement the restraint & under what circumstances the restraint can & cannot be used before they can work with the person. All provider direct support professionals (DSPs), QDDPs, & others implementing services, including professional staff, must receive training in the Management of Aggressive & severe challenging behavior as part of their orientation training as well as annual refreshers. DSPs are required to have some high school education, but a high school diploma or GED is not required. The QDDP must have a minimum of a bachelor's degree & training on the Behavioral Guidelines. It is strongly encouraged for provider agencies that serve individuals who require restraints to either employ or contract with a Board-Certified Behavior Analyst or other certified behavior professional, to allow for more informed decisions regarding the use of such procedures. Qualified behavior professionals are trained in the use of targeted interventions & positive behavior strategies that serve as alternatives to the use of restraint. Emergency use of restraints requires authorization from a QDDP, Program Director, or Physician. DSPs cannot decide to implement a restraint without that authorization. Restraints are considered a method of last resort & must go through due process before being used as a regular part of a persons BSP.

Level 1 & Level 2 interventions:

Level 1 Intervention Requirements

- In general, doesn't require BSP, IDT approval
- Inform Individual of procedure
- Parents/Guardians to receive copy if put in BSP
- Staff to be trained in procedures
- New Plan Annually Level One Intervention Procedures

• Anger Management
• Apology
• Behavior Contracting/Momentum
• Chaining (Forward or Backward)
• Cognitive Rehearsal
• Comfort Statements
• Compliance Training
• Contingent/Continuous Reinforcement
• Desensitization
• Differential Reinforcement (DR)
  - DR High Rates of Behavior (DRH)
  - DR of Alternative Behaviors (DRA)
  - DR of Incompatible Behavior (DRI)
  - DR of Low Rates of Behavior (DRL)
  - DR of Other Behaviors (DRO)

• Discrete Trial Teaching
• Environmental Adaptation
• Escorting
• Extinction
• Fading
• Functional Communication Training
• Hand-Over-Hand
• Incidental Teaching
• Intermittent Reinforcement
• Planned Ignoring
• Positive Reinforcement
• Problem Solving
• Prompts
• Redirection
• Response Blocking/Interruption
• Restoring the Environment
• Role Playing
• Self-Monitoring
• Stimulus Control Training
• Talk Times
• Task Analysis
• Token Reinforcement
• Verbal Prompt to Stop

Level 2 Intervention Requirements:
• BSP
• Staff to be trained in procedures.
• Approval/consent from Individual and his/her IDT, BPRC chair, HRC, Parent/Guardian.
■ New Plan Annually
Level Two Intervention Procedures:
• Contingent Observation
• Escape Extinction
• Extraordinary Blocking
• Negative Reinforcement
• Positive Practice
• Removal
• Reparation of Property/Restitution
• Response Cost
• Restriction of Environmental Access
• Restriction of Mobility
• Satiation
• Search
• Suspension
• Timeout
- Exclusionary
- Non-exclusionary
• Timeout Ribbon
• Transporting

NOTE: Use of ANY restrictive procedure requires a plan for restoration of whatever is restricted – Due Process right This is typically referred to as a Fading Plan – a plan for “fading” the restriction.

Manual Restraints are listed in the behavioral guidelines as a Level 3 procedure in a BSP, which requires approval by the individual & team, the Behavior Program Review Committee (BPRC), & the Human Rights Committee (HRC). Mechanical Restraints are listed in the guidelines as a Level 4 (most restrictive) procedure in a BSP, which requires all of the previously listed reviews/approvals & must also be submitted for approval by ADMH-DDD to the individual's respective Community Services Office via procedures listed below. Reviews by both the BPRC & HRC committees include that they ascertain whether less restrictive procedures have been tried & documented to be ineffective prior to approving restrictive procedures, including restraints.

Per the BSPG, Level 3 Procedures are restrictive and may only be used by direct care professionals when they are included in a BSP. Some of the procedures may be used in emergency situations & are so designated. Emergency use of these procedures requires an order from a QDDP. The use of an Emergency Procedure 3 times in a 6-month period requires the individuals planning team to meet, within 5 working days of the 3rd 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 BPRC, review by the HRC, & approval/consent by the individual or the parent/guardian & must be reviewed & updated at least annually. Of note, Specialized Staffing (i.e., increased staffing supervision) intended to mitigate behavioral risk (not medical) is considered a Level 3 Procedure & must be included in a BSP. Level 4 Procedures are considered the most restrictive & must be included in a BSP (exception is Emergency Mechanical Restraint, which has an IPMS documentation requirement & a limit regarding the number of times it can be used). Level 4 Procedures must receive ADMH-DDD approval prior to use & for continued use. They must be reviewed & approved by submitting RFA to Community Services Regional Office with request to use specific Level 4 procedures (accompanied by the individual's BSP, supporting data, & documentation relevant to the request), in addition to approvals from individual/guardian, IDT, HRC, & full BPRC. Reviews by both the BPRC & HRC committees include that they ascertain whether less restrictive procedures have been tried & documented to have been ineffective prior to approving restrictive procedures, including restraints. Staff must be trained in the used of approved procedures prior to using. The frequency for review & updating of the BSP with Level 4 Procedures will be indicated in the response sent back from the Community Services Regional Office, however a review is required at least annually.

Manual, Mechanical & Chemical Restraints are permitted in emergency situations & as procedures in properly designed & professionally monitored behavior support plans & implemented by trained staff, as follows:
1. Manual: Use of a holding procedure that lasts more than 5 consecutive seconds to control an identified action by restricting the movement or function of the individual's head, neck, torso, one or more limbs, or entire body, holding or disabling a waiver participant's wheelchair or other mobility device. Not included is a method that is routinely used during a medical procedure for persons w/o developmental disabilities.
2. Chemical (psychotropic medication): Administration of a medication, prescribed to modify, control, or alter a specific behavior. Does not include medications prescribed for the treatment of a diagnosed disorder identified in the "Diagnostic & Statistical Manual of Mental Disorders" (5th edition), medications prescribed for treatment of a seizure disorder, or a medication that is routinely prescribed in conjunction with a medical procedure for persons without developmental disabilities. The use of a chemical restraint that is medically contraindicated, that causes pain or harm to a waiver participant, or if used as punishment, retaliation, or for the convenience of staff, is prohibited.
3. Mechanical: Restricting a waiver participant's movement or function by use of a mechanical

restraint device. Approved mechanical restraint devices include arm splints, wrist cuffs, or four-and five-point restraint devices of the quick-release type. Not included is a seatbelt in an ordinary passenger vehicle or an age-appropriate child safety seat, a medically necessary device used for supporting or positioning the individual's body, or a device used during a medical procedure for persons w/o developmental disabilities. Any potential to inhibit or restrict an individual's ability to breathe or that is medically contraindicated, potentially cause pain or harm, or if used as punishment, retaliation, or for the convenience of staff, is prohibited.

Any type of restraint must only be used as a method of last resort and only when necessary to protect the waiver participant or others from injury.

Al. Administrative Code Chapters 580-3-23, 580-3-25, 580-3-26, 580-5-30-.10 (10), Nurse Delegation Program, BSPG, Psychological and Behavioral Service (PBS), IPMS, and DD Operational Policies & Procedures: Positive Services and Supports. DDD will ensure organizations implement policies, procedures, & effective practices that address the positive implementation of services & supports for the individuals they support, focused on the expectation that every individual is capable of learning & growing & every individual has strengths that can be built upon to facilitate the individual’s ability to achieve, not solely pursue, their desired goals & outcomes.

The Person-Centered Plan (PCP), which is monitored by the Regional Support Coordination 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
• Honoring preferences, note the desired future state and what is being done to increase independence and reduce any restrictions, and is monitored by the regional case management liaisons.

Unauthorized use of restraints are primarily detected through provider report. Additional knowledge of unauthorized restraints would be documented in the IPMS system through incident reporting, onsite monitoring or observation, interview of persons served, & through IDT, HRC, & BPRC meeting discussion & supporting documentation. Unauthorized use of restraints may also be documented in the support coordination quarterly report.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Alabama Department of Mental Health
--Division of Developmental Disabilities Central and Regional Offices
-Office of Advocacy Services

Incident Managers conduct daily reviews of General Event Reports (GERS) in the DD Incident Management System, Therap. The Regional Community Services Incident Review Committee conducts weekly meetings to review reportable incidents and make recommendations to community providers regarding quality of services provided.

Moreover, restraint data and other reportable incident data is collected and analyzed on a quarterly basis by Statewide Incident Coordinator and the Office of Quality of Assurance. Multi-Event Summary Reports are generated which outline all reportable incidents that occurred within each quarter. Therap enables aggregation and export of restraint data into an excel spreadsheet. The Statewide Incident Coordinator filters 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 Support Coordination 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 Assurance collects aggregate incident data, including excessive use of restraints from the Statewide and Regional Incident Manager and QES and compiles data for waiver reporting.

The HRC (Human Rights Committee) reviews the frequencies and reasons surrounding the use of restraints. The HRC reviews any restrictions of rights initially and periodically thereafter, but at least annually during the period of restriction.

All restrictions are included in the person-centered plan. The continued need for the restriction is reviewed at least quarterly by the Qualified Developmental Disabilities Professional (QDDP) or more often upon request of the individual whose rights are restricted.

The Statewide Incident Coordinator compiles quarterly reports of all reportable incidents for distribution to the Associate Commissioner for DDD, Director of Community Services, Director of Internal Advocacy, Director of Certification, Director of Quality Assurance, RCS Director, Regional Advocate, and Regional Certification Team member. Data is reviewed and presented in aggregate. The Quality Assurance Office compiles and report all incidents to the DD Sub-Committee Quality Council quarterly. The DD Sub-Committee is responsible for reviewing reportable incident data across the DDD service system to identify trends and patterns and recommend strategies for improving safety of the environment of care in certified community programs.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

Safeguards Concerning the Use of Restrictive Interventions

The behavioral guidelines describe all of the behavioral training and intervention strategies that are approved for use in Alabama. There are four (4) levels of procedures with each successive level indicative of greater restrictiveness, such that Level 1 procedures are not restrictive at all and Level 4 is highly restrictive. Level 2 procedures that are considered to be somewhat restrictive and require reviews by the BPRC chairperson and the HRC include procedures such as: Escape Extinction, Negative Reinforcement, Positive Practice, Reparation of Property or Restitution, Response Cost Restriction of Environmental Access, Restriction of Movement inside or outside facility, Search, and Exclusionary Timeout procedures. Level 3 procedures require review by the entire BPRC and HRC prior to implementation and include: Modification of Clothing to Limit Access to Self, One to One Staffing due to behaviors, Overcorrection, Manual Restraint, Restriction of Personal Property/visitors/phone calls, Use of Psychotropic Medications, and Closed –Door Timeout. Level 4 procedures must be approved by the BPRC, HRC, and submitted to the DPBS for additional approval and more frequent review to ensure effectiveness of the procedure. There are only four procedures listed at this level of intervention: Mechanical Restraint – Programmatic Use, Mechanical Restraint – Emergency Use, Sensory Screening, and Manual Restraints not otherwise specified in Level 3 (these would be modifications of the usual manual holds that may need to occur with a person). ALL of the restrictive procedures must be directly related to a behavioral challenge and the function being served by that behavior. There must also be training and reinforcement to assist the person in developing more appropriate behaviors to replace the one(s) that led to the restriction. Furthermore, there must be a plan for lifting the restriction that is reasonable in terms of the individual being able to achieve the criteria set. Procedures that are prohibited include: Use of aversive stimuli, such as spray mists or bitter tasting liquids contingent upon behaviors occurring and Corporal Punishment of any kind. While there is not a section in the behavior guidelines that lists the procedures as specifically prohibited, they are not allowed by virtue of not being in the procedures listed. Some of the definitions of procedure do refer to the fact that these are not allowed when the acceptable procedures are defined.

Prior to being assigned to a person who has a BSP, each staff person who works with an individual for whom restrictive procedures are a part of their BSP must receive specific training regarding how to implement the procedure and under what circumstances they can and cannot be used. All provider direct support professionals, QDDPs, and others must receive training in the Management of Aggressive and severe Challenging Behavior as part of their orientation training as well as via annual refreshers. Professional staff must also have that kind of training. All individuals must have Person Centered Plan in which the procedures of a BSP must be included and approved by the team and the person and then approved by the BPRC and HRC and, for the most restrictive procedures, by the DPBS. The Division of Developmental Disabilities offers training opportunities to assist service providers develop the skills related to determining the functions of behaviors being exhibited by individuals served and to connect the prevention and intervention strategies to the behavioral functions in order to increase the likelihood of successful outcomes. BSPs require renewal on an annual basis and all of the review/approval groups mentioned above must assess the new plan and determine whether to approve the revised or new plan based upon the data presented from the previous program. Finally, certification staff routinely review personnel files for all necessary and required training.

Due process is defined as providing people supported, and their legally authorized representatives, with a fair process requiring, at least, an opportunity to present objections to the proposed action being contemplated. Due process, including review by a Human Rights Committee, is implemented when it is proposed that a person's rights be restricted for any reason.

Staff are trained in due process procedures including any procedures for placing a limitation or restriction on a person's rights.

A Human Rights Committee (HRC) reviews any restriction of a person's right(s) initially and periodically thereafter, but at least annually, during the period which the restriction is imposed and will document such.

When any restrictions are being proposed for a person, the person is supported to attend and provide input at the HRC meeting in which the proposed restriction is being reviewed.

People supported are provided adequate training in due process procedures including any procedures for

placing a limitation or restriction on a person's rights and training that supports the removal of rights restrictions.

The continued need for the restriction is reviewed at least quarterly by the Qualified Developmental Disabilities Professional (QDDP) 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.

The PCP, which is monitored by the Regional Support Coordination 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
- Honoring preferences, note the desired future state and what is being done to increase independence & reduce any restrictions, d is monitored by the regional case management liaisons.

The Regional Support Coordinator reviews the PCP, which must include documentation of the least restrictive measures that were tried prior to the implementation of the restriction or modification. There are specific questions about HCBS settings rule included in the monitoring tool used by Regional Support Coordination Liaisons to review the PCP. In addition, the HCBS Modification addendum, which is signed by the waiver recipient, guardian (if applicable), support coordinator and provider are reviewed by Regional Support Coordination Liaisons during their review.

Unauthorized use of restraints is primarily detected through provider report. Additional knowledge of unauthorized restraints would be documented in the IPMS system through incident reporting, onsite monitoring or observation, interview of persons served, and through IDT, HRC, and BPRC meeting discussion and supporting documentation. Unauthorized use of restraints may also be documented in the support coordination quarterly report.

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

Incident Managers conduct daily reviews of General Event Reports (GERs) in the DDD Incident Management System, Therap. The Regional Incident Review Committees conduct weekly meetings to review reportable incidents and make recommendations to community providers regarding quality of services provided.

Moreover, restraint data and other reportable incident data is collected and analyzed monthly by the Statewide Incident Coordinator and regional IPMS managers. Reports are generated outlining reportable incidents for each month regionally, which are compiled statewide quarterly. Restraint incidents are included in the monthly reports. Quality Assurance Specialists review 100% of restraint incidents utilizing a Restraint Evaluation Form. This data is also tracked to identify any patterns are trends and is shared monthly with the Office of Psychological and Behavioral Services.

Waiver individuals meeting the threshold of three emergency restraints within a six-month period 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 emergency 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 IPMS Manager.

The Office of Quality Assurance collects aggregate incident data, including excessive use of restraints and compiles data for waiver reporting.

The HRC (Human Rights Committee) reviews the frequencies and reasons surrounding the use of restraints. The HRC reviews any restrictions of rights initially and periodically thereafter, but at least annually during the period of restriction. All restrictions are included in the person-centered plan. The continued need for the restriction is reviewed at least quarterly by the Qualified Developmental Disabilities Professional (QDDP) or more often upon request of the participant whose rights are restricted.

The ADMH-DDD Associate Commissioner will appoint members to a standing committee to review statewide incident data and trends information on a quarterly basis. The committee includes the ADMH-DDD Associate Commissioner, Statewide Incident Management Coordinator, Quality Assurance Director, DD Community Services Director, Psychological & Behavioral Services Director, Provider Certification Director, Support Coordination Director, ADMH Advocacy Program representative, Bureau of Special Investigations representative, ADMH Director of Nurse Delegation, a representative from the Alabama Medicaid Agency, a representative from ADHR, a representative from ADAP, a direct service provider representative, a support coordination agency representative, a person with lived experience, and a family member stakeholder. Other members may be appointed at the discretion of the ADMH-DDD Associate Commissioner. The RCS Directors, Regional Incident Managers, and Quality Assurance Specialists will serve as ad hoc members of this committee and will be asked to participate on an as-needed basis.

4) The Statewide IMC will prepare a data presentation for review by the Committee. This presentation will include:

a) Statewide frequency data and trend graphics for each type of critical incident.

b) Frequency data and trend graphs from each region for each type of critical incident.

c) A summary of trends identified by the regional IPMS managers over the past quarter and a summary of follow-up actions and status of each, and a summary of follow-up actions from each monthly regional data analysis review over the quarter.

d) Data regarding provider non-compliance with incident reporting requirements and responsiveness to requests for GER/GER Resolution corrections. This data is maintained by the Regional Incident Manager.

5) The statewide quarterly review will focus on:

a) Review of critical incident frequency data to identify provider and/or region-specific trends or patterns in the incident data and the impact of follow-up actions taken by regional quality assurance staff.

b) Identification of any statewide trends or patterns that require follow-up beyond follow-up actions

taken by the regional quality assurance staff.

c) Determination of any statewide remedial actions that are necessary to address statewide or region-specific trends and patterns and take appropriate action to address each.

6) For each trend/pattern or recommended remedial action:

a) The ADMH-DDD Associate Commissioner will make assignments for necessary follow-up and establish a response date for each identified action. The response date must allow sufficient time for review of the findings and actions by the Associate Commissioner and Statewide IMC prior to the next quarterly Committee meeting.

b) The Statewide IMC will be responsible for tracking the completion of these assignments within the assigned timeframes.

c) A summary of the findings and actions will be discussed and evaluated as to whether they address and are positively impacting the identified data trend.

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.

In accordance with state law, the Nurse Delegation Program applies only in ADMH residential programs and community extensions, including day habilitation. There is not a Nurse Delegation Program for Self-Directed Services. Participants who self-direct are served exclusively in their own personal residences or in the home of a family member. The waiver does not restrict self-directed employees who are immediate family members and legal liable relative from assisting with medication administration. However, self-directed employees who are not immediate family members or legal liable relative cannot administer medication to participants as a part of their job functions

The Behavioral Services Procedural Guidelines require that, for any person prescribed psychotropic or other medications for purposes of addressing/treating behavioral challenges and/or Psychiatric Symptoms, a Psychotropic Medication Plan be developed for the purpose of ensuring that reductions are considered and implemented whenever possible, based upon presentation of data to the treating Psychiatrist/Doctor. The person's habilitation team provides documentation of behavioral data and reports of psychiatric symptoms (if applicable) at every session with the treating doctor for review. If the criteria set by the team have been met, this information is presented to the doctor and consideration is given to a reduction in medication unless contra-indicated for medical or other extenuating circumstances that should be documented. The medication plan can be a section within the person's BSP. If a person is having "spikes" in their behaviors or in psychiatric symptoms, the provider is required to attempt to determine what factors might account for those peaks and make their findings known to the doctor. They are also required to modify the person's plan if necessary to address the factors leading to the ineffectiveness of the medications. Finally, certification staff routinely review records of individuals receiving Psychotropic Medication for all necessary monitoring and documentation including necessary lab work.

Sometimes individuals have behavioral episodes that result in visits to an ER or an admission to a hospital. This requires that notification be provided to the Regional IPMS Managers and the IPMS procedures are followed in those cases. If it becomes evident that there are problems with medication administration and/or follow-up monitoring and, sometimes, investigations are conducted as outlined in the IPMS. Finally, certification staff routinely review information related to Best Possible Health, Protection for Abuse, Neglect, Mistreatment, and Exploitation, and Safe Environments.

Medication errors are reported electronically through the Therap™ Incident Reporting and Management Solution. Medications are reviewed through the IPMS system, regional and Statewide Incident Coordinator/QA agency participation in the Nurse Delegation Program, and routine certification and "for-cause" 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.

In accordance with state law, the Nurse Delegation Program applies only in ADMH residential programs and community extensions, including day habilitation. There is not a Nurse Delegation Program for Self-Directed Services. Participants who self-direct are served exclusively in their own personal residences or in the home of a family member. The waiver does not restrict self-directed employees who are immediate family members and legal liable relatives from assisting with medication administration. However, self-directed employees who are not immediate family members or legal liable relatives cannot administer medication to participants as a part of their job functions.

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.

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 in ADMH residential programs and community extensions, including day habilitation, programs to a trained direct care staff under a protocol approved by the Board of Nursing.

There is no Nurse Delegation Program for Self-Directed Services. To assist with medication administration, self-directed employees who are immediate family members and legal liable relative are not required to participate in the Nursing Delegation Program. However, self-directed employees who are not immediate family members or legal liable relatives cannot administer medication to participants as a part of their job functions.

Alabama Department of Mental Health:
--Division of Developmental Disabilities
Three teams of professionals, including a medical doctor, a psychiatrist and a behavior analyst are available through the Regional Offices to advise and assist with programs for reducing medications. These teams also provide education to local doctors who sometimes do not know the risk factors and alternatives to combinations of certain medications.
Regional nurses are required to monitor the administration of medication at each site annually. During the monitoring visit, a sample size of 5% of medication administration records are reviewed by the regional nurses to assess provider performance and identify areas of improvement. Data is collected and recommendations are made on the Regional Nursing Monitoring form. Regional nurses schedule follow-up visits to validate implementation of recommended changes. A final copy is forwarded to the Community Services Director and the provider. Incident reports that include medication errors in three categories are required by IPMS and entered into an electronic database where they are tracked at the individual 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 Nurse 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 in ADMH residential programs and community extensions, including day habilitation, programs to a trained direct care staff under a protocol approved by the Board of Nursing.

There is no Nurse Delegation Program for Self-Directed Services. The waiver does not restrict self-directed employees who are immediate family members and legal liable relative from assisting with medication administration. However, self-directed employees who are not immediate family members or legal liable relative cannot administer medication to participants as a part of their job functions.

- **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:
Alabama Department of Mental Health:
--Division of Developmental Disabilities

The Division of Developmental Disabilities provides ongoing reports to the Alabama Board of Nursing. Agency reports to the DDD are included in the DDD reports to the Board of Nursing annually.

(b) Specify the types of medication errors that providers are required to *record:*

A. Medication Error a medication error occurs when a recipient receives an incorrect drug, drug dose, dose form, quantity, route, concentration, or rate of administration. A medication error is also defined as some form of variance of the administration of a drug on a schedule other than intended. Therefore, a missed dose or a dose administered one hour before or after the scheduled time constitutes a medication error.

Severities of medication errors are defined as follows:

A Level 1 medication error is a “monitoring error” and is defined as an incident in which the individual experienced no or minimal adverse consequences and no treatment or intervention other than monitoring or observation is required.
A Level 2 medication error is a “treatment/intervention error” and is defined as an incident in which the individual experienced short-term, reversible adverse consequence(s), and treatment or intervention in addition to monitoring is required.
A Level 3 medication error is a “sentinel event” and is defined as an incident in which the individual experienced life threatening and/or permanent adverse consequence(s).

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 all levels of medication errors to RCS. Level 3 errors must be reported verbally to ADMH-DDD within one hour and must be submitted and approved in Therap within 24 hours. No action follow-up is required by ADMH-DDD 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 of improvement. Data is collected and recommendations are made on the Regional Nursing Monitoring form. Regional nurses schedule follow-up visits to validate implementation of recommended changes. A final copy is forwarded to the Community Services Director and the provider. Immediate family members and legal liable relatives are not required to participate in the nurse delegation program.

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 unexplained death incidents reviewed/investigated within the required timeframe. Percentage = NUMERATOR [Total number of abuse, neglect and exploitation or unexplained death incidents reviewed/investigated within the required timeframe] / DENOMINATOR [Number of abuse, neglect and exploitation or unexplained death incidents]

Data Source (Select one):
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:
 # & % of support coordinators reviewed by certification during the rptg. period who successfully completed an annual refresher training on abuse, neglect, mistreatment, & exploitation. NUM [# of support coordinators who successfully completed an annual refresher training on abuse, neglect, mistreatment, & exploitation] / DEN [# of support coordinators reviewed by...

Data Source (Select one):
Other
If 'Other' is selected, specify:
con't from above... certification during the rptg. period] Certification Reviews

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: 10% of personnel files at each agency reviewed.
	☐ **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 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] / DENOMINATOR [Number of participant records reviewed]

Data Source (Select one):
Other
If 'Other' is selected, specify:
Certification Reviews

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% confidence level 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**	☐ **Annually**

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

Performance Measure:
 # and % of suspected abuse, neglect and exploitation (ANE) incidents and unexpected deaths referred to appropriate investigative entities, e.g., Adult Protective Services, Child Protective Services and/or law enforcement. %= NUM [# of suspected ANE incidents and unexpected deaths referred to appropriate investigative entities,e.g., Adult Protective Services, and/or law enforcement]/ DEN [# of...

Data Source (Select one):
Other
If 'Other' is selected, specify:
cntnd from above...suspected ANE incidents] ADMH-DDD 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**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
 # and % of closed cases of abuse/neglect/exploitation (ANE) for which the OA verified that the investigation conducted by the provider was done in accordance with state policy. %= NUM [# of closed cases investigated by the provider of ANE verified that the investigation was conducted in accordance with state policy]/DEN[# of closed cases of abuse/neglect/exploitation investigated by the provider]

Data Source (Select one):
Other
If 'Other' is selected, specify:
ADMH-DDD Incident Prevention Management System (IPMS)

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 =
☐ **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:
 # & % of service providers rev. by certification during the rptg. period whose employees successfully completed an annual refresher trng. which includes a session on abuse, neglect, mistreatment, & exploitation (ANE). %= NUM [# of service providers rev. by certification during the rptg. period whose employees successfully completed an annu. refresher trng. which includes a session on ANE] / DEN...

Data Source (Select one):
Other
If 'Other' is selected, specify:
con't from above... [# of service providers reviewed by certification during the rptg. period] Certification Reviews

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: 10% of personnel files at each agency reviewed
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
 # and % of critical incident trends for which systemic intervention was implemented that showed sustained improvement after three months, or the state implemented a corresponding revision to the intervention. %= NUM [Total number of critical incident trends where systemic intervention was implemented that showed sustained improvement after three months or the state implemented a corresponding...

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
con't from above...revision to the intervention]/ DEN [# of critical incident trends for which systemic intervention was implemented] ADMH-DDD 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 incidents that have been resolved by the ADMH-DDD within 60 days of the date of the critical incident report date. Percentage = NUMERATOR [Number of critical incidents resolved by the ADMH-DDD within 60 days of the date of the critical incident report date] / DENOMINATOR [Number of reported critical incidents during the 60-day time period of review]

Data Source (Select one):
Other
If 'Other' is selected, specify:
ADMH-DDD 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 [Total number of critical incident trends where systemic intervention was implemented] / DENOMINATOR [Number of critical incident trends]

Data Source (Select one):

Other
If 'Other' is selected, specify:
ADMH-DDD 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**

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:

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:
Number and percent of participant records reviewed that do not identify previously unreported incidents of unauthorized restrictive interventions or seclusion.
Percentage = NUMERATOR [Number of participant records reviewed that did not identify previously unreported incidents of unauthorized restrictive interventions or seclusion] / DENOMINATOR [Number of participant records reviewed]

Data Source (Select one):
Other
If 'Other' is selected, specify:
Certification Reviews

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 restrictive intervention critical incidents where proper procedures were followed. Percentage = NUMERATOR [Number of restrictive intervention critical incidents where proper procedures were followed] / DENOMINATOR [Number of restrictive intervention critical incidents]

Data Source (Select one):
Other
If 'Other' is selected, specify:
ADMH-DDD 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 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):
Other
If 'Other' is selected, specify:
ADMH-DDD 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:
 # & % of emergency restraints that were applied 3 times in a 6 month period for a participant & resulted in a team meeting to consider revision to the participant's BSP as req. by state policy. %= NUM[# of restraints that were applied 3 times in a 6 month period for a participant & resulted in a team meeting to consider revision to the participant's plan as required by state policy]/DEN [# of...

Data Source (Select one):
Other
If 'Other' is selected, specify:
con't from above...restraints that were applied 3 times in a 6 month period for a participant] ADMH-DDD 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:
 # & % of ptcp. records rev. that document trng. & edu. were provided to provider staff on how to identify & addr. health concerns of a ptcp., including any change in a ptcp. status that could jeopardize their health & safety in the community. % =NUM [# of ptcp. records rev. that doc. trng. & edu. were provided to provider stf. on how to id. & addr. concerns of a ptcp., including any change in a...

Data Source (Select one):
Other
If 'Other' is selected, specify:
con't...ptcp. status that could jeopardize their health & safety in the community]/DEN[# of ptcp. records rev.] Certification Reviews Includes corresponding provider training records(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% confidence level 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 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:
NCI

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

		95% with a margin of error of +/-9.8 (NCI)
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of people who responded that their overall health was Good, Very Good, or Excellent. Percentage = NUMERATOR [Number of people who responded that their overall health was Good, Very Good, or Excellent] / DENOMINATOR [Number of surveys containing responses regarding health reviewed]

Data Source (Select one):
Other
If 'Other' is selected, specify:
NCI Survey

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 = 95% confidence level with a margin of error of +/- 9.8
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: Sample size deemed appropriate by NCI.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **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 quarterly basis and reported to the Alabama Medicaid Agency. Trends in data will be addressed as appropriate depending on the results. Remediation by the ADMH-DDD Quality Assurance staff 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 quarterly to the Alabama Medicaid Agency (Medicaid) and data will be reviewed. Data reports will be reviewed via quarterly scheduled meetings with Medicaid LTC QA Director staff/Program Manager(s) and at scheduled quarterly collaborative meetings hosted by Medicaid with State Operating Agencies to discuss data and trends identified by Medicaid. Medicaid 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**

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

Appendix A Medicaid Oversight: Medicaid Agency will trend and analyze and share findings with the Administration of the Operating Agency. The quality assurance and improvement methodology employed by Medicaid staff gathers information from on-site and off-site record reviews and direct observation, as well as, from data forwarded from the operating agency. Weighting and trending of the multiple data elements is achieved with an algorithm designed by the University of Alabama at Birmingham to be used for all the State's HCBS Waiver Programs.

Appendix B Level of Care Evaluations: the Administration of the Operating Agency will jointly consider the findings from the performance measures and determine the necessary actions. Specifically, the Director of Quality Assurance and Director Systems Management will trend and analyze quarterly and annually; the Associate Commissioner will prioritize; and the Director of Quality Assurance will implement the prioritized recommendations with the support of the Director Systems Management. 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 Assurance and the Director of Provider Certification will analyze and trend the information quarterly and annually and share this information with the Quality Improvement Committee. This committee 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 Administration of the Operating Agency will review the information from the monitoring of support coordination agencies and provide quarterly summaries of findings and recommendations. Specifically, the Director of Quality Assurance and the Director of Support Coordination will analyze and trend the information quarterly and annually and share this information with the Quality Improvement Committee. 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 Support Coordination Services will analyze and trend statewide data and also consider and prioritize the recommendations of the Quality Improvement Committee. 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 ADMH-DDD Office of Quality Assurance reviews all incident and investigation reports quarterly and provide summaries and analysis to the Statewide Incident Review Committee. This committee 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 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 Assurance, the Director of Systems Management will provide quarterly summaries and analysis of waiver discovery and remediation indicators. Quality Improvement Strategy data for Health and Welfare, as well as Level of Care, Qualified Providers, Service Planning, and Self-Directed Services will be presented during the same Quality Improvement Committee. This committee 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 requires 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. 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 on-going as data is presented quarterly. The QIS will be updated to track discovery and remediation data as program requirements change. At a minimum, the QIS plan will be reviewed upon CMS three year assurances review and updated upon renewal. All system changes related to the waiver are shared with the Alabama Medicaid Agency prior to implementation.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

All system design changes have a component of evaluation built into the plan before the design change is implemented. For example, the Division implemented a new set of regulatory standards October 1, 2012. DDD continues to review and make modifications of regulatory standards as needed. The Division contracted with the Council on Quality and Leadership (CQL) to align our requirements with their Basic Assurances(c). DDD has again contracted with CQL to work on continued development of a Quality Assurance program, including updating the certification review process in 2024. The change required extensive and ongoing training of community services providers. It included ongoing reports and evaluations by the Department of Mental Health-DDD.

The current direction of system design change is multifaceted. Provider organizations are required to develop and implement an ongoing Quality Improvement System. Providers complete an organizational assessment of their compliance with certification standards. Based on the assessment, they identify priority areas to target for improvement and/or develop monitoring systems to ensure maintenance of compliance. Additionally, the ADMH-DDD utilizes the Quality Improvement Committee to identify improvement opportunities at the statewide level and monitor compliance throughout the services network.

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

ADMH-DDD's Quality Improvement Committee meets on a quarterly basis to receive reports from DDD staff on regarding waiver services, provider certification, individual health and welfare, service planning 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 (Medicaid) serves as the administering agency for this Waiver Program. The operating agency is the Alabama Department of Mental Health. The Medicaid Agency and the Department of Mental Health are both audited externally by the Alabama Department of Examiners of Public Accounts on an annual basis.

All providers are required to secure an independent audit of their financial statements.

The Operating Agency is responsible for initial certification and annual audits of providers. Medicaid's Networks and Quality Assurance Division will take a sample of each type of provider over a rolling three-year period to audit from all Waivers. Data is collected from providers by any of the following sources: reviewing a sample of the waiver Support Coordination records, direct service providers records, consumer satisfaction surveys, and tracking complaints and grievances. Additionally, the person centered plan and data sheets are reviewed and compared against the person centered plan to ensure that services were provided according to the person centered plan.

The audits completed by the OA have a confidence level of at least 95% with a +/- 5% margin of error. Medicaid will choose one provider from each type (roughly about 15 types of providers across all Waivers) each quarter to audit (desk review). Audits do not differ by service or provider.

The results of the audit are provided to the Operating Agency. We do not have a contract with the provider; therefore, it is the responsibility of the OA to credential and provide audit feedback to the provider.

If Medicaid 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, Medicaid 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 person centered plan, or not sufficiently documented, is recouped. Medicaid implemented the following system to ensure services are billed according to the person centered plan 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 individuals. 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, Companion Care, 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 Support Coordinators/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 individual. 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.

For those services not subject to EVV, the post-payment process is no different from those subject to EVV.

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 person centered plan. 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 review and compare the PCP and data sheets 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. Beginning January 1, 2024, the certification review process, in collaboration with the ADMH Office of Finance, will include a methodology for 1) obtaining a sample of participants of a size sufficient to reach the 95% confidence level and +/- 5 percent margin of error, and 2) comparing those sample participants' paid claims from the certification look back period to the onsite documentation in the respective participants' individual record of services that those services were rendered as claimed.

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 participant records that show claims were coded correctly, and paid, only for services that were rendered. Percentage = NUMERATOR [Number of participant records 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

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% confidence level with a margin of error of +/- 5%*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver document. Percentage = NUMERATOR [Number of claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver] / DENOMINATOR [Number of claims paid]

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Claims data

Responsible Party for data collection/generation	***Frequency of data collection/generation***	***Sampling Approach****(check each that applies):*

(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***
	☐ ***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:*

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:
Number and percent of rates that remain consistent with the approved rate methodology throughout the five-year waiver cycle. Percentage = NUMERATOR [Number of rates that remain consistent with the approved rate methodology throughout the five-year waiver cycle]/DENOMINATOR [Number of rates reviewed]

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Claims data

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

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

Data Aggregation and Analysis:

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

Payment rates are determined by the Alabama Department of Mental Health/Division of Developmental Disabilities (Operating Agency - OA) and are reviewed and approved by the Alabama Medicaid Agency, which oversees the rate determination process. Payment made by Medicaid to the waiver providers are on a fee-for-service basis, with the exceptions noted below related primarily to items and services that are manually priced. The Alabama Medicaid Agency solicits public comments on rate determination methods through the public input process for this waiver as described in this application, in Section 6-I – Public Input.

The methodology to ensure that payments are consistent with economy, efficiency, and quality of care and are sufficient to enlist enough providers include the following:

1. Identification of benchmark data, such as Alabama-specific cross-industry wage data from the Bureau of Labor Statistics.

2. Development of rate models that include specific assumptions related to the various costs associated with delivering each service, including direct care worker wages, benefits, and 'productivity' (i.e., billable time); staffing ratios; mileage; facility expenses; and agency program support and administration.

3. A public comment process through which proposed rate models were posted online and emailed.

The rate methodologies listed above are applicable for WY's 1-5 in this renewal.

Rates established are reasonable and customary to ensure continuity of care, quality of care, and continued access to care.

For certain self-directed employee services (personal care, adult companion, and respite) rates vary from provider managed employee rates in the following manner. There is a base wage rate, which is the same for both self-directed and provider managed. ADMH then includes provider-managed administrative costs in that provider rate, which is billed as a waiver service cost. For self-directed, ADMH pays only the base rate as a waiver service, pays self-directed administrative costs to the FMSA separately, and bills this using administrative claiming.

Rates do not vary by provider. Rates do not vary geographically. The rates are posted on the ADMH website at the following link: https://mh.alabama.gov/wp-content/uploads/2024/01/ID-LAH-Waiver-Rates.pdf. Individuals can retrieve additional information about rates, upon request.

Assistive Technology, Environmental Accessibility Adaptations, Individual Goods and Services, Personal Emergency Response System (other than monthly fees), Remote Support (other than technology and back-up supports), and Specialized Medical Supplies are reimbursed based on the cost of the item(s). Each service is subject to an annual maximum as described in Appendix C-1/C-3.

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.

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 the Alabama Medicaid Agency policies. The MMIS then performs audits by validating claims history information against information on the current claim. Audits check for duplicate services, limited services, and related services and compare them to Alabama Medicaid policy to ensure that recipient benefits are paid according to current policies.

Rates established are reasonable and customary to ensure continuity of care, quality of care, and continued access to care. All rates are posted on ADMH's website. Re-evaluation of pricing and rate increases are considered as warranted based upon provider inquiries, problems with service access, and budgetary considerations. In cases where allocations from the state Legislature are received, rates increase are determined by the OA based on provider inquiries, problems

with service access or where services have not been adequately adjusted due to budget constraints.

ADMH link to fee schedule: https://mh.alabama.gov/wp-content/uploads/2024/01/ID-LAH-Waiver-Rates.pdf

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

Each waiver participant, once approved, is added to the Alabama Medicaid's Recipient Level of Care Panel. This file holds approved dates of eligibility for waiver services.

No provider billings for LAH Waiver services are submitted directly to Medicaid. 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 person centered plan. 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 LAH 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.

No provider billings for LAH Waiver services are submitted directly to Medicaid.

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. To be eligible for payment, a service must be first authorized on the Person-Centered Plan (PCP). ADMH has established procedures to ensure that all claims for payment are only made when the following criteria is met: 1. Medicaid Eligibility Verification-the individual must be eligible for Medicaid waiver payment on the date of service which is verified through the Medicaid Management Information System. 2. Service Authorization-All waiver services must be authorized in accordance with the approved PCP. The authorization specifies the type, frequency, and duration of services to be delivered.

All services must be authorized in the individuals' PCP before delivery. Claims are then reviewed to confirm that the billed service matches the authorized service, provider, waiver participant, and the date of service. ADMH providers are required to maintain detailed service records which include but are not limited to: service delivery logs, progress notes, and attendance. ADMH staff along with Support Coordinators conduct periodic reviews of the provider records to verify that documentation support billed claims.

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.

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 Self-directed services subjected to EVV are Personal Care, Adult Companion, Skilled Nursing (RN and LPN), and In-Home-Respite. The employees are required to use EVV for clocking-in and clocking-out. There is not policy for exceptions for EVV.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

- ◉ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ○ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal

funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☒ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

- ◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***
- ○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- ○ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ◉ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

State DMH (Alabama Department of Mental Health) is the operating agency for the LAH waiver. The State agency provide LAH waiver services such as: Day Habilitation, Employment Support, Personal Care, Prevocational Services, Respite Services, Adult Companion Services, Assistive Technology Services, Benefits and Career Counseling, Community Experience, Crisis Intervention, Environmental Accessibility Adaptations, Individual Directed Goods and Services, Occupational Therapy, Personal Emergency Response System, Physical Therapy, Positive Behavior Support, Skilled Nursing, Specialized Medical Supplies, Speech and Language Therapy, and Supported Employment Transportation.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- ◉ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***

○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***

○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***

○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

○ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***

◉ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR § 447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

Providers may reassign payments only to DMH, the operating agency for the LAH 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:

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 (DMH). This is managed through an IGT process in which the Medicaid Agency determines, during each billing cycle, how much non-federal match is needed to reimburse adjudicated claims, and invoices DMH, whereupon DMH transfers these funds to the Medicaid Agency.

For Medicaid payments under this waiver, the source of non-federal match transferred to the Medicaid Agency by the Department of Mental Health, as 100% appropriated by the legislature to the DMH from three tax-based funds: The General Fund; the Education Trust Fund; and the Mental Health Trust Fund.

The Department of Mental Health is adding the use Local Match to the non-federal match payment in this renewal.

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

○ ***Not Applicable***. *There are no local government level sources of funds utilized as the non-federal share.*

◉ ***Applicable***

Check each that applies:

☒ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

For Medicaid payments under this waiver, the source of non-federal match transferred to the Medicaid Agency by the Department of Mental Health, as
100% appropriated by the legislature to the DMH from three tax-based funds: The General Fund; the Education Trust Fund; and the Mental Health Trust Fund.

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***

○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

◉ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***

○ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ○ ***Yes. Per 42 CFR § 441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ ***Nominal deductible***
- ☐ ***Coinsurance***
- ☐ ***Co-Payment***
- ☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- ◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: 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	15140.32	4040.00	19180.32	81538.00	1551.00	83089.00	63908.68
2	14878.94	4161.00	19039.94	83984.00	1597.00	85581.00	66541.06

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)
3	14572.43	4286.00	18858.43	86503.00	1645.00	88148.00	69289.57
4	14199.89	4414.00	18613.89	89098.00	1694.00	90792.00	72178.11
5	14028.06	4547.00	18575.06	91771.00	1745.00	93516.00	74940.94

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	544	544
Year 2	569	569
Year 3	594	594
Year 4	619	619
Year 5	644	644

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

The average length of stay was derived from the most recently filed CMS 372 report for the Home and Community-Based Services Waiver for the period 10/1/2021 through 9/30/2022 (354 days).

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

This information is based on data and utilization trends on the most recent 372 report for reporting period year 2022 (10/01/2021-9/30/2022 date range). Actual changes are unknown due to other waiver program options moving forward.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

This information is based on data and utilization trends on the most recent 372 report for year 2022 (10/01/2021-9/30/2022 date range). Factor D estimates note an increase due to the implementation of a rate increase for WY 4 based on a rate study. Annual trends were estimated based on the most recent 372 report for reporting year 2022 (10/01/2021-9/30/2022). Factor D' is not constant and is estimated to trend overtime.

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 represents the per capita amount based on enrollment and expenditures from the states MMIS for beneficiaries who were residing in ICF/IID for 2018. The Factor G represents ICF institutional costs only. This estimate is trended with a 3% increase per year. The 3% growth trend is based on the CPI unadjusted % change in nursing home costs as of 2018. The state updated factor G in WY4 and WY5 based on the per capita amounts, considering enrollments and expenditures for beneficiaries residing in ICF/IID during FY23. Between 2009 and 2011, the actual Factor G' values were analyzed and trended to project the G' values for the waiver that was approved from 2015 to 2018. This trend was continued at the same rate for the first three years of the waiver. In the fourth and fifth years, the State updated the Factor G' values based on the per capita state plan expenditures for beneficiaries living in ICF/IID during fiscal year 2023.

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' represents the per capita amount based on enrollment and expenditures from the states MMIS for state plan services used by beneficiaries residing in an ICF/IID. This estimate is trended with a 3% increase per year. Actual 372 Factor G' values from 2009 through 2011 were trended to project the G' values for the waiver approved from 2015 through 2018. The trend was continued at the same rate for WYs 1-3 of this waiver. The State then updated Factor G' in WY4 and WY5 based on the per capita state plan expenditures for beneficiaries residing in ICF/IID in FY 23. The 3% growth trend is based on the CPI unadjusted % change in nursing home costs as of 2018.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Day Habilitation	
Employment Support	
Personal Care	
Prevocational Services	
Respite	
Adult Companion Services	
Assistance in Community Integration	
Assistive Technology Services	
Benefits and Career Counseling	
Community Experience	
Crisis Intervention	
Environmental Accessibility Adaptations	
Housing Stabilization Service	
Individual Directed Goods and Services	
Occupational Therapy	
Personal Emergency Response System	
Physical Therapy	

Waiver Services	
Positive Behavior Support	
Remote Supports	
Skilled Nursing	
Specialized Medical Supplies	
Speech and Language Therapy	
Supported Employment Transportation	
Supported Living Service	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						**4037567.59**
Day Habilitation Level 3 w Transport	15 minutes	17	3200.00	4.99	**271456.00**	
Day Habilitation Level 4	15 minutes	3	3003.00	5.89	**53063.01**	
Community Day Habilitation Level 2	15 minutes	17	2672.00	6.19	**281174.56**	
Community Day Habilitation Level 1	15 minutes	17	3532.00	5.41	**324838.04**	
Community Day Habilitation Level 4 w/Transport	15 minutes	2	3859.00	12.61	**97323.98**	
Day Habilitation Level 2 w Transport	15 minutes	42	2786.00	3.97	**464537.64**	
Community Day Habilitation Level 2 w Transport	15 minutes	18	2786.00	7.02	**352038.96**	
Community Day Habilitation Level 4	15 minutes	2	3003.00	11.78	**70750.68**	
Community Day Habilitation Level 3	15 minutes	9	2846.00	7.72	**197740.08**	
Day Habilitation Level 3	15 minutes	18	2846.00	4.59	**235136.52**	
Day Habilitation Level 4 w Transport	15 minutes	4	3859.00	4.85	**74864.60**	
Day Habilitation					**341628.00**	

GRAND TOTAL: 8236333.84

Total Estimated Unduplicated Participants: 544

Factor D (Divide total by number of participants): 15140.32

Average Length of Stay on the Waiver: 354

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Level 1 w Transport	15 minutes	35	3320.00	2.94		
Community Day Habilitation Level 3 w/Transport	15 minutes	7	3200.00	8.55	191520.00	
Community Day Habilitation Level 1 w/ Transport	15 minutes	18	3320.00	6.24	372902.40	
Day Habilitation Level 2	15 minutes	38	2672.00	3.56	361468.16	
Day Habilitation Level 1	15 minutes	39	3532.00	2.52	347124.96	
Employment Support Total:						175520.57
Supported Employment Small Group 1:2-3	15 minutes	7	1244.00	10.27	89431.16	
Supported Employment Small Group 1:4	15 minutes	3	1244.00	5.88	21944.16	
Discovery/Assessment	15 minutes	2	55.00	13.00	1430.00	
Individual Job Developer	15 minutes	2	38.00	13.00	988.00	
Individual Job Coach	15 minutes	13	487.00	9.75	61727.25	
Personal Care Total:						1311015.18
Personal Care on Worksite	15 minutes	4	1820.00	6.00	43680.00	
Self-Directed Personal Care	15 minutes	24	2701.00	6.37	412928.88	
Personal Care Transportation	mile	35	1485.00	0.67	34823.25	
Personal Care	15 minutes	57	2011.00	7.15	819583.05	
Prevocational Services Total:						324923.82
Prevocational Services	hour	17	591.00	15.86	159345.42	
Community Prevocational Services	hour	9	580.00	31.72	165578.40	
Respite Total:						389905.40
Respite Out of Home	15 minutes	24	1644.00	7.15	282110.40	
Respite In Home	15 minutes	5	2084.00	7.15	74503.00	
Respite Self Directed (in home)	15 minutes				33292.00	

GRAND TOTAL: 8236333.84

Total Estimated Unduplicated Participants: 544

Factor D (Divide total by number of participants): 15140.32

Average Length of Stay on the Waiver: 354

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		4	2050.00	4.06		
Adult Companion Services Total:						**162114.00**
Adult Companion	15 minutes	26	1200.00	4.06	**126672.00**	
Adult Companion Self Directed	15 minutes	9	1100.00	3.58	**35442.00**	
Assistance in Community Integration Total:						**0.00**
Assistance in Community Integration	15 minutes	0	0.00	0.01	**0.00**	
Assistive Technology Services Total:						**32233.00**
Assistive Technology	item	15	1.00	1895.00	**28425.00**	
Self-Directed Assistive Technology	item	2	1.00	1904.00	**3808.00**	
Benefits and Career Counseling Total:						**26.00**
Benefits Reporting Service	15 minutes	1	2.00	3.00	**6.00**	
Benefits and Career Counseling	15 minutes	1	2.00	10.00	**20.00**	
Community Experience Total:						**149381.26**
Community Experience 1:4	15 minutes	26	477.00	7.93	**98347.86**	
Community Experience Self Directed	15 minutes	3	868.00	11.85	**30857.40**	
Community Experience 1:1	15 minutes	4	400.00	12.61	**20176.00**	
Crisis Intervention Total:						**51480.00**
Crisis Intervention	15 minutes	5	1100.00	9.36	**51480.00**	
Environmental Accessibility Adaptations Total:						**14100.00**
Environmental Accessibility Adaptations Self-Directed	item	1	1.00	4700.00	**4700.00**	
Environmental Accessibility Adaptations	item	2	1.00	4700.00	**9400.00**	
Housing Stabilization Service Total:						**780.00**
Housing Stabilization					**780.00**	

GRAND TOTAL: 8236333.84

Total Estimated Unduplicated Participants: 544

Factor D (Divide total by number of participants): 15140.32

Average Length of Stay on the Waiver: 354

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Service	15 minutes	6	10.00	13.00		
Individual Directed Goods and Services Total:						**5000.00**
Individual Directed Goods and Services	item	5	1.00	1000.00	**5000.00**	
Occupational Therapy Total:						**2762.76**
Occupational Therapy	15 minutes	3	28.00	18.59	**1561.56**	
Occupational Therapy Self-Directed	15 minutes	3	28.00	14.30	**1201.20**	
Personal Emergency Response System Total:						**14960.00**
Personal Emergency Response System	item	5	1.00	2000.00	**10000.00**	
Personal Emergency Response System Self-Directed	item	2	1.00	2000.00	**4000.00**	
PERS Monthly Fee	monthly	1	12.00	40.00	**480.00**	
PERS Monthly Fee Self-directed	monthly	1	12.00	40.00	**480.00**	
Physical Therapy Total:						**8322.60**
Physical Therapy-Self-Directed	15 minutes	9	30.00	14.30	**3861.00**	
Physical Therapy	15 minutes	8	30.00	18.59	**4461.60**	
Positive Behavior Support Total:						**128700.00**
Positive Behavior Support Level 1 Prof Certified	15 minutes	100	40.00	19.50	**78000.00**	
Positive Behavior Support Level 2 Professional	15 minutes	50	20.00	14.30	**14300.00**	
Positive Behavior Support Level 3 Technician	15 minutes	100	40.00	9.10	**36400.00**	
Remote Supports Total:						**58543.50**
Remote Supports (paid back up)	15 Minutes	57	33.00	3.50	**6583.50**	
Remote Supports Vendor	Per Vendor	72	1.00	250.00	**18000.00**	
Remote Supports Provider	Per Provider	72	1.00	150.00	**10800.00**	
Remote Supports Per Residence	Per Residence	6	1.00	1000.00	**6000.00**	

GRAND TOTAL: 8236333.84

Total Estimated Unduplicated Participants: 544

Factor D (Divide total by number of participants): 15140.32

Average Length of Stay on the Waiver: 354

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Remote Supports Vendor Technology Support	15 Minutes	80	33.00	6.50	17160.00	
Skilled Nursing Total:						501243.60
Home Visit IM Injection	15 minutes	3	64.00	9.10	1747.20	
Self-Directed LPN Nursing	hour	3	1430.00	27.04	116001.60	
RN Nursing	hour	9	371.00	47.32	158001.48	
Self-Directed RN Nursing	hour	3	1477.00	47.32	209674.92	
LPN Nursing	hour	9	65.00	27.04	15818.40	
Specialized Medical Supplies Total:						153600.00
Specialized Medical Supplies Self-Directed	month	62	12.00	200.00	148800.00	
Specialized Medical Supplies	month	2	12.00	200.00	4800.00	
Speech and Language Therapy Total:						3279.36
Speech and Language Therapy	encounter	6	7.00	78.08	3279.36	
Supported Employment Transportation Total:						6834.00
Supported Employment Emergency Transportation mile	mile	4	850.00	0.67	2278.00	
Supported Employment Emergency Transportation- item	item	4	850.00	0.67	2278.00	
Supported Employment Transportation	mile	4	850.00	0.67	2278.00	
Supported Living Service Total:						704041.20
Supported Living Service	monthly	19	12.00	3087.90	704041.20	

GRAND TOTAL: 8236333.84

Total Estimated Unduplicated Participants: 544

Factor D (Divide total by number of participants): 15140.32

Average Length of Stay on the Waiver: 354

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to*

automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
Day Habilitation Total:						***4205021.41***
Day Habilitation Level 3 w Transport	*15 minutes*	*17*	*3200.00*	*4.99*	***271456.00***	
Day Habilitation Level 4	*15 minutes*	*3*	*3003.00*	*5.89*	***53063.01***	
Community Day Habilitation Level 2	*15 minutes*	*18*	*2672.00*	*6.19*	***297714.24***	
Community Day Habilitation Level 1	*15 minutes*	*18*	*3532.00*	*5.41*	***343946.16***	
Community Day Habilitation Level 4 w/Transport	*15 minutes*	*2*	*3859.00*	*12.61*	***97323.98***	
Day Habilitation Level 2 w Transport	*15 minutes*	*44*	*2786.00*	*3.97*	***486658.48***	
Community Day Habilitation Level 2 w Transport	*15 minutes*	*19*	*2786.00*	*7.02*	***371596.68***	
Community Day Habilitation Level 4	*15 minutes*	*2*	*3003.00*	*11.78*	***70750.68***	
Community Day Habilitation Level 3	*15 minutes*	*9*	*2846.00*	*7.72*	***197740.08***	
Day Habilitation Level 3	*15 minutes*	*19*	*2846.00*	*4.59*	***248199.66***	
Day Habilitation Level 4 w Transport	*15 minutes*	*4*	*3859.00*	*4.85*	***74864.60***	
Day Habilitation Level 1 w Transport	*15 minutes*	*37*	*3320.00*	*2.94*	***361149.60***	
Community Day Habilitation Level 3 w/Transport	*15 minutes*	*7*	*3200.00*	*8.55*	***191520.00***	
Community Day Habilitation Level 1 w/ Transport	*15 minutes*	*19*	*3320.00*	*6.24*	***393619.20***	
Day Habilitation Level 2	*15 minutes*	*40*	*2672.00*	*3.56*	***380492.80***	
Day Habilitation Level 1	*15 minutes*	*41*	*3532.00*	*2.52*	***364926.24***	
Employment Support Total:						***175520.57***
Supported Employment Small Group 1:2-3	*15 minutes*	*7*	*1244.00*	*10.27*	***89431.16***	
Supported Employment Small Group 1:4	*15 minutes*	*3*	*1244.00*	*5.88*	***21944.16***	

GRAND TOTAL: 8466118.88

Total Estimated Unduplicated Participants: 569

Factor D (Divide total by number of participants): 14878.94

Average Length of Stay on the Waiver: *354*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Discovery/Assessment	15 minutes	2	55.00	13.00	1430.00	
Individual Job Developer	15 minutes	2	38.00	13.00	988.00	
Individual Job Coach	15 minutes	13	487.00	9.75	61727.25	
Personal Care Total:						1373346.40
Personal Care on Worksite	15 minutes	4	1820.00	6.00	43680.00	
Self-Directed Personal Care	15 minutes	25	2701.00	6.37	430134.25	
Personal Care Transportation	mile	37	1485.00	0.67	36813.15	
Personal Care	15 minutes	60	2011.00	7.15	862719.00	
Prevocational Services Total:						324923.82
Prevocational Services	hour	17	591.00	15.86	159345.42	
Community Prevocational Services	hour	9	580.00	31.72	165578.40	
Respite Total:						389905.40
Respite Out of Home	15 minutes	24	1644.00	7.15	282110.40	
Respite In Home	15 minutes	5	2084.00	7.15	74503.00	
Respite Self Directed (in home)	15 minutes	4	2050.00	4.06	33292.00	
Adult Companion Services Total:						162114.00
Adult Companion	15 minutes	26	1200.00	4.06	126672.00	
Adult Companion Self Directed	15 minutes	9	1100.00	3.58	35442.00	
Assistance in Community Integration Total:						0.00
Assistance in Community Integration	15 minutes	0	0.00	0.01	0.00	
Assistive Technology Services Total:						32233.00
Assistive Technology	item	15	1.00	1895.00	28425.00	
Self-Directed Assistive Technology	item	2	1.00	1904.00	3808.00	

GRAND TOTAL: 8466118.88

Total Estimated Unduplicated Participants: 569

Factor D (Divide total by number of participants): 14878.94

Average Length of Stay on the Waiver: 354

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Benefits and Career Counseling Total:						**26.00**
Benefits Reporting Service	15 minutes	1	2.00	3.00	**6.00**	
Benefits and Career Counseling	15 minutes	1	2.00	10.00	**20.00**	
Community Experience Total:						**149381.26**
Community Experience 1:4	15 minutes	26	477.00	7.93	**98347.86**	
Community Experience Self Directed	15 minutes	3	868.00	11.85	**30857.40**	
Community Experience 1:1	15 minutes	4	400.00	12.61	**20176.00**	
Crisis Intervention Total:						**51480.00**
Crisis Intervention	15 minutes	5	1100.00	9.36	**51480.00**	
Environmental Accessibility Adaptations Total:						**14100.00**
Environmental Accessibility Adaptations Self-Directed	item	1	1.00	4700.00	**4700.00**	
Environmental Accessibility Adaptations	item	2	1.00	4700.00	**9400.00**	
Housing Stabilization Service Total:						**780.00**
Housing Stabilization Service	15 minutes	6	10.00	13.00	**780.00**	
Individual Directed Goods and Services Total:						**5000.00**
Individual Directed Goods and Services	item	5	1.00	1000.00	**5000.00**	
Occupational Therapy Total:						**2762.76**
Occupational Therapy	15 minutes	3	28.00	18.59	**1561.56**	
Occupational Therapy Self-Directed	15 minutes	3	28.00	14.30	**1201.20**	
Personal Emergency Response System Total:						**14960.00**
Personal Emergency Response System	item	5	1.00	2000.00	**10000.00**	
Personal Emergency Response System Self-Directed	item	2	1.00	2000.00	**4000.00**	

GRAND TOTAL: 8466118.88

Total Estimated Unduplicated Participants: 569

Factor D (Divide total by number of participants): 14878.94

Average Length of Stay on the Waiver: 354

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
PERS Monthly Fee	monthly	1	12.00	40.00	480.00	
PERS Monthly Fee Self-directed	monthly	1	12.00	40.00	480.00	
Physical Therapy Total:						8322.60
Physical Therapy-Self-Directed	15 minutes	9	30.00	14.30	3861.00	
Physical Therapy	15 minutes	8	30.00	18.59	4461.60	
Positive Behavior Support Total:						128700.00
Positive Behavior Support Level 1 Prof Certified	15 minutes	100	40.00	19.50	78000.00	
Positive Behavior Support Level 2 Professional	15 minutes	50	20.00	14.30	14300.00	
Positive Behavior Support Level 3 Technician	15 minutes	100	40.00	9.10	36400.00	
Remote Supports Total:						58543.50
Remote Supports (paid back up)	15 minutes	57	33.00	3.50	6583.50	
Remote Supports Vendor	Per Vendor	72	1.00	250.00	18000.00	
Remote Supports Provider	Per Provider	72	1.00	150.00	10800.00	
Remote Supports Per Residence	Per Residence	6	1.00	1000.00	6000.00	
Remote Supports Vendor Technology Support	15 minutes	80	33.00	6.50	17160.00	
Skilled Nursing Total:						501243.60
Home Visit IM Injection	15 minutes	3	64.00	9.10	1747.20	
Self-Directed LPN Nursing	hour	3	1430.00	27.04	116001.60	
RN Nursing	hour	9	371.00	47.32	158001.48	
Self-Directed RN Nursing	hour	3	1477.00	47.32	209674.92	
LPN Nursing	hour	9	65.00	27.04	15818.40	
Specialized Medical Supplies Total:						153600.00
Specialized Medical Supplies Self-Directed	month	62	12.00	200.00	148800.00	

GRAND TOTAL: 8466118.88

Total Estimated Unduplicated Participants: 569

Factor D (Divide total by number of participants): 14878.94

Average Length of Stay on the Waiver: 354

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Supplies	month	2	12.00	200.00	4800.00	
Speech and Language Therapy Total:						3279.36
Speech and Language Therapy	encounter	6	7.00	78.08	3279.36	
Supported Employment Transportation Total:						6834.00
Supported Employment Emergency Transportation mile	mile	4	850.00	0.67	2278.00	
Supported Employment Emergency Transportation- item	item	4	850.00	0.67	2278.00	
Supported Employment Transportation	mile	4	850.00	0.67	2278.00	
Supported Living Service Total:						704041.20
Supported Living Service	monthly	19	12.00	3087.90	704041.20	

GRAND TOTAL: 8466118.88
Total Estimated Unduplicated Participants: 569
Factor D (Divide total by number of participants): 14878.94
Average Length of Stay on the Waiver: 354

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						4349944.70
Day Habilitation Level 3 w Transport	15 minutes	17	3200.00	4.99	271456.00	
Day Habilitation Level 4	15 minutes	3	3003.00	5.89	53063.01	
Community Day Habilitation Level 2	15 minutes	19	2672.00	6.19	314253.92	
Community Day					363054.28	

GRAND TOTAL: 8656022.56
Total Estimated Unduplicated Participants: 594
Factor D (Divide total by number of participants): 14572.43
Average Length of Stay on the Waiver: 354

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Habilitation Level 1	15 minutes	19	3532.00	5.41		
Community Day Habilitation Level 4 w/Transport	15 minutes	2	3859.00	12.61	97323.98	
Day Habilitation Level 2 w Transport	15 minutes	46	2786.00	3.97	508779.32	
Community Day Habilitation Level 2 w Transport	15 minutes	20	2786.00	7.02	391154.40	
Community Day Habilitation Level 4	15 minutes	2	3003.00	11.78	70750.68	
Community Day Habilitation Level 3	15 minutes	9	2846.00	7.72	197740.08	
Day Habilitation Level 3	15 minutes	20	2846.00	4.59	261262.80	
Day Habilitation Level 4 w Transport	15 minutes	3	3859.00	6.31	73050.87	
Day Habilitation Level 1 w Transport	15 minutes	39	3320.00	2.94	380671.20	
Community Day Habilitation Level 3 w/Transport	15 minutes	7	3200.00	8.55	191520.00	
Community Day Habilitation Level 1 w/ Transport	15 minutes	19	3320.00	6.24	393619.20	
Day Habilitation Level 2	15 minutes	42	2672.00	3.56	399517.44	
Day Habilitation Level 1	15 minutes	43	3532.00	2.52	382727.52	
Employment Support Total:						175520.57
Supported Employment Small Group 1:2-3	15 minutes	7	1244.00	10.27	89431.16	
Supported Employment Small Group 1:4	15 minutes	3	1244.00	5.88	21944.16	
Discovery/Assessment	15 minutes	2	55.00	13.00	1430.00	
Individual Job Developer	15 minutes	2	38.00	13.00	988.00	
Individual Job Coach	15 minutes	13	487.00	9.75	61727.25	
Personal Care Total:						1422545.79
Personal Care on Worksite	15 minutes	4	1820.00	6.00	43680.00	
Self-Directed Personal Care	15 minutes	26	2701.00	6.37	447339.62	

GRAND TOTAL: 8656022.56

Total Estimated Unduplicated Participants: 594

Factor D (Divide total by number of participants): 14572.43

Average Length of Stay on the Waiver: 354

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care Transportation	mile	39	1485.00	0.67	38803.05	
Personal Care	15 minutes	62	2011.00	7.16	892723.12	
Prevocational Services Total:						324923.82
Prevocational Services	hour	17	591.00	15.86	159345.42	
Community Prevocational Services	hour	9	580.00	31.72	165578.40	
Respite Total:						389905.40
Respite Out of Home	15 minutes	24	1644.00	7.15	282110.40	
Respite In Home	15 minutes	5	2084.00	7.15	74503.00	
Respite Self Directed (in home)	15 minutes	4	2050.00	4.06	33292.00	
Adult Companion Services Total:						162114.00
Adult Companion	15 minutes	26	1200.00	4.06	126672.00	
Adult Companion Self Directed	15 minutes	9	1100.00	3.58	35442.00	
Assistance in Community Integration Total:						0.00
Assistance in Community Integration	15 minutes	0	0.00	0.01	0.00	
Assistive Technology Services Total:						28443.00
Assistive Technology	item	13	1.00	1895.00	24635.00	
Self-Directed Assistive Technology	item	2	1.00	1904.00	3808.00	
Benefits and Career Counseling Total:						26.00
Benefits Reporting Service	15 minutes	1	2.00	3.00	6.00	
Benefits and Career Counseling	15 minutes	1	2.00	10.00	20.00	
Community Experience Total:						149381.26
Community Experience 1:4	15 minutes	26	477.00	7.93	98347.86	
Community Experience Self Directed	15 minutes	3	868.00	11.85	30857.40	

GRAND TOTAL: 8656022.56

Total Estimated Unduplicated Participants: 594

Factor D (Divide total by number of participants): 14572.43

Average Length of Stay on the Waiver: 354

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Experience 1:1	15 minutes	4	400.00	12.61	20176.00	
Crisis Intervention Total:						51480.00
Crisis Intervention	15 minutes	5	1100.00	9.36	51480.00	
Environmental Accessibility Adaptations Total:						14100.00
Environmental Accessibility Adaptations Self-Directed	item	1	1.00	4700.00	4700.00	
Environmental Accessibility Adaptations	item	2	1.00	4700.00	9400.00	
Housing Stabilization Service Total:						780.00
Housing Stabilization Service	15 minutes	6	10.00	13.00	780.00	
Individual Directed Goods and Services Total:						5000.00
Individual Directed Goods and Services	item	5	1.00	1000.00	5000.00	
Occupational Therapy Total:						2762.76
Occupational Therapy	15 minutes	3	28.00	18.59	1561.56	
Occupational Therapy Self-Directed	15 minutes	3	28.00	14.30	1201.20	
Personal Emergency Response System Total:						14960.00
Personal Emergency Response System	item	5	1.00	2000.00	10000.00	
Personal Emergency Response System Self-Directed	item	2	1.00	2000.00	4000.00	
PERS Monthly Fee	monthly	1	12.00	40.00	480.00	
PERS Monthly Fee Self-directed	monthly	1	12.00	40.00	480.00	
Physical Therapy Total:						7893.60
Physical Therapy-Self-Directed	15 minutes	8	30.00	14.30	3432.00	
Physical Therapy	15 minutes	8	30.00	18.59	4461.60	
Positive Behavior Support Total:						128700.00
Positive Behavior					78000.00	

GRAND TOTAL: 8656022.56

Total Estimated Unduplicated Participants: 594

Factor D (Divide total by number of participants): 14572.43

Average Length of Stay on the Waiver: 354

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Support Level 1 Prof Certified	15 minutes	100	40.00	19.50		
Positive Behavior Support Level 2 Professional	15 minutes	50	20.00	14.30	14300.00	
Positive Behavior Support Level 3 Technician	15 minutes	100	40.00	9.10	36400.00	
Remote Supports Total:						58543.50
Remote Supports (paid back up)	15 minutes	57	33.00	3.50	6583.50	
Remote Supports Vendor	Per Vendor	72	1.00	250.00	18000.00	
Remote Supports Provider	Per Provider	72	1.00	150.00	10800.00	
Remote Supports Per Residence	Per Residence	6	1.00	1000.00	6000.00	
Remote Supports Vendor Technology Support	15 minutes	80	33.00	6.50	17160.00	
Skilled Nursing Total:						501243.60
Home Visit IM Injection	15 minutes	3	64.00	9.10	1747.20	
Self-Directed LPN Nursing	hour	3	1430.00	27.04	116001.60	
RN Nursing	hour	9	371.00	47.32	158001.48	
Self-Directed RN Nursing	hour	3	1477.00	47.32	209674.92	
LPN Nursing	hour	9	65.00	27.04	15818.40	
Specialized Medical Supplies Total:						153600.00
Specialized Medical Supplies Self-Directed	month	62	12.00	200.00	148800.00	
Specialized Medical Supplies	month	2	12.00	200.00	4800.00	
Speech and Language Therapy Total:						3279.36
Speech and Language Therapy	enconter	6	7.00	78.08	3279.36	
Supported Employment Transportation Total:						6834.00
Supported Employment Emergency Transportation mile	mile	4	850.00	0.67	2278.00	
Supported					2278.00	

GRAND TOTAL: 8656022.56

Total Estimated Unduplicated Participants: 594

Factor D (Divide total by number of participants): 14572.43

Average Length of Stay on the Waiver: 354

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Employment Emergency Transportation- item	item	4	850.00	0.67		
Supported Employment Transportation	mile	4	850.00	0.67	2278.00	
Supported Living Service Total:						704041.20
Supported Living Service	monthly	19	12.00	3087.90	704041.20	

GRAND TOTAL: 8656022.56
Total Estimated Unduplicated Participants: 594
Factor D (Divide total by number of participants): 14572.43
Average Length of Stay on the Waiver: 354

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						4496681.72
Day Habilitation Level 3 w Transport	15 minutes	17	3200.00	4.99	271456.00	
Day Habilitation Level 4	15 minutes	3	3003.00	5.89	53063.01	
Community Day Habilitation Level 2	15 minutes	20	2672.00	6.19	330793.60	
Community Day Habilitation Level 1	15 minutes	20	3532.00	5.41	382162.40	
Community Day Habilitation Level 4 w/Transport	15 minutes	2	3859.00	12.61	97323.98	
Day Habilitation Level 2 w Transport	15 minutes	48	2786.00	3.97	530900.16	
Community Day Habilitation Level 2 w Transport	15 minutes	21	2786.00	7.02	410712.12	
Community Day Habilitation Level 4	15 minutes	2	3003.00	11.78	70750.68	
Community Day					197740.08	

GRAND TOTAL: 8789729.33
Total Estimated Unduplicated Participants: 619
Factor D (Divide total by number of participants): 14199.89
Average Length of Stay on the Waiver: 354

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Habilitation Level 3	15 minutes	9	2846.00	7.72		
Day Habilitation Level 3	15 minutes	21	2846.00	4.59	274325.94	
Day Habilitation Level 4 w Transport	15 minutes	3	3859.00	6.31	73050.87	
Day Habilitation Level 1 w Transport	15 minutes	41	3320.00	2.94	400192.80	
Community Day Habilitation Level 3 w/Transport	15 minutes	7	3200.00	8.55	191520.00	
Community Day Habilitation Level 1 w/ Transport	15 minutes	19	3320.00	6.24	393619.20	
Day Habilitation Level 2	15 minutes	44	2672.00	3.56	418542.08	
Day Habilitation Level 1	15 minutes	45	3532.00	2.52	400528.80	
Employment Support Total:						175520.57
Supported Employment Small Group 1:2-3	15 minutes	7	1244.00	10.27	89431.16	
Supported Employment Small Group 1:4	15 minutes	3	1244.00	5.88	21944.16	
Discovery/Assessment	15 minutes	2	55.00	13.00	1430.00	
Individual Job Developer	15 minutes	2	38.00	13.00	988.00	
Individual Job Coach	15 minutes	13	487.00	9.75	61727.25	
Personal Care Total:						1468159.54
Personal Care on Worksite	15 minutes	3	1820.00	7.80	42588.00	
Self-Directed Personal Care	15 minutes	27	2701.00	6.37	464544.99	
Personal Care Transportation	mile	41	1485.00	0.67	40792.95	
Personal Care	15 minutes	64	2011.00	7.15	920233.60	
Prevocational Services Total:						324923.82
Prevocational Services	hour	17	591.00	15.86	159345.42	
Community Prevocational Services	hour	9	580.00	31.72	165578.40	
Respite Total:						389905.40

GRAND TOTAL: 8789729.33

Total Estimated Unduplicated Participants: 619

Factor D (Divide total by number of participants): 14199.89

Average Length of Stay on the Waiver: 354

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Out of Home	15 minutes	24	1644.00	7.15	282110.40	
Respite In Home	15 minutes	5	2084.00	7.15	74503.00	
Respite Self Directed (in home)	15 minutes	4	2050.00	4.06	33292.00	
Adult Companion Services Total:						162114.00
Adult Companion	15 minutes	26	1200.00	4.06	126672.00	
Adult Companion Self Directed	15 minutes	9	1100.00	3.58	35442.00	
Assistance in Community Integration Total:						0.00
Assistance in Community Integration	15 minutes	0	0.00	0.01	0.00	
Assistive Technology Services Total:						28443.00
Assistive Technology	item	13	1.00	1895.00	24635.00	
Self-Directed Assistive Technology	item	2	1.00	1904.00	3808.00	
Benefits and Career Counseling Total:						26.00
Benefits Reporting Service	15 minutes	1	2.00	3.00	6.00	
Benefits and Career Counseling	15 minutes	1	2.00	10.00	20.00	
Community Experience Total:						149381.26
Community Experience 1:4	15 minutes	26	477.00	7.93	98347.86	
Community Experience Self Directed	15 minutes	3	868.00	11.85	30857.40	
Community Experience 1:1	15 minutes	4	400.00	12.61	20176.00	
Crisis Intervention Total:						41184.00
Crisis Intervention	15 minutes	4	1100.00	9.36	41184.00	
Environmental Accessibility Adaptations Total:						14100.00
Environmental Accessibility Adaptations Self-Directed	item	1	1.00	4700.00	4700.00	

GRAND TOTAL: 8789729.33

Total Estimated Unduplicated Participants: 619

Factor D (Divide total by number of participants): 14199.89

Average Length of Stay on the Waiver: 354

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Accessibility Adaptations	item	2	1.00	4700.00	9400.00	
Housing Stabilization Service Total:						650.00
Housing Stabilization Service	15 minutes	5	10.00	13.00	650.00	
Individual Directed Goods and Services Total:						4000.00
Individual Directed Goods and Services	item	4	1.00	1000.00	4000.00	
Occupational Therapy Total:						2762.76
Occupational Therapy	15 minutes	3	28.00	18.59	1561.56	
Occupational Therapy Self-Directed	15 minutes	3	28.00	14.30	1201.20	
Personal Emergency Response System Total:						4960.00
Personal Emergency Response System	item	1	1.00	2000.00	2000.00	
Personal Emergency Response System Self-Directed	item	1	1.00	2000.00	2000.00	
PERS Monthly Fee	monthly	1	12.00	40.00	480.00	
PERS Monthly Fee Self-directed	monthly	1	12.00	40.00	480.00	
Physical Therapy Total:						7893.60
Physical Therapy-Self-Directed	15 minutes	8	30.00	14.30	3432.00	
Physical Therapy	15 minutes	8	30.00	18.59	4461.60	
Positive Behavior Support Total:						110682.00
Positive Behavior Support Level 1 Prof Certified	15 minutes	86	40.00	19.50	67080.00	
Positive Behavior Support Level 2 Professional	15 minutes	43	20.00	14.30	12298.00	
Positive Behavior Support Level 3 Technician	15 minutes	86	40.00	9.10	31304.00	
Remote Supports Total:						58543.50
Remote Supports (paid back up)	15 minutes	57	33.00	3.50	6583.50	
Remote Supports Vendor					18000.00	

GRAND TOTAL: 8789729.33

Total Estimated Unduplicated Participants: 619

Factor D (Divide total by number of participants): 14199.89

Average Length of Stay on the Waiver: 354

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Per Vendor	72	1.00	250.00		
Remote Supports Provider	Per Provider	72	1.00	150.00	10800.00	
Remote Supports Per Residence	Per Residence	6	1.00	1000.00	6000.00	
Remote Supports Vendor Technology Support	15 minutes	80	33.00	6.50	17160.00	
Skilled Nursing Total:						501243.60
Home Visit IM Injection	15 minutes	3	64.00	9.10	1747.20	
Self-Directed LPN Nursing	hour	3	1430.00	27.04	116001.60	
RN Nursing	hour	9	371.00	47.32	158001.48	
Self-Directed RN Nursing	hour	3	1477.00	47.32	209674.92	
LPN Nursing	hour	9	65.00	27.04	15818.40	
Specialized Medical Supplies Total:						134400.00
Specialized Medical Supplies Self-Directed	month	54	12.00	200.00	129600.00	
Specialized Medical Supplies	month	2	12.00	200.00	4800.00	
Speech and Language Therapy Total:						3279.36
Speech and Language Therapy	encounter	6	7.00	78.08	3279.36	
Supported Employment Transportation Total:						6834.00
Supported Employment Emergency Transportation mile	mile	4	850.00	0.67	2278.00	
Supported Employment Emergency Transportation- item	item	4	850.00	0.67	2278.00	
Supported Employment Transportation	mile	4	850.00	0.67	2278.00	
Supported Living Service Total:						704041.20
Supported Living Service	monthly	19	12.00	3087.90	704041.20	

GRAND TOTAL: 8789729.33

Total Estimated Unduplicated Participants: 619

Factor D (Divide total by number of participants): 14199.89

Average Length of Stay on the Waiver: 354

Appendix J: Cost Neutrality Demonstration

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
Day Habilitation Total:						***4607770.94***
Day Habilitation Level 3 w Transport	*15 minutes*	*17*	*3200.00*	*4.99*	***271456.00***	
Day Habilitation Level 4	*15 minutes*	*3*	*3003.00*	*5.89*	***53063.01***	
Community Day Habilitation Level 2	*15 minutes*	*20*	*2672.00*	*6.19*	***330793.60***	
Community Day Habilitation Level 1	*15 minutes*	*20*	*3532.00*	*5.41*	***382162.40***	
Community Day Habilitation Level 4 w/Transport	*15 minutes*	*2*	*3859.00*	*12.61*	***97323.98***	
Day Habilitation Level 2 w Transport	*15 minutes*	*50*	*2786.00*	*3.97*	***553021.00***	
Community Day Habilitation Level 2 w Transport	*15 minutes*	*22*	*2786.00*	*7.02*	***430269.84***	
Community Day Habilitation Level 4	*15 minutes*	*2*	*3003.00*	*11.78*	***70750.68***	
Community Day Habilitation Level 3	*15 minutes*	*9*	*2846.00*	*7.72*	***197740.08***	
Day Habilitation Level 3	*15 minutes*	*22*	*2846.00*	*4.59*	***287389.08***	
Day Habilitation Level 4 w Transport	*15 minutes*	*3*	*3859.00*	*6.31*	***73050.87***	
Day Habilitation Level 1 w Transport	*15 minutes*	*43*	*3320.00*	*2.94*	***419714.40***	
Community Day Habilitation Level 3 w/Transport	*15 minutes*	*7*	*3200.00*	*8.55*	***191520.00***	
Community Day Habilitation Level 1 w/ Transport	*15 minutes*	*19*	*3320.00*	*6.24*	***393619.20***	
Day Habilitation Level 2	*15 minutes*	*46*	*2672.00*	*3.56*	***437566.72***	
Day Habilitation Level 1	*15 minutes*	*47*	*3532.00*	*2.52*	***418330.08***	

GRAND TOTAL: 9034069.42

Total Estimated Unduplicated Participants: 644

Factor D (Divide total by number of participants): 14028.06

Average Length of Stay on the Waiver: *354*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Employment Support Total:						**175520.57**
Supported Employment Small Group 1:2-3	15 minutes	7	1244.00	10.27	**89431.16**	
Supported Employment Small Group 1:4	15 minutes	3	1244.00	5.88	**21944.16**	
Discovery/Assessment	15 minutes	2	55.00	13.00	**1430.00**	
Individual Job Developer	15 minutes	2	38.00	13.00	**988.00**	
Individual Job Coach	15 minutes	13	487.00	9.75	**61727.25**	
Personal Care Total:						**1538547.41**
Personal Care on Worksite	15 minutes	4	1820.00	6.00	**43680.00**	
Self-Directed Personal Care	15 minutes	28	2701.00	6.37	**481750.36**	
Personal Care Transportation	mile	50	1485.00	0.67	**49747.50**	
Personal Care	15 minutes	67	2011.00	7.15	**963369.55**	
Prevocational Services Total:						**324923.82**
Prevocational Services	hour	17	591.00	15.86	**159345.42**	
Community Prevocational Services	hour	9	580.00	31.72	**165578.40**	
Respite Total:						**389905.40**
Respite Out of Home	15 minutes	24	1644.00	7.15	**282110.40**	
Respite In Home	15 minutes	5	2084.00	7.15	**74503.00**	
Respite Self Directed (in home)	15 minutes	4	2050.00	4.06	**33292.00**	
Adult Companion Services Total:						**162114.00**
Adult Companion	15 minutes	26	1200.00	4.06	**126672.00**	
Adult Companion Self Directed	15 minutes	9	1100.00	3.58	**35442.00**	
Assistance in Community Integration Total:						**0.00**
Assistance in Community	15 minutes	0	0.00	0.01	**0.00**	

GRAND TOTAL: 9034069.42

Total Estimated Unduplicated Participants: 644

Factor D (Divide total by number of participants): 14028.06

Average Length of Stay on the Waiver: 354

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Integration						
Assistive Technology Services Total:						**32233.00**
Assistive Technology	item	15	1.00	1895.00	**28425.00**	
Self-Directed Assistive Technology	item	2	1.00	1904.00	**3808.00**	
Benefits and Career Counseling Total:						**26.00**
Benefits Reporting Service	15 minutes	1	2.00	3.00	**6.00**	
Benefits and Career Counseling	15 minutes	1	2.00	10.00	**20.00**	
Community Experience Total:						**149381.26**
Community Experience 1:4	15 minutes	26	477.00	7.93	**98347.86**	
Community Experience Self Directed	15 minutes	3	868.00	11.85	**30857.40**	
Community Experience 1:1	15 minutes	4	400.00	12.61	**20176.00**	
Crisis Intervention Total:						**51480.00**
Crisis Intervention	15 minutes	5	1100.00	9.36	**51480.00**	
Environmental Accessibility Adaptations Total:						**14100.00**
Environmental Accessibility Adaptations Self-Directed	item	1	1.00	4700.00	**4700.00**	
Environmental Accessibility Adaptations	item	2	1.00	4700.00	**9400.00**	
Housing Stabilization Service Total:						**780.00**
Housing Stabilization Service	15 minutes	6	10.00	13.00	**780.00**	
Individual Directed Goods and Services Total:						**5000.00**
Individual Directed Goods and Services	item	5	1.00	1000.00	**5000.00**	
Occupational Therapy Total:						**2762.76**
Occupational Therapy	15 minutes	3	28.00	18.59	**1561.56**	
Occupational Therapy Self-	15 minutes	3	28.00	14.30	**1201.20**	

GRAND TOTAL: 9034069.42

Total Estimated Unduplicated Participants: 644

Factor D (Divide total by number of participants): 14028.06

Average Length of Stay on the Waiver: 354

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Directed						
Personal Emergency Response System Total:						**14960.00**
Personal Emergency Response System	item	5	1.00	2000.00	**10000.00**	
Personal Emergency Response System Self-Directed	item	2	1.00	2000.00	**4000.00**	
PERS Monthly Fee	monthly	1	12.00	40.00	**480.00**	
PERS Monthly Fee Self-directed	monthly	1	12.00	40.00	**480.00**	
Physical Therapy Total:						**8322.60**
Physical Therapy-Self-Directed	15 minutes	9	30.00	14.30	**3861.00**	
Physical Therapy	15 minutes	8	30.00	18.59	**4461.60**	
Positive Behavior Support Total:						**128700.00**
Positive Behavior Support Level 1 Prof Certified	15 minutes	100	40.00	19.50	**78000.00**	
Positive Behavior Support Level 2 Professional	15 minutes	50	20.00	14.30	**14300.00**	
Positive Behavior Support Level 3 Technician	15 minutes	100	40.00	9.10	**36400.00**	
Remote Supports Total:						**58543.50**
Remote Supports (paid back up)	15 Minutes	57	33.00	3.50	**6583.50**	
Remote Supports Vendor	Per Vendor	72	1.00	250.00	**18000.00**	
Remote Supports Provider	Per Provider	72	1.00	150.00	**10800.00**	
Remote Supports Per Residence	Per Residence	6	1.00	1000.00	**6000.00**	
Remote Supports Vendor Technology Support	15 Minutes	80	33.00	6.50	**17160.00**	
Skilled Nursing Total:						**501243.60**
Home Visit IM Injection	15 minutes	3	64.00	9.10	**1747.20**	
Self-Directed LPN Nursing	hour	3	1430.00	27.04	**116001.60**	
RN Nursing	hour	9	371.00	47.32	**158001.48**	
Self-Directed RN					**209674.92**	

GRAND TOTAL: 9034069.42

Total Estimated Unduplicated Participants: 644

Factor D (Divide total by number of participants): 14028.06

Average Length of Stay on the Waiver: 354

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Nursing	hour	3	1477.00	47.32		
LPN Nursing	hour	9	65.00	27.04	15818.40	
Specialized Medical Supplies Total:						153600.00
Specialized Medical Supplies Self-Directed	month	62	12.00	200.00	148800.00	
Specialized Medical Supplies	month	2	12.00	200.00	4800.00	
Speech and Language Therapy Total:						3279.36
Speech and Language Therapy	encounter	6	7.00	78.08	3279.36	
Supported Employment Transportation Total:						6834.00
Supported Employment Emergency Transportation mile	mile	4	850.00	0.67	2278.00	
Supported Employment Emergency Transportation- item	item	4	850.00	0.67	2278.00	
Supported Employment Transportation	mile	4	850.00	0.67	2278.00	
Supported Living Service Total:						704041.20
Supported Living Service	monthly	19	12.00	3087.90	704041.20	

GRAND TOTAL: 9034069.42

Total Estimated Unduplicated Participants: 644

Factor D (Divide total by number of participants): 14028.06

Average Length of Stay on the Waiver: 354